STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968099	**03/27/2019**
NAME OF PROVIDER OR SUPPLIER **CUTLER BAY VILLAGE ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **10425 SW 212 STREET** **MIAMI, FL 33189**	

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

0000 - Initial Comments

An Abbreviated Biennial survey was conducted on . . . . . Cutler Bay Village ALF had deficiencies identified at the time of the survey:

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview, the facility failed to have accurate health assessment for three out of 16 sampled residents (Resident #4, 5 and 15).

Findings included:

Review of Resident #4's health assessment dated . . . . . , Resident #5's health assessment dated , and Resident #15's health assessment done on showed the residents needed assistance with self-administered medication.

Hospice record review showed the physician ordered medication administration on . . . . . for Residents #4, #5 and #15.

On at 3:55 PM, the Administrator stated the facility's nurse administered the medications to Resident #4, #5 and #15.

Class III

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

Based on observation, record review and interview the facility failed to submit an adverse incident report within one business day.

Findings included:

On . . . . . at 1:45 PM, observed Resident # 1 with a brace to her left arm. Resident # 1 stated she'd had a about a week earlier when she'd attempted to move into the shade, and had lost her balance and . .

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Review of the facility's onsite incident report showed Resident #1 on . Review of the resident record showed that the resident needed precautions, ambulated with a Rollator and had a bed rail attached to her bed. On at 2:55 pm, the Administrator stated that the daughter had left the Resident alone as she went inside the facility, and had returned to find the resident lying on the terrace porch. The administrator further stated that the following day the resident started to have , and in the left arm, and he notified the daughter, who declined to have the resident taken to the emergency room, saying that she'd take Resident #1 herself. Further record review showed no documentation that the resident received precaution assistance from staff to walk into the facility.

Review of Adverse Incident Report System showed that the facility did not file a reportone business day after the incident for Resident #1.

On at 2:55 PM, the Administrator stated he did not report the incident. He stated he did not think the incident needed to be reported.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on record review, and interview, the facility failed to develop a written policy or procedure ensuring the alternate power source and fuel could be effectively operated and maintained. The facility failed to notify its residents and/or the resident's representative of the implementation of the facility's Emergency Plan.

Findings included:

Facility's record review showed the facility did not have written policies and procedures detailing and instructing staff how to operate and maintain the generator.

Resident record review showed no documentation that the facility notified residents and/or their legal representatives of the facility's emergency plan and use of an alternate power source.

Interview conducted on at 3:55 PM, Administrator confirmed that the facility did not have written policies and procedures detailing and instructing staff how to operate and maintain the generator. He further stated that they would notify the resident's and/or their representative of the implementation of the plan.

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Class III