STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968608	**07/31/2018**
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 complaint inspection was conducted on . . . . . (CCR# 2018010143). Floridian Gardens Assisted Living Facility, with Limited mental health, Limited Nursing and Extended Congregate Care components, License #12489 had the following deficiencies identified at the time of survey:

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

Based on observation, interview, and record review, the Assisted Living Facility failed to honor 11 out of 18 sampled residents' rights to privacy, Eleven residents' confidential information was posted in an area that was viewable by the public. (#2, #3, #4, #5, #6, #7, #8, #9, #10, #11 and #12). . One resident complained of losing food (#13), two residents complained of missing money (#1, #18) and two complained of missing personal items (#16 and #17). The facility failed to provide progress notes for the incidents reported by residents.

Findings included:

1. On at 6:41 AM observed that there were a list posted on each dining the west wing. The list stated, "Residents with (. . . . .) . . " and showed the names of Residents #2, #3, #4, #5, #6, #7, #8, #9, #10, #11 and #12.

On at 8:20 AM the Assistant Administrator revealed that family members had access to the dining . . . . She confirmed that it was the list of residents that had a . . . . . On at 8:20 AM Registered Nurse A confirmed that it was the list of residents that had . . . . . .

Review of Resident #2's record showed that there was a . . . . . signed on . . . . .

Review of Resident #3's record showed that there was a . . . . . signed on . . . . . .

Review of Resident #4's record showed that there was a . . . . . signed on . . . . . .

Review of Resident #5's record showed that there was a . . . . . signed on . . . . . .

Review of Resident #6's record showed that there was a . . . . . signed on . . . . .

Review of Resident #7's record showed that there was a . . . . . signed on . . . . . .

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Review of Resident #9's record showed that there was a signed on .

Review of Resident #10's record showed that there was a signed on .

Review of Resident #11's record showed that there was a signed on .

Review of Resident #12's record showed that there was a signed on .

2. On at 6:59 AM Resident #13 revealed that she lost food from her . The resident left the when returned, the food was gone.

On at 6:40 am, Resident 1 stated, "I have been missing things since last year. I had $20 locked with a lock that belongs to the facility. My power of attorney gave me five $20 bills with my name on it and still disappeared. I called DCF (Department of Children and Families) and they came on , 26th; they asked me to get a lock from outside and not use the one from the facility.

On at 6:35 am, Resident 17 stated, "Clothes that they took to the laundry to wash and never came back, this happened two weeks ago; I am missing pants, socks, underwear and shirts. The first time, I reported it and they did not know where they were".

On at 7:15 am, Resident 16 stated, "I had a pair of pants that disappeared in the laundry."

On at 7:20 am, the family member of Resident 18 stated, "Resident 18 lost $20 in , it was inside the drawer of the dresser".

On , at 7:20 am, Resident 18 stated, regarding missing items, "It happened in , that was the only time."

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on record review, observation and interview, the Assisted Living Facility failed to obtain clarification in the directions for the use of 'as needed' medications for one out of 18 sampled residents (#1).

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Findings included:

Review of Resident #1's Medication Observation Record (MOR) revealed that there was an order of / / Tab- 1 or 2 tablets by mouth 4 to 6 hours as needed not to exceed 6 tablets in 24 hours. It did not indicate what the medication was ordered for. There was an order of 50 mg tablet- take one tablet by mouth every four to 6 hours. It did not indicate what the medication was ordered for.

On at 11:20 AM there was a medication bottle labeled with Resident #13's name. It had the order of / / Tab- 1 or 2 tablets by mouth 4 to 6 hours as needed not to exceed 6 tablets in 24 hours. There was a medication card labeled with Resident #1's name and the order of / / Tab- 1 or 2 tablets by mouth 4 to 6 hours as needed not to exceed 6 tablets in 24 hour.

On at 1:13 PM Registered Nurse (RN) B revealed that staff who assisted Resident #1 with / / Tab and 50 mg tablet were not licensed staff. The RN confirmed that medicines were PRN (ordered as needed).

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2-3) FAC

Based on record review and interview, the Assisted Living Facility failed to ensure that one out of one sampled newly hired staff received at least 2 hours of orientation prior to interacting with residents (A). The facility also failed to ensure that staff completed training on reporting adverse incidents , resident rights training, recognizing and reporting resident , neglect, and within 30 days of employment for one out of one sampled staff (A).

Findings included:

Review of Staff A's personnel record showed a hire date of . There was no evidence in record about the sign by the facility's administrator and staff for the 2 hour orientation. There was no evidence of completion of reporting adverse incidents training, resident rights training, recognizing and reporting resident , neglect, and .

On at 2:10 PM the administrator confirmed that Staff A's hire date was . "I haven't heard about that new orientation training. We were working on the medication training."

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Class III

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

Based on record review and interview, the facility failed to provide documentation of at least 1 Hour of training on ( ) within 30 days after employment for one of four sampled staff (Staff B).

Findings included:

A review of Staff B's personnel record showed a hire date of and a job description of Direct Care Staff.

On , , 2018 at 2:45 pm, the Administrator acknowledged that the training was missing.

Class III

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

Based on record review and interview, the facility failed to provide proof of a new health assessment for one of 18 sampled residents, (Resident 1) who presented a change of condition. The facility failed to exclude a 14-Day notice in a resident's contract or correspondence.

Findings included:

Resident record review of Resident 1 showed an admission date of . The last health assessment was dated . Diagnoses: , , , , , , and giddiness, , , right eye. Physical: functional decline. Difficulty in walking, rolling walker. precautions. Supervision with ambulation, bathing, dressing and self-care. Independent with eating, toileting and transferring.

A review of Resident 1's progress notes for stated, "Resident 1 has woken up today behaving very differently, the resident is slurring the words and complaining of , low , and that staff doesn't work because they don't speak English".

On , , 2018 at 10:40 am, the Administrator stated, "The resident is complaining continuously, opening complaints and arguing about the facility. Facility is questioning the intention. The resident was

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complaining about missing stuff and has been arguing with the administration. The resident complained that I screamed and I decided not to talk to the resident without a witness in order to avoid misunderstandings. Residents know that they need to keep their valuables locked. The facility sometimes provides a lock, if the resident does not have access to it and we do not keep a second key. I don't think that the resident is a liar but the resident does not like to be here and the measures we have implemented. When there is a change of a resident behavior, we send them to the hospital".

Record review of facility's Termination of Residency form showed a last paragraph that read:

B) Resident is being requested to move within 14 days of receipt of this notice for the following reason (s):

On , 2018 at 2:45 pm, the Administrator acknowledged the error and stated that the form will be corrected.

Class III