STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968608	R 12/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDIAN GARDENS ASSISTED LIVING FACILITY	**17250 SW 137 AVENUE MIAMI, FL 33177**

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

0000 - Initial Comments

A Third Revisit to a Biennial Inspection was conducted on 12/18/18 and concluded on 12/19/18. Floridian Gardens Assisted Living Facility, with Limited Mental Health, Limited Nursing and Extended Congregate Care components. Deficiencies were identified at the time of the Visit:

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

Based on record review and interview, the facility failed to provide at least 45 days' notice of relocation or termination from the facility for 1 out of 79 sampled residents when there was no certification by a physician that an emergency relocation was required (Resident #62).

Findings included:

Review of Resident #62's record showed Progress notes dated - 2:45 PM which stated 'Resident was transferred to the Hospital via rescue; the administrator and the POA (Power of Attorney) was notified.' Progress notes dated stated "The Assisted Living Facility (ALF) nurse was called by a staff to assist the resident. When the nurse arrived to the resident room, he found her on the floor and she was alert and oriented. When the nurse proceeds to make assessment, the resident refuses saying that she had already called 911. Nurse was standing next to the resident until the ambulance arrived." Further review showed progress notes dated stated "While on the phone with the resident's POA(Power of Attorney), facility nurse was advised by an HHA (Home Health Aid), that resident's roommate was lying on the floor. Staff DD and nurse initiated the assessment, resident said that she was not well refusing to be touched because she called 911 and they are on their way. Resident was alert and oriented times 3 was talking normally. The rescue team arrived and resident explained that she has . Rescue team found vital signs within the normal limits and informed the resident that she does not need to be transferred to the hospital. Administrator asked to transfer resident to the emergency room for further studies but the rescue leader that she cannot transport the resident against her will." Progress notes dated stated "Administrator called resident's POA to inform the decision of terminating the residency agreement. "

Further record review found no documentation that the facility contacted the resident's primary care physician when she was found on the floor.

On at 11:03 AM, the Resident's POA stated "The Administrator said the government will not let her readmit Resident #62 because of the moratorium." A review of AHCA's (Agency for Health Care Administration) records found no documentation that the agency was notified of the occurrence.

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On at 1:15 PM, the Administrator stated ' I did not contact Resident #62's Primary Care Physician because she was in a medical facility. She called 911 herself. She was causing problems in the facility. She couldn't stay here.'

Uncorrected
Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation, record review and interview, the Assisted Living Facility failed to ensure that staff follow the right procedures during the assistance with self-administration of medications for one out of 63 sampled residents (#59). Staff did not ensure that the resident's documented did not match with any of the current medications.

Findings included:

On at 6:40 AM, Staff PP assisted Resident #59 with self-administration of medication. The staff read loud the medications' labels to the residents and one of the medications was 500 mg tablet. The resident took all his medications, including the . The staff signed the Medication Observation Record after observing that the resident took his medications.

Reconciliation of Resident #59's medications showed that one of the medications was ( ) tab 500 mg DR, to take one tablet by twice daily. The pharmacy dispensed the medication on .
Review of Resident #59's MORs showed that the resident had to , Dilatair, and . There was one order for ( ) tab 500 mg DR to take one tablet by twice daily; it was scheduled at 7 AM and 4 PM. Staff initialed MORs from to for a total of 35 doses.

According to U.S. Food Drug Administration, ( )'s possible reaction are hepatotoxicity, including fatalities, usually during the first 6 months of treatment. Patients need to be monitor closely and perform testing prior to , and at frequent intervals thereafter. It can also cause , including fatal cases. Also, 's most common adverse reactions are , accidental injury, , amblyopia/blurred vision, amnesia, , asthenia, ataxia, , emotional lability, , increased appetite,

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SUMMARY STATEMENT OF DEFICIENCIES
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, , nervousness, nystagmus, , somnolence, thinking abnormal, , tinnitus, tremor, , gain, loss.

