STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966238	R 02/22/2019
NAME OF PROVIDER OR SUPPLIER **JUAN PABLO II ALF, CORP.**	STREET ADDRESS, CITY, STATE, ZIP CODE **15680 SW 139 AVENUE** **MIAMI, FL 33177**	

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

0000 - Initial Comments

A complaint (CCR#2018013533) revisit survey was conducted on through . Juan Pablo II ALF, Corp. with a standard license, had the following deficiencies identified at the time of survey:

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

Based on record review and interview, the facility failed to provide adequate supervision to one of seven sampled residents who was at risk for (Resident #6). The resident while toileting unsupervised by staff , broke her , , and later due to complications of surgery. The facility also failed to provide documentation of significant changes in resident #6's health status, and failed to obtain an updated health assessment highlighting the resident's need for assistance or the high risk of that her physician had identified.

Findings included:

On during the tour of the facility at 7:30 AM, observed that Resident 6 was not at the facility. The Administrator stated the resident had ,

Review of the facility's admission and discharge log showed an admission date and a discharge date of . Review of Resident 6's record showed no documentation in reference to the and discharge from the facility. The last health assessment dated showed physical or sensory limitations: Walking. or behavioral status: Awake, alert and oriented. Independent on ambulation, eating, grooming, toileting and transferring. Assistance with bathing and . Special precautions (Left blank).

On at 10:45 AM, the Administrator stated, "She here at the facility when she was going to the bathroom. The doctor gave her a walker that she used to use mainly to hold her . That day she walked without the walker to the bathroom, and broke her , . She was taken to the hospital, had surgery, came out Ok, before going to rehab, they found an on her that apparently they did not notice; the went to her and ."

On at 7:12 PM during a phone interview with the resident 'son, he stated, "Her doctor prescribed a walker with a seat; she had it from before going to the facility; she used to use it occasionally. They call me and when I got there, she was on the floor and the walker was inside the bathroom. They told me that she was coming out the bathroom. I did not want to ask my mom how it

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happened."

On , , at 12:47 pm, Staff E stated in a phone interview, "She wanted to go to the bathroom so I went with her and semi-closed the bathroom door for privacy; she had the walker that she used to have mainly to carry her , , she had big problems breathing. I asked her to call me if she needed anything and I went to the kitchen; few minutes later I went to the bathroom and I found her on the floor. She left the walker inside the bathroom and did not call me; I asked her "What happened" and she reply that she had and that had on her ; she was alert. At that same moment, her son was coming to visit her; I call 911 and call the administrator who was doing some errands."

On , , at 2:19 pm, the resident's physician stated, "I saw her for the first time on as a courtesy visit. On , I prescribed a rolling walker because of her critical medical condition, , failure; she was high risk of . On , I saw her for the second time. She was always high risk for because of her condition and I spoke to her son multiple of times about it. She would walk 10 and the risk of something happening was extremely high."

Review of hospital record for Resident 6 showed admission , . Patient with significant condition including permanent , , , , , type 2, . Admitted after mechanical , patient found with a left , . Left , status post-surgical procedure performed on , , patient developed some kind of acute on after surgery. Patient with acute , failure and patient found with , , transferred to intensive care with , support, progressive several complication including , , , , aneurysm reported on computed , scan of the , severe carotid . Evaluation by neurosurgery and recommended medical treatment, Doppler performed for better evaluation with combined , -diastolic failure. Patient remaining critical condition. Patient developed bed acute , , , severe decline in function , and patient at .

Class II

0092 - Food Service - General Responsibilities - 58A-5.020(1) FAC

Based on record review and interview, the facility failed to provide documentation of an certificate for Nutrition and Food Service training for two of seven sampled staff (Staff B and G) which contained the trainer's unique verification of having provided the training.

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Findings included:

Review of Staff B and G's records showed a Nutrition and Food Service training certificate without the licensed nutritionist's verification.

On , , at 11:50 AM during the exit conference, the Administrator stated, "We need to do the nutrition training again anyway, so I will make sure the trainer provide the ones with the seal."

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(&) FS; 58A-5.0241 FAC

Based on record review and interview, the facility failed to submit the required adverse incident report within one business day after an incident and a complete report within 15 days of the incident for one of seven sampled residents (Resident 3).

Findings included:

Review of Resident 3's record showed progress notes dated:

: Resident 3 around 5:30 am going to the bathroom, her got weak and to the front; sent to the hospital.
: Resident 3 broke the and is getting surgery,Thursday the 18th.
: The surgery was a success.
: Resident 3 sent to rehab, she feels a lot better.
: I went to see the resident and is receiving , ; the family is happy with the process.
: Today the resident went to the hospital and they took the bandage and sent her for exercises for the arm. She has an , , with the doctor .
No more notes on record.

On , , at 8:20 AM, the Administrator stated, "The consultant told me that after a year, the incident can not be reported in the system."

Uncorrected
Class III