STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910961	05/21/2018
NAME OF PROVIDER OR SUPPLIER **SOUTH HIALEAH MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **240 EAST 5TH STREET** **HIALEAH, FL 33010**	

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

0000 - Initial Comments

A Standard Biennial Survey was conducted on , , 2018 and concluded on , , 2018. South Hialeah Manor (License #6033) with Limited Mental Health component had the following deficiencies identified at time of the survey:

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review and interview the facility failed to have a written documentation that one out of six sampled residents (Resident #2) was admitted to the hospital and had an amputation.

Findings included:

During an interview on at 8:35 AM Resident #2 stated, "I went to the hospital. When I got back from the hospital, they checked my toes every day to make sure it was not . My toe was , and they have to remove it. That has nothing to do with . I guess my toe was rubbing in my shoes. Every time I was taking a shower, my toe was hurting, I told them but they did not take it seriously. I had an annual examination for my feet, they noticed that my toe was . Then, they got me a , . The bone was slightly in the surface. The bone was showing. The , had an investigation and told me that the toes needed to be removed. They called an ambulance and took me to the hospital. The podiatrist removed the toe three to four days after I have been to the hospital. I came back here after a week. On , , the podiatrist removed the stitches and stated that it has been successful. Now, I am moving normally. I cannot even feel that I am missing a toe. Before, I couldn't because the toe was painful. That happened about 4-5 months ago. My toe started hurting when I got here."

Hospital records for Resident #2 dated stated, "Patient states the started 6 months ago and has progressively been getting worse over the next 4 months." Progress Note -Assessment: Left foot , left foot ." On Resident #2 procedure performed 1. Amputation of second digit 2. Second partial .

The facility's observation log documented on at 8 PM, staff reported that resident had a reddened area missing skin on his left foot second toe. Podiatrist came to the facility to see resident. It was decided to send to hospital. Podiatrist also stated upon return he will be fitted for shoe because his shoes are not appropriate. Attending physician and his daughter were advised of his admission. The facility did not document that Resident #2's toe was amputated.

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Review of Resident #2's health assessment (dated) showed diagnoses of , , , , , and , . Resident #2 required supervision with activities of daily living. This health assessment did not document that Resident #2 was . Resident #2's previous health assessment dated had a medical history and diagnoses of type 1 ( ). Resident #2's home health record revealed the resident received daily.

On at 1:10 PM Staff H reported during an interview, "Resident #2 came from another assisted living facility to here. He has been here for about eight months. He needs assistance and is not alert. He never complains. I am a certified nurse assistant (CNA) and I know that he needed to be checked out. It is part of our training to check the patient's body from head to toe. However, I am not always the one who is assigned to this resident. I gave him a shower and I noticed the foot had something and needed to be checked. Then, I took a picture and showed it to my supervisor Staff O. I told Staff O that Resident #2 needed assistance immediately. I do not have the picture because the supervisor told me to delete it because I did not need it. I think I did everything correctly. I really feel sorry for what happened to him. I did everything I had to do in my power."

On at 11:11 AM Podiatrist stated, "I saw him at the facility for routine foot care. Two weeks later he had and redness on toe. I saw him and he had an bone exposure. I had them send him to the hospital."

Class III

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

Based on observations and interview the facility failed to honor residents rights for privacy by failing to knock on the doors before entering each residents .

Finding included:

Observations made on at 9:15 AM Staff D did not knock on the door when entering residents . The residents were sleeping in their beds and Staff D opened the doors, turned on the light, and then left the light on and door open to continue with the next residents . Residents asked Surveyor conducted our to turn off the light and shut the doors for # through 10 and # through 30.

Interview on at 1:50 AM findings were discussed with Staff A, who acknowledged the findings of staff entering knocking.

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Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on record review and interview the facility failed to conduct two elopement drills yearly.

Findings included:

A review of the facility's records on revealed that the facility failed to have proof of completing at least two elopement drills yearly. Document on elopement drills found was dated: , , and 2016.

During an interview on at 12:51 PM, Staff A went through the files and stated "we do elopement drill twice a year in and in . Next one is going to be in . I can't find the one that we did in 2017."

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview the facility failed to provide a safe living environment, free of hazards and ensure that appurtenances are maintained in good working order for the residents.

Findings included:

During the facility tour on at 9:35 AM the followings were observed: the shower in # attached broken tiles; the to # had missing tiles; # and #16 had broken armoires; the vent in # was very dusty and stained.

During an interview on at 1:14 PM, Staff A acknowledged that the armoires in #14 and #16 were broken and stated "I already replaced the armoire in ."

Class III

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

Based on record review and interview the facility failed to have documentation of the appointment of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney for one out of

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20 sampled residents (Resident #3).

Findings included:

Record review of Resident #3's files revealed that the contract, informed consent to assist with medication, and admission package had been signed by his sister. The facility did not have documentation of the appointment of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney.

On . . . . . at 4:00 PM Staff A revealed the resident's son is his power of attorney.

Class III

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(8) FAC

Based on record review and interview, the facility failed to have one (Staff C) out of 12 sampled staff who have direct contact with mental health residents receive a minimum of 6 hours of specialized training in working with individuals with mental health diagnoses. Additionally, the facility failed to have one (Staff I) receive a minimum of 3 hours of continuing education on mental health diagnoses and treatment.

Findings included:

A review of the facility's personnel file on . revealed Staff C hired on . . . . did not have a minimum of six hours of Limited Mental Health (LMH) training in file. Also, Staff I hired on . . . . . did not have a minimum of three additional hours of continuing education on mental health diagnoses and treatment. Staff I's last training was dated . . . . . .

During an interview on . . . . . at 1:14 PM Staff A stated "I know Staff C does not have the training, Staff C is scheduled to take that class."

Class III

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Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC

Based on record review and interview the facility failed to have a signed copy of the attestation of compliance with background screening requirements in file four out of 12 sampled staff (G, I, J, and L).

Findings included:

A review of the facility's records on . . . . revealed Staff G, I, J, and L did not have a signed attestation of compliance with background screening requirements in file.

During an interview on . . . . . at 12:51 PM, Staff A acknowledged the facility did not have the documentation.

Class III