STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966629	R 09/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALON ALF	**7046 S W 103 PLACE** **MIAMI, FL 33173**

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

0000 - Initial Comments

A revisit to a Complaint (CCR #2018004742) survey was conducted at Shalon ALF on . . . . . Shalon ALF, license #10809, had deficiencies at the time of the visit.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review and interview the facility failed to have written record after 1 out of 7 sampled residents went to the hospital for a . . . . (Resident #2). The facility also failed to notify the family member that 1 out of 7 sampled residents was transferred to the hospital.

Findings Included:

On at 9:30 AM Staff C stated that Resident #2 had gone to the hospital for a follow up for a previous . . . . that he had had and he thought that he stayed in the hospital one night.

On at 9:45 AM the Administrator stated that he did not remember when the resident went to the hospital, if it was in the beginning of . or at the end of . He forgot to write it on the progress note.

Resident #2's health assessment dated . . . . documented a medical history of Acute Left Thalamic, Is Chemic , , , , , , , Gait, , Type II. The resident needed assistance with bathing, dressing, self-care (. . . . .), toileting and transfer. Resident needed supervision with ambulation and eating.

Review of the progress notes showed the facility did not have any documentation of Resident #2 going to the hospital or that the family member was notified.

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 complete a 1 day and 15 day full report for 1 out of 7 sampled residents (Resident #7). Resident #7 . . in the facility and had injuries.

Findings included:

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NAME OF PROVIDER OR SUPPLIER **SHALON ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **7046 S W 103 PLACE** **MIAMI, FL 33173**	

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

On at 8:50 AM Staff B stated Resident #7 had already when she came to work to facility on . She stated Resident #7 could not ambulate well due to Parkinson's . She stated Resident #7 had when he was waking up from bed. She stated resident did not use a walker because he refused it. Resident #7 had a walker in facility. Staff B reported his wife came to see him and observed he had a and wife decided to take him to the hospital. She stated Resident #7's wife took all his belongings, medications and med sheets. Staff B stated Resident #7 scratched the arm of the chair and ripped the leather, exposing a wire on the bottom and cutting his finger.

Record review found the facility did not complete an adverse incident for Resident #7, who required precautions. Resident #7 in the facility in , 2018.

Incident report web site was checked and the facility had not completed an incident report.

On at 9:00 AM according to the Administrator, "AHCA never told me to do an incident report otherwise I would have done it. I cannot do the incident report because it never happen"

Uncorrected Class III