On at 6:48 AM, Staff PP stated, "It should be a mistake", when he was asked about the resident's .

On at 7 AM, the registered nurse revealed that the pharmacy filled the medication carts with medications and completed the MORs. He came and check the MORs and included any new doctor orders for a resident who had been out to the doctor in the days before the month ended. The assistant administrator usually checked the health assessment when the residents returned from the doctor/ when the doctor completed. matched the MORs and the health assessment. He has talked to the resident's primary physician multiple times. The resident has been in the hospital but not due to an .

Review of Resident # 59's record showed that he was a male resident. Initial health assessment (AHCA form 1823) completed on showed that the resident needed assistance with self- administration of medications. The resident had to , , , and . Medical history and diagnoses of , , , , Klinefelter . The resident needed assistance for all activities of daily living eating, ambulation, bathing, , self-care, toileting, and transferring.

Resident #59's last health assessment (AHCA form 1823) completed on and needed assistance with self- administration of medications. The resident had to , , , and . Previous health assessment completed on showed also that the resident had to , , , and . Medical history and diagnoses of , , , , , Klinefelter . The resident was ambulatory with assistance/ walker. The resident needed supervision for all activities of daily living except eating that was independent (ambulation, bathing, , self-care, toileting, and transferring).
Review of progress notes did not show that the facility shared any communication or information with the primary care physician related to any contradiction of the resident having to and been taking .

On at 7:22 AM, the registered nurse revealed that the resident returned from the hospital but the hospital just copied the . He did not send the resident to hospital, the administrator was the one who called the emergency services and sent him to the hospital. The paramedics checked the resident's vital signs and everything was perfect. The resident has never reacted to . He has taken for 2 years.

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There was a progress note dated and signed by the registered nurse. It showed that the doctor was contacted about the resident's discrepancy. The doctor determined to send the resident to the ER (Emergency Room) for work and will visit the resident tomorrow (next day). After evaluating him, he will decide if to decrease/discontinue medication. He explained that might be a between side effects and reactions since the resident has been taking medication for more than 2 years and was stable.

Review of hospital discharge summary available at the facility for Resident #59 on at 10:45 AM showed that the resident went to the hospital on for diagnosis: encounter for other administrative examinations. It showed home medications recorded during the visit no active home medications. Medications received during the visit: none. Prescriptions received during the visit: none. Post- departure prescriptions: none.

Review of Resident #59's MORs for , , , , , , , and showed that the resident had to , , Dilatair and , . They included that the order for , (,) tab 500 mg DR to take one tablet by twice daily; it was scheduled at 7 AM and 4 PM. Staff initialed MORs twice daily on daily basis.

On at 12:25 PM, the doctor confirmed that Resident #59 was his patient. He stated the resident probably commented that he had some sensitivity to the medication on the past. He instructed to staff every month when visited the facility to be aware about any changes in the residents , physical or mental. He wrote in the box for in the health assessment (AHCA form 1823) the sensitivities and .

Class III
Uncorrected

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview, the facility failed to ensure that all medications were kept in a locked cabinet, locked cart, or other locked storage receptacle, room, or area at all times. Unlocked medications were found for 1 out of 44 sampled residents. (Resident 11).

On at 7:10AM in observed an open bedside drawer with several prescriptions and over the counter medications. There were prescriptions for 500mg, , 600mg, spr 50mcg, and , and and over the counter medications for

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, , C, spray, tract, relief, cream.

At 11:59am the Administrator stated Resident 11 made independent decisions with scheduling doctor's . She stated Resident 11 did not report to the facility with information of what the outside doctor's prescribed.

