STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965534	**05/07/2019**
NAME OF PROVIDER OR SUPPLIER **IMPERIAL CLUB**	STREET ADDRESS, CITY, STATE, ZIP CODE **2751 NE 183 STREET** **AVENTURA, FL 33160**	

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

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on record review and interview, the facility failed to update it's employee roster in the background screening clearinghouse database.

Findings included:

Review of the background screening clearinghouse database revealed that did not remove Staff # H,I,J,K and L, who no longer worked in the facility at the time of the survey.

Interview on at 10:00 am Staff A stated, "We have to remove all the staffing that are not working here anymore; the facility started new changes on ."

Interview on at 10:00 am Staff A stated, "We need to update the facility roster."

Unclassified

Z824 - Right of Inspection; Inspection Reports - 408.811 FS; 59A-35.120 FAC

Based on observation and interview, the center failed to have access to staffing records at the time of the survey.

Findings Included:

Record review revealed that the facility did not have any staff records on site at the time of survey.

Interview on at 11:00 am Staff A stated, "We do not have staff records on site. All residents' records are at the main office, and we do not have access through the computer, neither."

Unclassified

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0000 - Initial Comments

A Change of Ownership survey was conducted at Imperial Club on through . The facility had deficiencies identified at the time of the survey.

0027 - Resident Care - Arrangement for Health Care - 58A-5.0182(3) FAC

Base on record review and interview, the facility failed to assist one of four sampled residents in making and/or keeping for medical services (#1).

Findings included:

Record review revealed that the facility did not have observation notes regarding Resident #1's need for podiatry services.

On at 11:00 am Resident #1's private aide revealed that Resident #1 needed to see his podiatrist.

On at 11:39 am Resident #1's family member stated, "Resident #1 needs to see a podiatrist; he has not gone yet. I made a request to the facility, and he is still waiting on it. Hospice does not provide that service. It has taken a while for Resident #1 to see the podiatrist."

On at 11:45 am Staff A stated that the facility did not have in writing Resident #1 Podiatry consultation request. Staff A stated that the facility had a podiatry monthly consultation in the facility, or that the residents could go to the podiatrist's office. In addition, Staff A stated, "I do not know if Resident #1's health insurance will cover our podiatrist."

Class III

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

Based on observation and interview, the facility failed to treat two of fifteen sampled residents were in needed of their daily living assistance with consideration and respect, and due recognition of personal dignity (Resident # 1 and 15).

Findings included:

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Observation on at 8:00 am revealed that Resident #1 room and bathroom had an strong odor to due to a container with Resident #1's dirty clothes and bed linen inside of the bathroom.

On at 10:00 am, Staff A confirmed that Resident #1's bathroom and room had a odor.

Observation on at 9:00 am revealed that the facility had Resident #15 in # . The room's carpet had dark stains all over.

On at 10:45 am Staff A acknowledged that Resident #15 occupied a room that had dark stains all over.

On at 10:45 Staff F stated, "Resident #15 used to have a wheelchair, and it left those stains on the carpet."

On at 11:00 am Staff A stated that the facility did not wash the dirty clothes for residents. In addition, Staff A stated, "We provided cleaning of the bed linens and towel only. Resident #1 has a private staff, and she is in charge to wash his clothes."

Class III

0031 - Resident Care - Third Party Services - 58A-5.0182(7) FAC 429.255(1)(b). FS

Based on record review and interview, the facility failed to ensure that a third party provider left documentation for services provided to one out of 15 sampled residents (Resident #1).

Findings included:

A review of the residents' file on revealed that the last plan of care in file for Resident #1 dated . Plan of care for the month of not in file. Further review showed no documentation of the initial certification and recertification for Resident #1.

On at 12:38 PM, the Administrator acknowledged the findings.

Class III

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SUMMARY STATEMENT OF DEFICIENCIES
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0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observation, record review and interview, the facility failed to follow proper procedures when assisting one out of 15 sampled residents (Resident #2) with self-administration of medication.

Findings included:

On observed Staff C went to Resident #2 's room. Resident #2 was sitting on a recliner watching TV. At 8:04 AM Staff C washed her , unlocked the medication box, took the Medication Observation Record (MOR) out, read it, checked the morning medication one by one, opened the bottles, placed the dosage in a small cups, went to Resident #2 side with the small cups, handed it to him with a cup of water, watched the residents swallowed the medication, signed the MOR, placed the MOR and the bottles in the box, and locked the box. Staff C did not read the medications to Resident #2.

Review of the MOR and medication reconciliation on showed that the medications were:

- 40 mg tablet, take one tablet by twice daily
- 2.5 mg tablet, 1 tablet by twice daily
- 100 mg softgel, 1 capsule by twice daily
- 10 mg tablet, take 1 tablet by daily
- 25 mg tablet, take 1 tablet by twice a day
- 40 mg tablet, take 1 tablet by every day
- 135 mg capsule, take 1 capsule by everyday
- 25 mg tablet, take 1 tablet by once daily
- 81 mg tablet, take 1 tablet by every day
- 400 mg tablet, take 1 tablet by every day
- 80 mg tablet, take 1 tablet by every day
- 80 mg capsule, take 2 capsules by every
-Centrum MVI tablet, take 1 tablet by once daily
-Fish oil 1000 mg capsule, take 1 capsule by once daily.

On at 12:38 PM, the Administrator acknowledged the findings and said "okay."

Class III

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SUMMARY STATEMENT OF DEFICIENCIES
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0054 - Medication - Records - 58A-5.0185(5) FAC

Based on observation, record review and interview, the facility failed to maintain an accurate daily medication observation record (MOR) for one out of 15 sampled residents who received assistance with self-administration of medications (Resident #2).

Findings included:

On observed Staff C assist Resident #2 with self-administration of medication.

Review of the MOR and medication reconciliation on showed that the labels stated " 25 mg tablet, take 1 tablet by twice a day." However, the MOR was handwritten and stated " take 2 tablets by once daily."

In an interview on at 8:13 AM Staff C stated "I gave him 2 because the paper said 2."

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 free of hazards to its residents and failed to ensure that all existing architectural, mechanical, electrical and structural systems and appurtenances are maintained in good working order.

Findings included:

Observation on at 8:00 am showed a cabinet in a multipurpose room with a broken and missing door. # had peeling paint on bathroom door. Observed a worn stained carpet in hallway at third floor between . The facility removed the border of the floor and the wall, of the hallway, on third and fourth floor. In addition, the bathroom next to # had a lock in the sink desk.

Interview on at 8:41 am, Staff A stated, "The facility is under renovation."

Observation on at 8:03 am showed that the facility had stained furniture on the facility's common areas.

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On at 10:45 am, on vents on the third and fourth floor by the elevator, observed dark stains that look like mold.

In an interview on at 10:48 am, Staff A stated "It appeared that the previous owner never clean the duct. It was when removed the vents cover that we saw that there was mold. Our headquarters is contacting a company to come clean the vent."

Class III

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

Based on observation, record review and interview, the facility failed to have an accurate and complete health assessment for two out 15 sampled residents (Resident #1 and #2).

Findings included:

On at 9:08 AM observed Resident #1 in a hospital bed with half rails.

Review of the residents's files on showed health assessment dated for Resident #1 stated "Needs assistance with self-administration of medication." Physician orders dated stated "crush meds and administer in yogurt. Needs medication administration." Further review showed that Resident #1 did not have a signed informed consent to the use of bed rails in file.

Review of Resident #2's file on showed health assessment dated stated "cannot self-administer ." Physician orders dated stated " to administer his own ."

In an interview on at 12:38 PM, the Administrator acknowledged the findings.

Class III