STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966371	R 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABLES MANOR ENTERPRISES II INC	**670 EAST 57 STREET HIALEAH, FL 33013**

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

0000 - Initial Comments

A Standard Biennial Survey Revisit was conducted on [redacted] 09, 2018 through [redacted] 23, 2018. Gables Manor Enterprises II, Inc. (License #10608) 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 record review and interview, the facility failed to provide [redacted] ( ) to one of six sampled residents who did not have a [redacted] ( ) in place (Resident # 6). Resident #6 was discovered [redacted] by a fellow resident, having hanged himself in the shower with his wife's scarf.

Findings included:

Review of the facility's admission /discharge log during a routine reinspection showed Resident # 6 [redacted] on [redacted].

On [redacted] at 11:40 AM the Administrator stated Resident #6 hung himself in the [redacted] one of his wife's scarves on [redacted]. The Administrator further stated that she was working on the night of [redacted] and that she last saw Resident # 6 at 9:30 PM when she gave him his night snack. She said Resident #5 went to use the [redacted] 6:30 AM and found Resident #6 on the floor with the scarf tied around his neck and the other end around the shower safety handle. The Administrator stated that when she got to the [redacted] Resident #6 was still warm. The Administrator reported Resident #6 never showed or expressed any [redacted] feelings.

A review of the fire rescue report showed that Resident #6 was pulse-less, apneic (not breathing), [redacted] stiff and [redacted] (no heartbeat) when they arrived at 6:30 am on [redacted]. The report further showed that the resident had been [redacted] for greater than 20 minutes.

A review of the personnel record showed that the Administrator had a current and [redacted] training verification dated [redacted] and expiring in [redacted] of 2019. A review of the resident's record showed that Resident #6 did not have a [redacted] ( ).

On [redacted] at 1:55 PM, the Administrator stated that she made rounds every 2 or 3 hours at night for the residents on hospice and changed their adult briefs around 12:00 AM and at 4:00 AM or 5:00 AM. After giving Resident #3 (Resident #6's wife) and Resident #6 the night snack at 9:30 PM, she would not enter his [redacted] he did not want her going inside. She further stated that when she told the

resident she needed to change his wife's adult brief, he said that he would do it. At 2:05 PM the Administrator stated that from the time Resident #6 was found to the time that rescue arrived was less than 10 minutes and during that time she did not provide because Resident # 6 had no pulse and was not breathing.

On at 1:23 PM, Resident #6's son stated, "He never gave any signs or told us that he wanted to do that. He had with to the bones and the doctor had told him directly the week before and told him that there was nothing to do not even chemo because it was a . In 2012 he started the treatment for the and then he decided to stop and never had treatment again. He was in all his senses. Just a little depressed."

On at 11:13 am, Resident #6's doctor stated in an interview that Resident #6 was despondent for a long time because he was the care provider for his wife, who had , and because of his own . He further stated that the resident was depressed about a lack of family support from his children, and the fact that they had placed their parents in the Assisted Living Facility (ALF) after selling their home. The doctor stated that the resident had canceled recent appointments, and that he felt Resident #6 needed assistance at the appointments, but no one ever came with him.

A review of Resident #6's record showed a progress note dated which said (translated from Spanish) "In the morning at 6:30 AM Resident #5 woke up to go to the found Resident #6 had hung himself in the run to tell me. My name is [ ] the Administrator of the ALF. When he told me I immediately ran to the called 911, he was hung from one of his wife's scarf. I tried to see if he was breathing because his body was still warm. The police, the rescue and the kids came and later they took the body out. He never showed signs that he would do something like that but he was very depressed and did not want to live here. The police did not give me give a case number or any other paper because they said that the resident was fine and it was cleared that he is the one that decided to do it. He was not beaten or presented anything else." Resident #6's record contained a progress note dated . It stated that the resident was depressed, still not adjusting to not living on his own in the community. On the Administrator wrote, "He is still not getting used to living here. He wants to live alone in an apartment to do everything his own way. He feels depressed. I told the family." There was no documentation in the resident record that the facility coordinated with the care provider about the resident's condition or to find out if he was receiving adequate care for the health conditions. Resident #6's health assessment documented diagnoses of Secondary , of Bones, of , and Major . He required supervision with his activities of daily living and had mild

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On and , facility staff and the Administrator were not able to accurately explain what a was. A review of personnel records showed that all staff had a training certificate stating that they had been trained on the facility's policies and procedures regarding .

On at around 4:50 pm, the Administrator, when interviewed, stated that she didn't know where the facility's policy on was. At 5:07 pm, Staff B stated regarding the policy, "Looked one by one and I could not find it."

Class I

0076 - ( ) - 58A-5.0186 FAC

Based on record review and interview the facility failed to have written policies and procedures that explain its implementation of state laws and rules relative to ( ).

Findings included:

Review of staff training records showed documentation that all staff were trained on the facility's policies regarding . Record review revealed that there was no documentation of a written policy and procedure regarding .

On at 5:07 PM, Administrator and Staff B stated they looked in the policies and procedures book to find the policies and procedures and they could not find it. Staff B stated by phone, "looked one by one and I could not find it."

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on record review and interview, the facility failed to ensure that one out of five sampled direct care staff (Staff B) received at least one hour of adequate training in the facility's policies and procedures regarding ( ).

Findings included:

A review of the facility's personal file on revealed a 1 hour of training certificate in file issued on for Staff B, hired on .

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On . . . . . Staff B stated at 11:46 AM, "It was so easy and the day of the survey I forgot. Is an order of . The resident or the relative in charge has the right to choose to not be ."

Uncorrected
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 file an incident report within 1 business day after the occurrence of an adverse incident for 1 out of 7 sampled residents (#6).

Findings included:

Review of the admission / discharge log revealed that Resident # 6 had , ... , on . . . . . .

On . . . . . at 11:40 AM the Administrator stated that Resident # 6 hung himself onsite in the . . . . one of his wife's scarves on .

On . . . at 11:42 AM Administrator stated "I asked my consultant if I had to file an incident report with AHCA (the Agency for Health Care Administration) and she said that the word . . . . . was not in the regulation so I did not need to file an incident report."

Class III