Uncorrected
Class III

0058 - Pharmacy & Dietary; Uncorrected Deficiencies - 429.42( ) FS; 58A-5.033(3)(a) FAC

Based on observation, interview and record review, the Assisted Living Facility failed to correct deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, deliver, or administration during a survey. The facility has an uncorrected deficiency class II for assistance with self-administration of medications. The facility is required to employ the consultant services of a licensed pharmacist or a licensed registered nurse who will, at a minimum, provide onsite quarterly consultation until an inspection by the Agency's personnel determines that such consultation services are no longer required.

Findings included:

1. On at 6:40 AM, Staff PP assisted Resident #59 with self-administration of medication. The staff read loud the medications' labels to the residents and one of the medications was 500 mg tablet. The resident took all his medications, including the . The staff signed the Medication Observation Record after observing that the resident took his medications.

Reconciliation of Resident #59's medications showed that one of the medications was ( ) tab 500 mg DR, to take one tablet by twice daily. The pharmacy dispensed the medication on .
Review of Resident #59's MORs showed that the resident had to , Dilatair and . There was one order for ( ) tab 500 mg DR to take one tablet by twice daily; it was scheduled at 7 AM and 4 PM. Staff initialed MORs from to for a total of 35 doses.

On at 6:48 AM, Staff PP stated, "It should be a mistake", when he was asked about the resident's .

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On at 7 AM, Registered Nurse revealed that the pharmacy filled the medication carts with medications and the completed the MORs. He came and check the MORs to ensure to include any new doctor order that a resident who has been out to the doctor in the days before the month ends. The assistant administrator usually checked the health assessment when the residents returned from the doctor/ when the doctor completed. matched MORs and health assessment. He has talked to the resident primary physician in multiple times. The resident has been in the hospital but not due to an .

Review of Resident # 59's record showed that the initial health assessment (AHCA form 1823) completed on showed that the resident needed assistance with self- administration of medications. The resident had to , , , and , . Next health assessment completed on showed also that the resident had to , , , and , . The last last health assessment completed on and needed assistance with self- administration of medications. The resident had to , , , and , . Review of progress notes did not show that the facility shared any communication or information with the primary care physician related to any contradiction of the resident having to , and been taking , .

On at 7:22 AM, the registered nurse revealed that the resident returned from the hospital but the hospital just copied the . He did not send the resident to hospital, the administrator was the one who called the emergency services and sent him to the hospital. The paramedics checked the resident's vital signs and everything was perfect. The resident has never reacted to , . He has taken , for 2 years.
There was a progress note dated and signed by the registered nurse. It showed that the doctor was contacted about the resident's , discrepancy. The doctor determined to send the resident to the ER (Emergency Room) for work and will visit the resident tomorrow (next day). After evaluating him, he will decide if to decrease/discontinue medication. He explained that might be a between side effects and reactions since the resident has been taking medication for more than 2 years and was stable.

Review of hospital discharge summary available at the facility for Resident #59 on at 10:45 AM showed that the resident went to the hospital on for diagnosis: encounter for other administrative examinations. It showed home medications recorded during the visit no active home medications. Medications received during the visit: none. Prescriptions received during the visit: none. Post- departure prescriptions: none.

Review of Resident #59's MORs for , , , , , and showed that the resident had to , , Dilatair and , . They included

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that the order for , , (, ,) tab 500 mg DR to take one tablet by twice daily; it was scheduled at 7 AM and 4 PM. Staff initialed MORs twice daily on daily basis.

On at 12:25 PM, the doctor confirmed that Resident #59 was his patient. Probably the resident commented that he had some sensitivity to the medication on the past. He instructed to staff every month when visited the facility to be aware about any changes in the residents, physical or mental. He wrote in the box for in the health assessment (AHCA form 1823) the sensitivities and .

2. Facility has a history of uncorrected class III deficiencies regardings medications. On survey conducted from through , the facility had an uncorrected deficiencies related to assistance with the self-administration of medication, and labeling and orders of medication.
On survey conducted on through , the facility had an uncorrected deficiencies related to assistance with the self-administration of medication, storage and disposal of medications.

The facility did not have any documentation that the consultant services of a licensed pharmacist or a licensed registered nurse have been used.

