STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968608	**01/25/2018**
NAME OF PROVIDER OR SUPPLIER **FLORIDIAN GARDENS ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **17250 SW 137 AVENUE MIAMI, FL 33177**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

A Standard Biennial Survey was conducted on through . Floridian Gardens with Limited mental health , Limited Nursing and Extended Congregate Care services (AL 12489) had the following deficiencies identified at the time of the visit:

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observation, record review and interview the facility failed to ensure the appropriateness of continued residency for 1 out of 25 sampled residents (Resident #8).

Findings:

On at 9:15 a.m., observed Staff F feeding Resident #8, who was lying in bed.

On at 9:15 a.m. Staff F stated Resident #8 was not ambulatory and she had to bathe the resident and change her adult briefs in bed. She stated that resident had to be lifted by two staff to be transferred, and that resident could not stand up with assistance. Staff said that she fed the resident only at breakfast time to guarantee that the resident eats all the breakfast ,but she is capable of eat by herself the lunch and the dinner.

Record review showed the assessment of Resident #8 dated stated resident needed supervision with eating and assistance with ambulation, bathing, dressing, and toileting. Further record review showed no documentation that the resident was under hospice care.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, record review, and interview, the facility failed to honor resident's rights by not following physicians order to place full bed rails to prevent for 1 out of 24 sampled residents (Resident #14).

Findings Included:

On at 9:20 AM During Facility tour observed Resident #14 with half bed rails placed on bed.

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SUMMARY STATEMENT OF DEFICIENCIES
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A review of Resident #14's hospice record plan of care dated showed the resident had a full bed rail order by healthcare provider.

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation, record review and interview, the Assisted Living Facility failed to ensure that staff member read the medicines' name to residents when assisting with self-administration of medication for one out of 25 sampled residents (#9).

Findings included:

Observation on at 9:45 AM revealed Staff F unlocked the medication cart and took medicines bottles for Resident #9. There were nine bottles. At 9:47 AM that Staff put medicines in the little white disposable cup. Staff put some water in the cup, locked the medicine cart and went inside . At 9:48 AM Staff stated, "tus medicinas, no mas agua?" (your medicines, no more water?). At 9:49 AM Staff F initialed Medication Observation Record (MOR).
Reconciliation of Resident #9's medicines revealed that medications were:
- 5 mg tablet- take one tablet by mouth daily
- 88 mg mcg tablet- take one tablet by mouth daily
- 1 mg tablet- take one tablet by mouth daily
- 100 mg ER capsule- take one capsule by mouth three times a day
- 40 mg tablet- take one tablet by mouth daily
- 600 mg + D
-
- B- with
- 25 mg tablet- tablet by mouth daily

Review of Resident #9's MORs revealed that the following medicines were scheduled at 9 AM:
- 5 mg tablet- take one tablet by mouth daily
- 88 mg mcg tablet- take one tablet by mouth daily
- 1 mg tablet- take one tablet by mouth daily
- 100 mg ER capsule- take one capsule by mouth three times a day
- 40 mg tablet- take one tablet by mouth daily
- 600 mg + D - take one capsule by mouth once daily
- - take one capsule by mouth one time daily

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

- B- , with - take one capsule by mouth once daily
- 25 mg tablet- tablet by mouth daily

In an interview on at 9:55 AM Staff stated, "I tell them to residents who are more alert. I understand I should tell them. The majority of them are not alert."

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record review and interview, the Assisted Living Facility failed to have Medication Observation Records (MORs) that showed residents' health care provider name and the health care provider's telephone number for one out of 25 sampled residents (Resident #9) .

Findings included:

Review of Resident #9's MORs revealed that resident' health care provider name and the health care provider's telephone number was blank.

In an interview on at 2:02 PM Staff H stated, "Resident #9's MORs were hand written by the facility because the clinic did not send the MORs."

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview, the facility failed to keep prescribed medication for 2 of 8 sampled residents in a secure place that is out of sight of other residents (Resident 11 and 14).

Findings included:

On between 9:20 am and 9:54 am during the facility tour, observed prescribed medications for Resident 14, HFA 108 including hand written statement "Please return med to , spec after dose, has already lost the 1st", and Robafen- Syrup on top of cabinet at resident's . Observed prescribed medication for Resident 11, on top of cabinet at resident's .

When asked about why the medications were not locked, Staff D stated on , 2018 around 3:00 pm, "Ok, we'll check."

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SUMMARY STATEMENT OF DEFICIENCIES
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Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on record review and interview, the Assisted Living Facility failed to ensure that Staff followed doctor order for two out of 25 sampled residents (#18 and #25).

Findings included:

Review of Resident #18's Medication Observation Records (MORs) revealed that there was a doctor's order for , 325 mg (take one tablet my mouth every 8 hours). It was scheduled at 9 AM, 3 PM and 9 PM. Medicine signed at 9 AM, 3 PM, and 9 PM every single dose during .

Review of Resident #25's MORs revealed that there was a a doctor's order for 50 mg take one tablet my mouth every 8 hours. It was scheduled at 9 AM, 3 PM and 9 PM. Medicine signed at 9 AM, 3 PM, and 9 PM every single dose during .

