STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911005	R **10/25/2018**
NAME OF PROVIDER OR SUPPLIER **MIDWAY RETIREMENT RESIDENCE**	STREET ADDRESS, CITY, STATE, ZIP CODE **93 SW 79 COURT** **MIAMI, FL 33144**	

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

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

Based on record review and interview, the facility failed to register with the clearinghouse and maintain the employment status of Staff F and G within the background screening database clearinghouse.

Findings included:

Review of the facility's roster did not show Staff F and G as employees.

Review of the facility's staff schedule showed Staff F scheduled for:

, 2018 from 8:00 PM to 8:00 AM
, 2018 from 7:00 PM to 7:00 AM
, 2018 from 8:00 PM to 8:00 AM

On , 2018 at 10:22 AM, Staff D stated, "Staff F has been here less than a month."

On , 2018 at 11:23 AM, Staff G on a phone interview stated, "I left 2 or 3 weeks ago; I was working at night."

Unclassified

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0000 - Initial Comments

A standard biennial revisit survey was conducted on , 2018. Midway Retirement Residence with a Limited Mental Health component license number 6647, had the following deficiencies identified at the time of the survey:

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

Based on observation, record review and interview, the facility failed to provide progress notes on the resident record for one of 14 sampled residents (Resident 13), who twice and was taken to the hospital with a head injury.

Findings included:

On , 2018 at 8:00 AM, observed Resident 13 seating in the dining table with a visible on the forehead.

On , 2018 at 10:48 AM, Staff C stated, "The first time the resident was in the ; the second time, Resident 13 was seating in the living breakfast; when I walked away I guess the resident tried to get up and maybe got ; we called 911 and they took her to the hospital."

Record review found the facility did not have any notes regarding Resident 13's injuries or transfer to the hospital.

Class III

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

Based on observation and record review, the facility failed to provide a safe and decent living environment, free from for four of 14 sampled residents (Residents 8, 9, 12 and 13).

Findings included:

On , 2018, observed Resident 8's bed with 1/2 rail with a recliner obstructing the side of the bed. Observed Resident 9's bed with 1/2 bed rail located in the middle of the bed which was used as barrier to prevent the resident from exiting the bed. Observed Resident 12's bed with a wheel chair and a hospital table obstructing the side of the bed. Observed Resident 13's bed with 1/2 bed rail located in

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SUMMARY STATEMENT OF DEFICIENCIES
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the middle of the bed and a recliner obstructing the side of the bed.

Review of Residents 9, 12 and 13's records showed 1/2 bed rail prescriptions from a licensed physician.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on record review and interview, the facility failed to have personnel records for one of seven sampled staff (Staff G).

Findings included:

Review of the facility staff's personnel records showed no records for Staff G.

On , 2018 at 11:15 AM, Staff C stated, "Staff G was the staff who was here when Resident 13 , but does not work here anymore."

On , 2018 at 11:23 AM, on a telephone interview, Staff G stated, "I left the facility 2 or 3 weeks ago."

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 adverse incident report to the agency within 1 day and a complete report within 15 days for one of 14 sampled residents (Resident 13).

Findings included:

On , 2018 at 8:00 AM, observed Resident 13 seating in the dining table with a visible on the forehead.

On , 2018 at 10:48 AM, Staff C stated, "The first time the resident was in the ; the second time, Resident 13 was seating in the living breakfast; when I walked away I guess the resident tried to get up and maybe got ; we called 911 and they took her to the hospital."

Review of adverse incidents reported to the agency showed an adverse incident report for the Resident

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13 'second and no report for the first when the resident had to be taken to the hospital with a cut on the forehead.

11:23 AM, Staff G stated, "I was with the resident the first time. I was working at night. The walker was next to the door. I found the resident on the floor. I have no idea what happened; I think it happened around 5:00 am; the resident was . I called staff E because E lives closer to the facility. I call 911 and they took the resident."

Class III