STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966762	R 08/29/2018
NAME OF PROVIDER OR SUPPLIER **SOUTH MIAMI HEIGHTS ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **11720 SW 181 TERRACE** **MIAMI, FL 33177**	

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

0000 - Initial Comments

An Abbreviated Biennial revisit survey was conducted on , 2018 and extended to , 2018 at South Miami Heights ALF inc. with limited mental health component, license 10904 had the following 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 observations, record reviews, and interviews, the facility failed to ensure that one of seven sampled residents lived in a safe and decent living environment, free from . Resident 2 was found in a locked her arms and legs tied to the bed and rails with sheets and strips of fabric. The resident had been tied up for over 12 hours, and had been routinely tied up for at least two months. The facility also failed to honor the right to privacy for one of seven sampled residents. (Resident #3). The resident was sharing her an unqualified staff person (Staff D).

Findings included:

During the facility tour on , 2018 at 7:20 am, observed Staff D alone in the facility with a census of seven six residents (the facility is licensed for six beds). Further observations found with the door lock turned inside out, so that it could only be unlocked from outside. When the door was unlocked, observed Resident 2 with her arms and legs tied to the bed and bed rails with sheets and strips of fabric knotted in several places (photographic evidence obtained). At 7:25 am Resident 2 stated, "They do this to me every day and I don't like it, I want to get up."

A review of the resident record showed that Resident 2 was admitted on , 2015. The health assessment dated revealed the following diagnoses: , (,), CKD3 (Kidney), , and Gait disturbance. Resident #2 needed supervision with ambulation and eating, assistance with bathing, dressing, , toileting and transferring. The resident was not identified as an elopement risk on the health assessment.

On , 2018 at 7:30 am, Staff D stated, "Resident 2 gets up at night and goes into the kitchen. The resident years ago. The resident has family but I do not know if they know that we tie the resident up. You have to watch the resident all the time. We lock the front door because the resident will walk around at night and go to the kitchen."

On , 2018 at 8:15 am, the Administrator (a licensed practical nurse) stated, "We lock the refrigerator sometimes because of Resident 2; the resident takes everything out." Further interview with

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the Administrator at 8:29 am revealed, "Resident 2 went to a party yesterday with the cousins around 12:30 pm and came back at 7:00 pm, when they came back, the resident was agitated. I noticed that sometimes the resident gets up at night. A long time ago the resident , maybe 2 years ago. We also have a belt but the resident does not like it (referring to a waist belt that was used on Resident 2 while in bed), we used to put it sometimes, not all the time". The Administrator found the belt and showed it to the Agency staff demonstrating how the facility staff placed it around the bed.

On , 2018 at 10:24 am, the Administrator stated, "We don't tie the resident up that often." The Administrator further stated that they tied up Resident 2 for her own safety. The Administrator reported she tied Resident 2's legs, and that she didn't know if her daughter (Staff B, a registered nurse) had tied the resident's arms up. She said Staff B had worked the night before.

Observation on at around 10:45 am revealed an unlabeled 2 beds. The bed next to the window had what appeared to be tied at the foot of the bed, white strings of cloth, with knots in them (photographic evidence obtained). At 10:50 am Staff D stated that this was where Resident #3 slept. Staff D reported she slept in the bed next to the resident. Staff D stated, "Maybe the bed used to belong to Resident 2 but Resident 3 does not use that." In reference to Resident 2 being tied, Staff D stated, "It is done to protect the resident, the Administrator tied the resident to the bed, not me."

A review of Resident 3's health assessment dated showed diagnoses of major , , , , , ( ), , , ( ), incontinence, gait disturbance, (OA), , , ( ), and Dyshplemia. The resident needed precautions, presented no risk of elopement, and needed assistance with ambulation, bathing, dressing, , , toileting and transferring; supervision with eating.

On , 2018 at 12:58 pm Staff D stated Resident 2 was put to bed around 7:00 pm, and that Resident 2 was usually let out of bed by 7:00 am. Staff D reported the Administrator was the one who usually tied Resident 2 up, and that she herself had not tied the resident. Staff D reported Resident 2 had been tied up before, always by the Administrator, because she got out of bed at night to seek food in the kitchen, often taking things out of the refrigerator or rummaging through it. Staff D stated that she didn't know how often Resident 2 had been tied up, and that sometimes they changed the resident's adult brief during the night, but they didn't change her every night.

