STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967124	03/20/2019
NAME OF PROVIDER OR SUPPLIER **ZUNI ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **370 NW 133RD PLACE** **MIAMI, FL 33182**	

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

0000 - Initial Comments

A Complaint Survey (CCR #201900125) was conducted on and concluded on . Zuni ALF, Inc. with standard license had the following deficiencies identified 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 care and services and to offer personal supervision appropriate to the needs of 2 out of 5 (Residents #1 and #5) sampled residents who at the facility and were transferred to a higher level of care. The facility also failed to have written documentation for 2 out of 5 (Residents #1 and #5) sampled resident who at the facility.

Findings as follow:

1) On at 10:00 AM Staff B stated on Resident #1 before going to the hospital for . Staff stated that Resident #1 is very active, she was sitting on a recliner and crossed her , moved to one side and . The resident did not complaint about , , the facility called rescue who evaluated her and decided she was ok. She reported Resident #1 always has that persists after surgery. Staff stated that Resident #1 had about four times because she had and gets agitated. In order to avoid the , the Administrator talked to her son to place the resident in hospice so they can order a safer bed with full rails.

Hospital records revealed Resident #1 was admitted on for . Medical Certification for long term services conducted on documented Resident #1 had a right , a , all over body and right , . An additional medical certification for long term services conducted on documented Resident #1 had a right arm , , and a on right , .

Record review showed the facility failed to maintain written record after each of Resident #1's or falling following up with Resident #1's doctor. The facility failed to document what steps or interventions were taken after Resident #1 at least four times in the facility.
The facility failed to developed a plan to avoid other in the future for Resident #1.

Record review showed Resident #1 was admitted to facility on . Resident #1's health assessment date stated that resident needed assistance with transferring, ambulation, , eating, self -care. Resident #1 had precautions.

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On at 1:30 PM the Administrator acknowledged the facility did not develop a personalized plan to avoid for Residents under risks. The Administrator also stated the facility failed to have documentation of staff interventions after the . The Administrator added that the facility did not document Resident #1's and .

2) On at 9:50 AM Staff B stated Resident #5 on after bathing her. She stated resident was standing up grabbed of her walker and started coughing, she moved out from the walker and to her . She stated that after the staff called the rescue who transferred her to the hospital. She stated due to the Resident #5 had .

Facility incident report documented that on at 08:15 AM, "Patient was out of the shower getting dress. Patient was stable and holding bathroom rail. She started coughing and lost control and ."

Hospital records revealed Resident #5 was admitted on . Fire rescue arrived to the ALF site on at 8:40 to evaluate Resident #5 for a injury. The chief complaint was for a and had discomfort on the lower right extremity. Imaging section stated Resident #5 had of the right , six and seven . Correlate with point tenderness and , .

Resident #5 was admitted to facility on . Resident #5's health assessment dated stated the resident had a history of right , . The resident was independent eating, needed supervision with grooming and toileting, and required assistance ambulating, bathing, and . Resident #5 had precautions.

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 complete the one day and 15 full day incident report to the Agency.

Findings as follow:

On at 9:50 AM Staff B stated Resident #5 on after bathing her. She stated resident was standing up grabbed of her walker and started coughing, she moved out from the walker and to her . She stated that after the staff called the rescue who transferred her to the

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Resident #5 was admitted to facility on . Resident #5's health assessment dated stated Resident #5 had precautions.

On at 1:32 PM the Administrator stated Resident #2 by accident while staff was assisting her in the bathroom. She stated resident complained of , and the called rescue who transported her to the hospital. Resident broke 2 . The Administrator acknowledged he had not sent a 24 hour incident report to AHCA.

Class III