STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968608	**06/25/2018**
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 resident wellness and moratorium Monitoring survey was conducted on [redacted] at Floridian Gardens ALF with Limited mental health, Limited Nursing and Extended Congregate Care services License #12489 had the following deficiecies identified at the time of survey:

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

Based on record review and interview, the Assisted Living Facility failed to maintain an updated written record after as resident had an illness that resulted in receiving medical attention for one out of 68 sampled residents (#5) .

Findings included:

Review of Resident #5's record revealed that the health assessment completed on [redacted]. It showed diagnoses and medical history of [redacted] II and [redacted].

Resident #5's observation log showed that on [redacted] showed that RN B assessed the resident at 9:30 AM after breakfast when the resident reported not feeling well. The resident's Sugar Level (BSL) was 275. Due to the high [redacted] sugar, the doctor was consulted and gave order to give the resident a one time [redacted] after lunch. RN B reassessed Resident #5 after lunch and the BSL was 223. The doctor was notified and gave orders to continue monitor and notify if any changes. On [redacted] RN B performed follow-up assessment as per orders of doctor at 10 AM. Sugar Level (BSL) was 332. The doctor was contacted and gave an order to continue to monitor resident's status and recheck [redacted] sugar after lunch. BSL after lunch was 312. The sugar change was communicated to the doctor. The Doctor gave an order to have the resident sent to the hospital for further evaluation and treatment. There was no documentation showing when the resident returned from the hospital after the hospitalization.

On [redacted] at 9:59 AM RN B revealed that nurses needed to complete the transfer out. If the resident was admitted to the hospital, the nurse needed to call to the hospital and documented. When the resident returned, the nurse needed to do the readmission.

Class III

0027 - Resident Care - Arrangement for Health Care - 58A-5.0182(3) FAC

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Based on record review and interview, the Assisted Living Facility failed to ensure that residents received follow up check with primary health care physician for two of 68 sampled residents (#5 and #68).

Findings included:

Review of Resident #68's record revealed that documentation in progress notes showed:

- On . . . . . Staff advised administration and nurse that the resident was observed having . . . on right leg. The resident was transferred to the emergency . The resident left the facility via ambulance at 8:45 PM.
- On Registered Nurse (RN) A completed the follow up to Resident #68 after being discharged from the hospital.
- On RN B completed the follow up to Resident #68 after being discharged from the hospital.
- On . . . . . RN B completed the follow up to Resident #68 after being discharged from the hospital.

On . . . . . at 11:55 AM RN A revealed that Resident #68 went to the Primary Care Physician (PCP) the previous week and stated, " Let me look for her paper."

There was no documentation that Resident #68 saw the PCP after being discharged from the hospital.

Review of Resident #5's record revealed that the health assessment completed on . It showed diagnoses and medical history of . ( ), , , II and , . Resident #5's observation log showed that on showed that RN B assessed the resident at 9:30 AM after breakfast after the resident reported that did not feel well. Sugar Level (BSL) was 275. Due to the high sugar, the doctor was consulted and gave order to give a one time , after lunch. RN B reassessed the resident after lunch and the BSL was 223. The doctor was notified and gave orders to continue monitor and notify if any changes. On . . . . . RN B performed follow-up assessment as per orders of doctor at 10 AM. . . . . Sugar Level (BSL) was 332. The doctor was contacted and order to continue to monitor resident's status and recheck . . . . sugar after lunch. BSL after lunch was 312. . . . . sugar change was communicated to doctor. Doctor gave order to have resident sent to the hospital for further evaluation and treatment.
There was no documentation when the resident returned from the hospital after first hospitalization.

On . . . . . at 9:59 AM RN B revealed that nurses needed to complete the transfer out. If the resident was admitted to the hospital, the nurse needed to call to the hospital and documented. When the restident returned, the nurse needed to do the readmission.

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Review of Resident #5's transfer out on . . . . . showed that staff advised administration and nurse the resident was observed having ᴗ ᴗ. The doctor was contacted and recommended to transfer the resident to the emergency . . . . The resident left the facility via ambulance at 10 AM.
Review of Resident #5's progress notes showed:
- On . . . . . the resident returned from the hospital with . . . . . treatment (. . . . . 500 mg twice a day for seven days), the nurse will follow on days 3 and 7 after arrival.
- On . . . . . showed that the resident has been stable and under . . . . . treatment. Resident was tolerating treatment well. Resident did not have more ᴗ ᴗ.

On at 12:12 PM RN B, revealed that Resident #5 was seen by the doctor after discharge from the hospital just that the note was missing.

A review of Resident #36's record showed the resident was admitted on . . . . . . Health Assessment showed medical history and diagnoses: type II, ᴗ , ᴗ , high , ... , , ... , PCI (, ... intervention). Physical or sensory limitations: None sensory, patient use a walker, extremely hard of hearing. ᴗ or behavioral status: Patient alert & oriented x 2. Nursing/ treatment/ . . . , service requirements: As required. precautions. The resident is not an elopement risk. The resident is independent with ambulation, bathing, dressing, eating, toileting, and transferring, needs supervision with self-care ᴗ . . . ᴗ. Special Diet instructions: Calorie controlled/no added salt/low fat/low . The resident needed assistance with self-administration.

A review of Resident #36's observation log dated showed the Nurse was notified by an aide that resident refusing to take shower. The log stated that upon the nurses arrival to his . . . . . resident's was dirty with feces and sat on his clean bed, then the resident proceeded to grab his dirty sheets that were covered with feces and threw it at the nurse and the staff. The nurse reported this event to the administrator.

On at 11:46 AM the facility's registered nurse stated "Resident #36 was not aggressive to the point that the doctor had to be notified. He usually gets upset because he refuses to bathe, so when the staff notifies me, I will go in there and calm him and get him to shower. The resident is from a Medical center and they do not provide any paperwork. The resident usually calms down."

A review of Resident #61's record showed the resident was admitted on . . . , on . . . . . Leon Medical Center sent resident to the hospital. On nurse contacted the hospital and they stated that resident was going to have an operation on . . . . . to repair . . . . . 6,7 and 8. After the operation she will be stabilize then resident will be transferred to a rehabilitation center. From

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to the ALF nurse contacted the hospital to check on resident and resident was transferred to rehabilitation center on . From to the ALF nurse was in contact with the rehabilitation center to see the status of resident. On requested re admission from resident to the ALF. Resident was re-admitted on , vital signs were checked every single day. Home health orders for Physical , , in facility.

On at 11:45 AM the registered nurse stated that the resident belonged to a Medical Center and she goes there every day. The nurse further stated that the resident sees her doctor there and also she receives her , , there and that the facility does not keep track of this because the center does not provide it.

Class III