STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968608	**06/04/2018**
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 resident wellness monitoring visit was conducted from . . . . . to . . . . . Floridian Gardens ALF with Limited mental health , Limited Nursing and Extended Congregate Care services (AL 12489) had the following deficiencies identified during the survey:

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

Based on observation, interview and record review, the assisted living facility failed to determine the appropriateness of readmission to the facility for one of 100 residents who was hospitalized after she and was injured. (Resident #22). Resident #22 was taken for emergency hospital care to treat injuries including a broken collar bone and facial . The resident returned nine hours later. The facility did not consult the Agency for Health Care Administration to determine whether the resident should be readmitted.

Findings included:

A review of facility records showed that a moratorium on admissions was imposed by the Agency for Health Care Administration on , , 2018 after a resident and several other residents and were injured. The facility was barred from admitting new clients, and from readmitting existing clients after temporary absences without first conferring with the Agency.

On at 11:15 AM during a monitoring visit, when asked about recent , the Administrator stated that only one resident had since the last agency visit. She identified the person who as Resident #22.

On at 12:00 pm, observed Resident #22 in the South Wing dining . Resident #22 had a on her right eye and forehead, and was wearing a sling on her right arm.

On at 12:00 pm, Resident #22 stated, "I did in my . I do not remember when and how." A female resident sitting at the same dining table stated to Resident #22, "You slipped and ." The resident identified herself as Resident # 49, stating "I'm her . We share # , and I called the staff for help and we helped her to get up from the floor. She down around 11:30 pm. Staff and I helped her." Resident #49 further stated, "Staff took a little bit long to arrive to our when she arrived we were able to put Resident #22 in her bed."

A review of Resident # 22's health assessment form dated showed diagnoses: ,

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, visual , , right . Her physical or sensory limitations showed decreased memory. The resident was alert and oriented times 2 and needed and universal precautions. Resident #22's activities of daily living were listed as independent with eating, supervision with ambulation, self-care, toileting and transferring. The resident needed assistance with bathing and dressing. Review of an earlier health assessment dated revealed diagnoses: , , , Visual , and she needed Precautions and Universal precautions. The resident's record contained a physician's order dated for half bed rails, and a consent for the bed rails was signed by resident on . There was no documentation of precautions between and .

Facility record review showed an internal incident report regarding Resident #22 which stated that on at 23:35, the Resident from bed to the floor when the resident wanted to go to the tripped with her blanket, resulting in injury. The emergency treatment given to Resident #22 by facility staff showed: 'took vital signs. Within the normal limits; 911 was called.' The Resident was taken to the emergency at around midnight.

A review of the Resident Observation Log note written by night shift supervisor Staff GG showed that 'at around 11:35 PM on , CNA Staff RR called to inform that Resident #22 had from the bed. Staff GG was completing a rounding tool (record of rounds conducted) when Resident #49 called to advise of the event.' Staff GG further wrote "Immediately I run in to her, she was still on the floor, she had hit her head and had a big bump, she was a little bit so I called 911".

Hospital record review showed that Resident #22 presented at the emergency right arm pain. The onset was 3 hours prior to arrival, and the incident location was 'at a nursing home.' The resident's general , exam of her right shoulder dated at 2:10 am revealed that there was an acute, displaced and mildly of the right .

Facility record review revealed no documentation that the Administrator contacted the Agency to get approval for the resident to be re-admitted.

Interviewed by telephone on at 11:58 am, the Administrator stated, "Resident #22 went to the hospital on at 00:10 AM and returned to the facility on at 9:42 AM. We did not request authorization because it was an emergency transfer because she ." Regarding why the facility listed the Resident's bed as being held during her absence at the hospital, The Administrator stated, "The bed hold was done by mistake, staff did the census at 8:00 AM on ." Regarding what precautions were put in place for Resident #22 between 2017 and the with on , the Administrator stated, "The resident did not have bed rails for prevention

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before the . The Resident was walking normally and the only thing that she liked was to leave small light on in her . The bed rail was ordered after the by a physician and the resident's daughter consented."

Class II

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Z828 - Administrative Fines; Violations - 408.813(3) FS

Based on observation, interview and record review, the assisted living facility violated a moratorium imposed by the Agency for Health Care Administration on , 2018 after a resident and several other residents and were injured. Resident #22 at the facility and was taken for emergency hospital care to treat injuries including a broken collar bone. The resident returned nine hours later. The facility did not consult the Agency for Health Care Administration to determine whether the resident should be readmitted.

Findings included:

A review of Agency and facility records showed that a moratorium on admissions was imposed by the Agency for Health Care Administration on , , 2018 after a resident and several other residents and were injured. The facility was barred from admitting new clients, and from readmitting existing clients after temporary absences without first conferring with the Agency.

Facility record review showed an internal incident report regarding Resident #22 which stated that on at 23:35, the Resident from bed to the floor when the resident wanted to go to the tripped with her blanket, resulting in injury. The emergency treatment given to Resident #22 by facility staff showed: 'took vital signs. Within the normal limits; 911 was called.' The Resident was taken to the emergency at around midnight.

Facility record review revealed no documentation that the Administrator contacted the Agency to get approval for the resident to be re-admitted.

Interviewed by telephone on at 11:58 am, the Administrator stated, "Resident #22 went to the hospital on at 00:10 AM and returned to the facility on at 9:42 AM. We did not request authorization because it was an emergency transfer because she ." Regarding why the facility listed the Resident's bed as being held during her absence at the hospital, The Administrator stated, "The bed hold was done by mistake, staff did the census at 8:00 AM on ."

Unclassified