On , 2018 at 10:55 am, the police officer stated that during an interview, the Administrator stated that she tied the resident's legs to the bed but that she did not know how the arms were tied.

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Multiple adult protective investigators from the Department of Children and Families (DCF) arrived to the facility on , 2018 at 10:10 AM, substantiated that the facility was using punishing methods against Resident 2 and removed seven residents, sending them to the hospital for assessment on , 2018 at 2:05 PM.

Hospital records dated , 2018 for Resident 2 revealed, she was positive for fatigue. Resident 2 weighed 110 pounds and had a preliminary diagnosis of and (AMS). The records further stated, "Patient has severe , even at rest and short of breath with moderated exertion and agitation."

Class I

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on observation, record review, and interview, the facility's Administrator, a licensed nurse, repeatedly locked a resident in a tied her to a bed for at least 12 hours at a time. Unqualified staff with no background screening was found alone with residents and was allowed to sleep in a resident .

Finding included:

1) During the facility tour on , 2018 at 7:20 am, observed Staff D alone in the facility with a census of seven six residents (the facility is licensed for six beds). Further observations found with the door lock turned inside out, so that it could only be unlocked from outside. When the door was unlocked, observed Resident 2 with her arms and legs tied to the bed and bed rails with sheets and strips of fabric knotted in several places (photographic evidence obtained). At 7:25 am Resident 2 stated, "They do this to me every day and I don't like it, I want to get up."

On , 2018 at 8:15 am, the Administrator (a licensed practical nurse) stated, "We lock the refrigerator sometimes because of Resident 2; the resident takes everything out." Further interview with the Administrator at 8:29 am revealed, "Resident 2 went to a party yesterday with the cousins around 12:30 pm and came back at 7:00 pm, when they came back, the resident was agitated. I noticed that sometimes the resident gets up at night. A long time ago the resident , maybe 2 years ago. We also have a belt but the resident does not like it (referring to a waist belt that was used on Resident 2 while in bed), we used to put it sometimes, not all the time". The Administrator found the belt and showed it to the Agency staff demonstrating how the facility staff placed it around the bed.

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Observation on at around 10:45 am revealed an unlabeled 2 beds. The bed next to the window had what appeared to be tied at the foot of the bed, white strings of cloth, with knots in them (photographic evidence obtained). At 10:50 am Staff D stated that this was where Resident #3 slept. Staff D reported she slept in the bed next to the resident. Staff D stated, "Maybe the bed used to belong to Resident 2 but Resident 3 does not use that." In reference to Resident 2 being tied, Staff D stated, "It is done to protect the resident, the Administrator tied the resident to the bed, not me."

A review of Resident 3's health assessment dated showed diagnoses of major , , , ( ), , , ( ), incontinence, gait disturbance, (OA), , ( ), and Dyshplemia. The resident needed precautions, presented no risk of elopement, and needed assistance with ambulation, bathing, dressing, , toileting and transferring; supervision with eating.

On , 2018 at 10:55 am, the police officer stated that during an interview, the Administrator stated that she tied the resident's legs to the bed but that she did not know how the arms were tied.

Multiple adult protective investigators from the Department of Children and Families (DCF) arrived to the facility on , 2018 at 10:10 AM, substantiated that the facility was using punishing methods against Resident 2 and removed seven residents, sending them to the hospital for assessment on , 2018 at 2:05 PM.

2) On , 2018 at 7:15, Staff D opened front door and identified herself as Staff C. Staff D was alone in the facility with a census of residents seven residents, helping Resident 5.

A review of the background screening database showed that the picture for the name Staff D originally gave did not match the staff's physical appearance.

On , 2018 at 12:59 pm, Staff D then gave her real name and acknowledged that she had initially identified herself as Staff C. Staff D stated, "I have been here since last month." Staff D

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reported she had come from Jamaica and did not have current valid documentation of legal immigration status. She provided her legal name and a passport for identification.

Personnel record review revealed Staff D did not have personnel records which included completed employment applications with employment dates of hire, level II background screenings and the following training: First Aid and ( ) control, residents rights and recognizing and reporting , neglect and , , emergency preparedness and evacuation and nutrition and safe food handling.

Staff D was in the facility caring for the following residents:

Resident 1's health assessment dated had the following diagnoses of , ( ), CKD4 (Kidney), , gait disturbance, poly . Resident 1 needed assistance with ambulation, bathing, dressing, , toileting and transferring. Supervision with eating and precautions.

