STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964797	**07/23/2018**
NAME OF PROVIDER OR SUPPLIER **MIAMI-DADE COUNTY**	STREET ADDRESS, CITY, STATE, ZIP CODE **1150 NW 11 STREET ROAD** **MIAMI, FL 33136**	

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

0000 - Initial Comments

An Abbreviated Biennial Survey was conducted on , 2018 and concluded on , 2018. Miami-Dade County (license #9359) with Extended Congregate Care component had deficiencies identified at the time of the survey:

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

Based on observation, record review, and interview the facility failed to ensure that one of 26 sampled residents (#12) lived in a safe environment free from . Resident #12, a nonverbal hospice resident was found with on her face.

Findings included:

Observation on at 11:00 am revealed Resident #12 was bedbound on her bed unable to talk.

Record review revealed Resident #12's notes from stated, "The CNA (certified nurse assistant) from hospice report that Resident #12 has two (0.5 x 0.5 cm) on both sides of facial commissures of mouth."

Record review revealed Resident #12, a , health assessment dated documented a medical history of: , , O/A, , , functional decline and . Resident #12 was under hospice care. Resident needed total assistance with her daily living activities. Resident #12 did not verbalize, alert, disoriented x 3 and bed bound. Resident #12 needed administration of medication and had a . Resident #12 did not have an updated health assessment.

Record review revealed Staff P wrote a statement on that stated, "On Monday 1st, 2018 approximately 9:20 pm during my tour, I saw on both side of Resident #12's , lips, which I documented with a photo."

Record review revealed Staff Q wrote a statement on that stated, "We arrived around 4:00 pm to changed and fed Resident #12. We found her on side and with her right hand on her face. We put her on horizontal position like facing her face up to change her (brief). We notice that she had her face red, and we thought that she could had . However, as we touch her, we realized that her temperature was good. Therefore, we did not give importance, and we did not call the Nurse. Then, we provided , care and changed to Resident #12, and we put her on sitting position to give her the food.

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Resident #12 did not eat all the food, but she drank all the orange juice and water, and leaved her on semi-sitting position.

Record review revealed Staff R wrote a statement on that stated, "On Monday 1st of , at 11:40 am, I went to give to eat to Resident #12. I did not see any marks on her face or any ."

Interview on at 8:48 am Staff M stated, "When I was doing my round, I check on Resident #12. Resident #12 did not response because she was a passive person and quiet. She is under Hospice care. Her face was purple. It look like when someone squeeze you or touch you hard. When I did my rounds at 1:30 pm, and I saw her (Resident #12). The administration did nothing regarding Resident #12's incident. I did not have any information from the administration. I did not have any training, or anything after of what happened."

Interview at 11:29 am the Administrator stated, "We are very concern for what happened with Resident #12. We had meeting with staff and explain proper procedure to provide services to all residents. In addition, we have meeting with all departments and they all agree that it should not had happened. We had review the video, and we saw several staff working on that day ( ), but we have no proof or idea who did it.

The Department of Children and Families verified a complaint investigation regarding Resident #12. Resident #12 was observed with on her face, the facility was unable to identify who caused the .

Facility record revealed that were no written interventions in placed regarding Resident #12. The facility does not provide documentation that staff received updated training in , neglect and , . Also, the updated training on incident reporting.

Interview on at 4:30 am Resident #12's family member stated, "I saw the between her lips and cheeks. I took a photo and made a complaint to the facility administration. I was not happy with what happen. They need to train their staffing to prevent this happen again or to another resident. This is my primary purpose."

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview, the facility failed to a written statement from a health care

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provider documenting that the individual does not have any signs or symptoms of communicable for two of 17 (Staff K and L) sampled staff.

Findings included:

Record review revealed Staff L (hired) did not have a a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable .

Record review revealed Staff K's (hired) did not have a a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable .

Interview on at 1:30 pm Staff A and B stated, "Staff K had an X-ray done for five years." However, it did not reflect by a physician that it was good for five years.

Class III

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

Based on record review and interview, the facility failed to have an accurate health assessment for 2 out of 26 sampled residents (#2 and # 9)

Findings included:

Review of Resident #2's record revealed he was admitted to hospice on . The plan of care dated documented Resident #2 is dependent for 6 out of 6 activities of daily living (ADLs).

On at 10:00 AM the registered nurse stated that at the moment Resident #2 required assistance with eating and total with the rest of his ADLs.

Review of Resident #9's record revealed she started receiving hospice services on . The last health assessment was dated , prior to the resident being in hospice. Resident #9 required supervision with ambulation, eating, toileting and transferring and assistance with bathing, dressing and .

On at 12:20 PM the registered nurse stated that at this time she required assistance with

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eating and total with the rest of her ADLs.

Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on record review and interview, the facility failed to have an approved emergency management plan on an annual basis.

Findings included:

Record review revealed the emergency plan was paid on . The facility did not have the last approved plan available for review.

On at 11:35 AM the Administrator stated that they had sent it already for approval but had not been approved yet.

Class III

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

Based on record review and interview, the facility failed to maintain the employment status of employees within the clearinghouse and any changes reported within 10 business days.

Findings included:

Review of the background screening database showed Staff O and P were listed as current staff.

Interview on at 9:00 am Staff B reported, "Staff O stopped working with us a while ago. Staff P recently resigned; she left three months ago."

Unclassified