Uncorrected
Class III

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

Based on record review and interview, the Assisted Living Facility failed to ensure that staff have evidence of a negative examination must be documented on an annual basis provided by the Florida Department of Health or a licensed health care provider.

Findings included:

Review of Staff RR's personnel record showed that hire date was . The screening checklist form in record was completed on by a Licensed Practical Nurse.

Review of Staff OO's personnel record showed that hire date was . The screening checklist form in record was completed on by a Licensed Practical Nurse.

Review of Staff PP's personnel record showed that hire date was . The screening checklist form in record was completed on by a Licensed Practical Nurse.

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Review of Registered Nurse's personnel record showed that hire date was . The screening checklist form in record was completed on by a Licensed Practical Nurse.

According to Florida Health Statutes Chapter 381 showed that health care provider was a physician licensed under chapter 458, an , physician licensed under chapter 459, or a podiatric physician licensed under chapter 461.

On at 1:25 PM, the Administrator revealed that all staff have the annual test done.

Class III
Uncorrected

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the facility failed to provide a clean, hazard free, well maintained living environment for 79 of 79 Residents in their chair. A roach was observed crawling inside a refrigerator unit; soiled dishes covers were used to serve and cover food for residents; closet doors were observed off hinges; and furniture had torn and ripped cushions, covered/wrapped in black plastic garbage bags.

Findings:

Observed a large, cockroach walking inside the refrigerator. Also saw a black substance resembling mildew or mold inside the refrigerator. Observed two covered plates sitting on a ledge/counter overlooking a food preparation area. The plates were covered with commercial grade food covers. The covers had dried food and stains on the outside and inside. When the covers were removed, untouched, complete dinner plates were discovered. The plates contained, what appeared to be, mash potatoes, cabbage/veggie mix and stewed meat. Observed sofas and chairs in both the facility's lounge area and arts and crafts room with tears and plastic bags used as cushion covers. Clear and black plastic bag material was used. Observed chairs in the facility's garden area with missing and broken and seat straps.

In an interview on at 7:54AM Staff D stated that the torn and damage furniture (Sofas and chairs in the lounge and Arts & Crafts rooms, in addition to the patio furniture in the facility's rear atrium area) were being repaired, but it's a long process. She stated that the facility plans to have all of the damaged furniture repaired or replaced by the end of the year. She said any repairs to other areas of

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the facility would be done at the end of the year as well.

In an interview on at 12:52PM Staff YY stated he was not aware that food (two dinner plates) from the night before had been left on the counter, covered with a dirty dish/food cover (warmer). He said that perhaps it was accidental because this never happens at the facility. He said food is never left out and dishes are always cleaned. He stated he would speak with his kitchen staff and will never let something like this happen again.

In an interview on at 1:35pm, Staff D stated she did not know how the roach got into the unit. She further reported that the facility is regularly sprayed for pests as documented in pest control paperwork presented at time of inspection.

Class III

0180 - Emergency Management - 58A-5.026(1) FAC

Based on observation and interview, the facility failed to have adequate water available for 79 of 79 residents in their care, in the event of an emergency.

Findings:

An observation and count revealed the facility had 29 boxes of 3, 1 gallon jugs of water in storage for a total of 87 gallons of water on . . . Based on the facility's census, 237 gallons of water would be needed to provide the required amount of water for the facility's current census, as per state regulation.

In an interview on . . at 1:35PM the Staff D stated that the facility had more than enough water for the residents.

Class III

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Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c) FS

Based on record review and interview, the facility failed to ensure that staff members had an eligible attestation of compliance with background screening requirements for one out 44 sampled staff (RR).

Findings included:

Review of Staff RR's personnel record showed that hire date was . There was not a signed attestation of compliance with background screening requirements.

On at 11:02 AM, the Administrator stated that she did not find the attestation of compliance with background screening requirement for Staff RR.

Class III