A review of the resident record showed that Resident 2 was admitted on , 2015. The health assessment dated revealed the following diagnoses: , (,), CKD3 (Kidney), , , and Gait disturbance. Resident #2 needed supervision with ambulation and eating, assistance with bathing, dressing, , toileting and transferring. The resident was not identified as an elopement risk on the health assessment.

Resident 4's health assessment dated had the following diagnoses of (ASCVD), gait , . precautions. Elopement risk not checked on assessment. Independent ambulation, bathing, dressing, eating, , toileting and transferring.

Resident 5's health assessment dated had the following diagnoses of hospice care, advanced . Safety precautions, no risk of elopement, total care, puree diet, thickened fluids.

Resident 6's health assessment dated had the following diagnoses of , ( ), , , gait disturbance, precautions. No elopement risk. Supervision with ambulation, bathing, dressing, eating, toileting. Assistance with and transferring.

Resident 7's health assessment dated had the following diagnoses of , , , Parkinson . precautions, no elopement risk. Assistance with bathing, dressing, , , toileting. Supervision with ambulation, eating, transferring.

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Class II

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

Based on record review and interview the facility failed to have a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable [redacted] for one of four sampled staff (Staff D).

Findings included:

Staff D did not have a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable [redacted] at the facility. Record review for Staff D showed no personnel records available at the facility.

On [redacted], 2018 at 12:59 pm, Staff D stated, "I have been here since last month."

Uncorrected Class III

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

Based on observation and record review, the facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period with qualify staff members to meet the needs of the residents.

Findings included:

The facility's schedule showed Staff A was scheduled to work from 7 AM to 7 PM, Staff B was scheduled to work from 7 PM to 7 AM and Staff C was scheduled to work from 9 AM to 6 PM.

On [redacted], 2018 at 7:15 AM observed Staff D working in facility alone with a census of seven residents.

Record review found Staff D did not have a personnel record at the facility which included a level 2 background screening or training documentation.

Uncorrected Class III

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0082 - Training - / - 58A-5.0191(3) FAC

Based on record review and interview the facility failed to have one of four sampled staff, (Staff D) trained in a one-time education course on / as required by law.

Findings included:

Staff D did not proof of / training at the facility. Record review for Staff D showed no personnel records available at the facility.

On , 2018 at 12:59 pm, Staff D stated, "I have been here since last month."

Uncorrected Class III

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Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on observations, interviews, and record review, the facility failed to ensure that one of four sampled employees had an eligible Level II background screening prior to providing care to a census of seven (7) residents (Staff D).

Findings included:

On [redacted], 2018 at 7:15, Staff D opened front door and identified herself as Staff C. Staff D was alone in the facility with a census of residents seven residents, helping Resident 5.

A review of the background screening database showed that the picture for the name Staff D originally gave did not match the staff's physical appearance.

On [redacted], 2018 at 12:59 pm, Staff D then gave her real name and acknowledged that she had initially identified herself as Staff C. Staff D stated, "I have been here since last month." Staff D reported she had come from Jamaica and did not have current valid documentation of legal immigration status. She provided her legal name and a passport for identification.

Unclassified

Z828 - Administrative Fines; Violations - 408.813(3) FS

Based on observation and record review, the facility exceeded its licensed capacity of six. The facility had a census of seven residents.

Findings included:

A review of the health finder database showed the facility was licensed for a capacity for six residents.

During the facility tour on [redacted] at 7:15 AM, observed that there were six residents in the facility. Further observations during the facility tour found the medication observation record with an additional resident, Resident 7.

Record review of the daily Medication Observation Record (MOR) showed Resident 7 medications: [redacted] 100 mg given at 8:00 am on [redacted], 10 mg not given as prescribed at 8:00 pm, [redacted], FUM 200 given at 8:00 pm on [redacted], PUM 100 given at 8:00 am on

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On , 2018 during the tour of the facility, Resident 7 not found at the facility.

On , 2018 at 7:50 am, the Administrator stated, "We do not have that name in the facility, this must be someone from a long time ago."

On , 2018 at 8:02 am, the Administrator stated, after admitting that there was a seventh resident in the facility and providing the resident's record, "Resident 7 was taken by my daughter who lives in Homestead last night because Resident 7 has a doctor's appointment this morning in hospital. Resident 7 is around or something." The hospital was called, they reported Resident 7 did not have an appointment there.

On , 2018 at 10:50 am, observed Staff B arrived with Resident 7.

Unclassified