STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968090	**07/19/2018**
NAME OF PROVIDER OR SUPPLIER **PARK PLACE ASSISTED LIVING, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **8200 SW 43RD TERRACE MIAMI, FL 33155**	

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

0000 - Initial Comments

A Complaint (CCR# 2018004359) Survey was conducted on , 2018 and concluded on , 2018. Park Place Assisted Living Inc. (license # 12042) with Limited Mental Health had deficiencies identified at the time of the survey:

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

Based on record review and interview the facility failed to ensure that 3 out of 9 sampled residents met continue residency criteria. Residents #1, #2, and #3 had , wounds that worsened at the facility.

Findings included:

On at 2:25 PM the registered nurse from hospice stated, "I was the one doing care for the 3 of them. When I was there I saw the caregivers turning them but I do not know after I left." On at 3:15 PM the registered nurse from hospice stated on the phone, "I would leave instructions for them to be turned but I do not know what happened after I left the facility."

Phone interview on at 4:43 PM the resident's care doctor stated, "I did the debridement for Resident #1 at the facility back on and then at the hospital when she was in the unit. The first time in she had a in the back but I do not remember the exact location and it was only one; two months after she was admitted to the unit with multiple wounds. The first time I saw her I recommended to her daughters to move her to a nursing home because the was a and was very difficult to be treated at the assisted living facility and the family refused to move her because the place was good. Later I saw her at the hospital with multiple wounds. I do not think they were turning her as they were supposed to do. It is very difficult to reposition a patient that is contracted and rigid."

Record review revealed Resident #1 was under hospice services since . Record review revealed Resident #1 developed multiple , . The first , appeared on and was sacrum, care was ordered three times a week. On Resident #1 had unstageable on the sacrum area, care was ordered every other day. An order to transfer Resident #1 to a skill nursing unit unit was written on . Resident #1 was transferred to the hospice unit on , Resident #1 had a right heel DTI (deep tissue injury), right hip and sacrum , that were unstageable and the left hip was .

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Record review revealed Resident #2 was admitted to hospice on . Resident #2's last plan of care available for review was dated stated she had a on right lower leg and sacrum, on right and left and right heel . First was a on right lower leg on , sacrum dated ; left anterior ankle on no stage. Resident #2 on at the facility under hospice services.

On at 11:50 AM the Administrator stated that the would heal and open again. Stated the resident had her feet turned inwards.

Record review revealed Resident #3 was admitted to hospice on . The last plan of care dated stated Resident #3 she had a in the sacrum. An order for care to right inner foot 3 times a day was written on . Another order for care to left inner foot 3 times a day was written on . The on the sacrum first appeared on . Resident #3 on at the facility under hospice services.

On at 11:24 AM a relative of one of the residents stated, "The place declined after the new owner bought the place. She lost a lot of weight. They were not moving her enough. Before they bought the place my mother walked; then they sat her and she stopped walking; from there she went to bed and never got up again. I used to go every week and the employees were new all the time, not trained. The doctor that came to do the treatment in her , told me that if I loved my mother I better take her out of there and placed her in a nursing home with 24 hours care because that place was horrible."

Class III

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

Based on record review and interview the facility failed to have an order for on file for one out of nine sampled residents (#6) who received treatments.

Findings included:

On at 9:29 AM observed Staff B putting the nasal cannula on Resident # 6.

On at 9:30 AM the Administrator stated Resident # 6 had been recently admitted and her daughter brought the with her but did not bring an prescription. He called the resident's daughter and told her to bring the prescription.

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On Resident # 6's daughter stated at 12:20 PM that she had the order for because her mother had been using it for a long time and that she would bring it to the facility.

Class III

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Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c) FS

Based on record review and interview the facility failed to ensure that a newly hired staff that had a break in service of more than 90 days in a position that requires screening by a specified agency submit a new level II background screening prior to working for one out of four sampled staff (Staff D).

Findings included:

Review of Staff D (hired on)'s record revealed her level II background screening was dated . Staff D's application stated she worked at another assisted living facility (ALF) from to ; staff did not have any other employment history. Review of the background screening database revealed confirmed she worked at the other ALF from to .

On at 11:20 AM the Administrator stated, "She said she only worked at that other ALF."

Unclassified