STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966629	**07/05/2018**
NAME OF PROVIDER OR SUPPLIER **SHALON ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **7046 S W 103 PLACE** **MIAMI, FL 33173**	

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

0000 - Initial Comments

A Complaint (CCR #2018004742) Survey was conducted on and concluded on . Shalon ALF (licensed #10809) had the following deficiencies identified at the 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 provide care and offer personal supervision appropriate to the needs of 1 out of 7 sampled residents (Resident #7). Resident #7 in the facility and did not receive medical attention. The facility also failed to notify the family member and doctor for 1 out of 7 sampled residents who sustained injuries from a and a chair. The facility did not document any significant changes or incidents for 1 out of 7 sampled residents who was transferred to the hospital by a family member (Resident #7).

Findings as follow:

On at 9:45 AM Staff B stated Resident #7 had already when she came to work to facility on . She stated Resident #7 could not ambulate well due to Parkinson's . She stated Resident #7 had when he was waking up from bed. She stated resident did not use a walker because he refused it. Resident #7 had a walker in facility. Staff B reported his wife came to see him and observed he had a and wife decided to take him to the hospital. She stated Resident #7's wife took all his belongings, medications and med sheets. Staff B stated Resident #7 scratched the arm of the chair and ripped the leather, exposing a wire on the bottom and cutting his finger.

On at 10:50 AM Staff C stated Resident #7 was a very active person and was diagnosed with Parkinson's and . He was working when Resident #7 . He in the middle of the night when he stand up from bed to go to the hit his head against the night stand. As a result of the he had a in his head and a scratch in his arm. He was not sent to the hospital, stated, because resident had no signs of cuts and the did not appear till the next day. Staff C stated Resident received assistance with all activities of daily living. Resident #7's wife came two or three days after the and decided to take him to hospital. He said Resident's wife took all his belongings, medications and med sheet with her and took resident to the hospital. Staff C stated that the cut resident had on his finger was because he scratched his finger the arm of the chair and cut himself with a wire after he broke the ripped the leather with his finger.

Resident #7's health assessment date documented a medical history of , , , , HCP, , Parkinson's, OA, , , . The resident needed

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assistance with ambulation, bathing, dressing, self care, toileting, and transferring. Resident needed supervision with bathing and needed precautions.

Review of the progress notes showed the facility did not have any documentation of Resident #7's or injuries from the chair. The facility did not have any documentation the Resident #7's family or doctor was called after the or injuries sustained from the chair.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on record review and interview the facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period

Findings as follow:

Record review showed the staffing pattern available for review was for 2018. The facility did not provide an updated staffing patten.

On at 11:00 PM Staff C stated they will talk to the Administrator to place a current month schedule on the board.

Class III

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

Based on observation and interview the facility failed to be maintain chairs which the residents used.

Findings as follow:

On at 10:00 AM observed two chairs in the Florida had holes in their arm rests.

On at 1:30 PM Resident #1 stated that her chair was not comfortable and made it difficult for her to stand up.

On at 2:00 PM Staff B stated the Administrator said would replaced the chairs

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

Based on record review and interview the facility failed to have a complete health assessment for 1 out of 7 (Resident #3) sampled residents.

Findings as follow:

Record review showed Resident #3's health assessment (date not provided) did not specify the type of assistance the resident needed with self administration of medications.

On at 2:00 PM Staff C stated they did not see that the health assessment of Resident #3 was incomplete.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and interview the facility failed to complete a 1 day and 15 day full report for 1 out of 7 sampled residents (Resident #7). Resident #7 in the facility and had injuries.

Findings as follow:

On at 9:45 AM Staff B stated Resident #7 had already when she came to work to facility on . She stated Resident #7 could not ambulate well due to Parkinson's . She stated Resident #7 had when he was waking up from bed. She stated resident did not use a walker because he refused it. Resident #7 had a walker in facility. Staff B reported his wife came to see him and observed he had a and wife decided to take him to the hospital. She stated Resident #7's wife took all his belongings, medications and med sheets. Staff B stated Resident #7 scratched the arm of the chair and ripped the leather, exposing a wire on the bottom and cutting his finger.

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belongings, medications and med sheet with her and took resident to the hospital. Staff C stated that the cut resident had on his finger was because he scratched his finger the arm of the chair and cut himself with a wire after he broke the ripped the leather with his finger.

Record review found the facility did not complete an adverse incident for Resident #7, who required precautions. Resident #7 in the facility in , 2018.

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Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on record review and interview the facility failed to update the employment status within the background screening's clearinghouse within 10 business days for 2 out of 6 sampled employees (Staff E and F).

Findings as follow:

Clearinghouse database review showed Staff E and E as current are facility staff.

On [redacted] at 9:15 AM Staff B stated Staff E and F are not facility employees anymore. She stated that facility had three staff members (A, B, and C).

Unclassified