In an interview on at 1:58 PM Staff H stated, "Resident #25 goes bed early and is for pain, if not we have to wake up the resident." At 2 PM stated in reference to Resident #18 "we adjust them to don't break the sleep hours.

In an interview on at 2 PM Staff F stated, "Yes, those are the hours give the medicines."

Class III

0057 - Medication - Over The Counter (OTC) Products - 58A-5.0185(8) FAC

Based on observation and interview, the Assisted Living Facility failed to ensure that over the counter products were label with residents' name for one out of 25 sampled residents (#9).

Findings included:

Observation on at 9:45 AM revealed Staff F unlocked med cart and took medicines bottles for Resident #9; there were nine bottles. At 9:47 AM that Staff put medicines in the little white disposable cup. Staff put some water in the cup, locked the medicine cart and went inside . At 9:48 AM Staff stated, "tus medicinas, no mas agua?" (your medicines, no more water?). At 9:49 AM Staff F initialed Medication Observation Record (MOR).

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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Reconciliation of Resident #9's medicines revealed that over the counter products were:
- 600 mg + D
-
- B- , with

Review of Resident #9's MORs revealed that the following medicines were scheduled at 9 AM:
- 600 mg + D - take one capsule by mouth once daily
- - take one capsule by mouth one time daily
- B- , with - take one capsule by mouth once daily

In an interview on at 2:05 PM Staff H revealed that those medicines came like that from the clinic.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record reviews and interview, the facility failed to provide a negative statement on an annual basis for 3 of 8 sampled employee records (Staff A,B,G). The facility failed to verify that the signature provided on the written statement for communicable for 1 of 8 sampled employees, (Staff G) was from a licensed health care provided.

Findings included:

Record review for Staff A showed a statement dated 11/ , for Staff B showed a statement dated and for Staff G showed a statement dated .

Staff D stated on , 2018 around 1:30 pm, "We will check our records".

Record review for Staff G showed a signature without a title.

Staff P stated, "I verified with upper managers and the signature is from a registered nurse."

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968608	01/25/2018
NAME OF PROVIDER OR SUPPLIER **FLORIDIAN GARDENS ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **17250 SW 137 AVENUE MIAMI, FL 33177**	

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0085 - Training - Nutrition & Food Service - 58A-5.0191(6) FAC

Based on observation, record review and interview, the facility failed to have the person designated by the administrator as responsible for the facility ' s food service (Staff K) trained annually in a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility.

Findings:

On and Staff K was observed in the facility's kitchen preparing food.

Staff record review showed the facility had no the Nutrition and food service continuing education training for Staff K. The last Staff K Nutrition training documented in records was dated 11/

On at 3:00 p.m. the administrator acknowledged the facility's chef's (Staff K) updated Nutrition training was not in records.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on record review and interview, the facility failed to maintain a completed employment application for 1 of 8 sampled employees (Staff I).

Findings included:

Record review for Staff I showed that no references were listed on the employment application .

Staff D stated on , 2018 around 1:30 pm, "I'll check to make sure it is completed."

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on observation, record review and interview the facility failed to have an accurate consent for the use of bedrails for 1 out of 25 residents (Resident #18). The facility also failed to ensure that the health assessment was accurate for one of 25 residents (Resident #24).

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NAME OF PROVIDER OR SUPPLIER **FLORIDIAN GARDENS ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **17250 SW 137 AVENUE** **MIAMI, FL 33177**	

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Findings:

On at 9:20 a.m. Resident #18 was observed in bed with full bedrails attached to his bed.

Record review showed Resident #18 signed a consent for the use of half bedrails on .
Record review also showed resident had a prescription for the use of full bedrails.

On at 3:00 p.m. the Administrator stated Resident #18 used half bedrails before being a Hospice resident. She stated they forgot to sign a new consent for the use of full bedrails.

Review of Resident #24's record revealed that health assessment (AHCA form 1823) completed on showed Resident needed total care for bathing.

In an interview on at 1:26 PM Assistance Administrator revealed that resident did not receive hospice services. Resident just received help for bathing.
Class III

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Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on record review and interview the facility failed to provide documentation of a current Level II background screening for 1 out of 24 sampled staff, (Staff K). Staff K had a break in service of more than 90 days without obtaining a new background screening.

Findings include:

A review of Staff K's employee file showed the resident was hired on and the last background screening on file was dated . A review of Staff K's employment application showed the staff worked as a production operator from to .

On at 3:28 PM interview with Staff M stated "Staff K was out of state and she worked as a production operator during that time."

Unclassified

Z821 - Reporting Requirements; Electronic Submission - 59A-35.110 FAC

Based on observation, record review and interview the facility failed to report to the agency within 21 days of the change of administrator together with all the information required.

Findings as follow:

On at 9:00 a.m. Staff D presented herself as the administrator.

Review of the facility finder database on at 1:00 p.m. and at 12:20 p.m. showed Staff D was not listed as the administrator.

Record review showed the facility submitted a change of administrator form on .

On at 1:00 p.m. the Administrator acknowledged she received an email from Tallahassee stating that the Change of administrator application was incomplete by missing her high school diploma. She stated that had not sent the document yet and proceeded to send it.

Unclassified

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