STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910951	**03/07/2019**
NAME OF PROVIDER OR SUPPLIER **SALMOS 23 #4 LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **70 EAST 21ST STREET** **HIALEAH, FL 33010**	

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

0000 - Initial Comments

A change of ownership survey was conducted on . . . . . Salmos . #4 LLC with Limited Mental Health (LMH) component had deficiencies identified at the time of survey.

0009 - Admissions - Admission Package - 58A-5.0181(3) FAC; 400.0078(2)

Based on record review and interview, the facility failed to ensure that residents did not sign a 45 day notice and other consent forms as the admission package to the facility.

Findings included:

Record review found Resident #3 was admitted to the facility on . . . . Resident #3's admission package included a
signed 45 day notice that was not dated and also a signed consent form to have residents of opposite to share a room.

On at 10:57 AM, the Administrator confirmed that the forms were part of the admission package.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on observation, record review, and interview, the facility failed to honor the resident's rights to be free of . . . . . for two out of twelve sampled residents (Residents # 5 and # 6). Residents #5 and #6 had a half (½) bed rail attached on the outside in the middle of the bed. The facility also failed to ensure that linen storage was not placed in resident closets.

Findings included:

1) On . . . . . at 8:55 AM observed Residents #5 and #6 with . bed rails attached on the outside in the middle of the beds. The residents demonstrated that they did not know how to put the bed rails in a down position.

Record review showed Resident's #5 and #6 had physician orders for . side rails for a portion of the bed.

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On . . . . . at 8:55 AM, Staff I stated the bed rails were attached on the outside in the middle of the beds to prevent residents from falling. She said the bed rails was difficult to put down, therefore the residents was not able to do so.

2) On . . . . . at 9:05 AM in room eight observed facility linen stored in resident closet. At 9:10 AM, in observed linen stored in resident closet.

On at 9:05 AM, Staff I stated there was not enough closet space to put the linen, therefore the residents closets was used to store the linen.

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observations, record review, and interview, the facility failed to ensure that one of eight staff members followed the step outlined by the state when assisting with self-administration of medications to residents.

Findings included:

Entered the facility on at 8:30 AM , found Staff E reviewing the medications observation records (MORs) after medication pass was completed. Further observations found Staff E initialing the MOR for Resident #1 after the medications were given to the resident.
Later during the tour on . . . . . the morning supervisor stated Staff E initialed because the resident was in the hospital.

Record review found Resident was not in the hospital but in the facility. Interview with Resident #1 on . . . . . at 2:35 PM that staff gave him medications.

Class III

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

Based on record review and interview the facility failed to ensure that two out of 11 sampled staff (G and H) submitted a communicable statement within 30 days of being hired. Facility failed to provide evidence of a negative . . . . . statement on an annual basis for one out of 11 sampled staff (F)

Findings included:

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Review of Staff G's personnel record revealed she was hired on . . . . . Review of Staff H's personnel record revealed she was hired on . . . . . Staff G and H did not have freedom from communicable statements.

Review of Staff F's personnel record revealed the last negative statement was dated . . . . . .

On . . . . . at 2:10 PM the Administrator stated that she will make sure that the staff get a new physical examination and tests.

Class III

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

Based on record review and interview the facility failed to provide at least 2 hours of pre-service orientation to all new assisted living facility employees who have not previously completed core training prior to interacting with residents for three out of 11 sampled staff (C, F and H).

Findings included:

Review of the personnel records revealed Staff C was hired on . . . . . , Staff F on . . . . . , and Staff H on . . . . . Staff did not have the 2 hours of pre-service orientation prior to interacting with residents.

On . . at 2:20 PM the Administrator stated, "I will start doing the pre-service. I did not know."

Class III

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

Based on observation and interview the facility failed to provide a safe living environment and to ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order.

Findings included:

During tour of the facility on at 8:50 AM observed that in the residents did not have a bedside table or night stand.

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On at 8:50 AM Staff D stated that Resident # 2 keeps braking the tables and throwing things at the other resident that sleeps in the room.

On at 8:45 AM observed that the bed belonging to Resident #4 was broken.

On at 1:45 PM observed that the bathroom by # had a dark substance mold like in the ceiling.

On the Administrator stated that the maintenance person was going to paint it.

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record review and interview, the facility failed to have an updated admission and discharge log which listed where the resident was transferred to and the reason.

Findings included:

Review of the admission and discharge log found Resident #8's legal name was not listed. Another resident was discharged on but the location of discharge and reason was discharge were not documented. Also, there was a number of residents that were discharged to the hospital and did not return to the facility.

On at 10:56 AM, the Administrator reviewed the log and reported that someone from the Agency told her she did not need to have the discharge information. She did not respond to why the residents did not return from the hospital. She acknowledged that the residents's legal names needed to be listed on the log.

Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on record review and interview the facility that went under new ownership failed to provide the emergency management plan approval letter.

Findings included:

Review of the emergency management plan letter posted in the bulletin board in the administrator's office revealed that it was dated and was for the previous owner of the facility.

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On at 9:10 AM the Administrator stated that they had already submitted the new emergency management plan under the new ownership but they had not received the approval letter yet. She provided the receipt of the payment dated .

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on record review and interview the facility failed to notify in writing each resident and the resident's legal representative of the implementation of the emergency power plan.

Findings Included:

Review of Residents #2, #3, #9, and #14 revealed that there was no written notification of the implementation of the emergency power plan.

On at 1:35 PM the Administrator stated that she would do the notifications.

Class III

L241 - LMH - Records - 429.075( ); 58A-5.029(2) FAC

Based on record review and interview, the facility failed to ensure that the annual community living support plans (CLSP) were specific to each resident.

Findings included:

On at 8:30 AM during the tour staff stated Resident #3 takes clothes out of closet constantly so the closets are locked.

Record review found Resident #3 and other residents had the same plan documented on the CLSP.

Class III