STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968608	R 05/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDIAN GARDENS ASSISTED LIVING FACILITY	**17250 SW 137 AVENUE MIAMI, FL 33177**

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

0000 - Initial Comments

A fourth revisit to a biennial survey was conducted at Floridian Gardens Assisted Living Facility on and concluded on . Deficiencies were identified at the time of survey:

0029 - Resident Care - Nursing Services - 58A-5.0182(5) FAC

Based on interview and record review, the facility failed to ensure that a licensed staff interpreted the vital signs and evaluated or assessed a resident's condition for one out of 65 sampled residents (#64).

Findings included:

A review of the facility's admission and discharge log for the month of revealed that Resident # 64 was transferred to the hospital on due to being unresponsive.

A review of Resident # 64's records showed that her admission date to the facility was on and her last health completed assessment was on . Resident # 64 had medical history and diagnoses of , and . Further review of Resident # 64's records showed she required assistance in ambulation, bathing, , toileting, and transferring. In addition, Resident # 64 required supervision for self - care (grooming) and was independent to eat on her own.

Further review of Resident # 64's progress notes dated revealed that Staff DDD wrote: "Approximately at 4:30 AM, when a staff who was assisting the resident, called me to observe Resident # 64 because she did not look good and was very calm. I started to check her vital signs: P. 76. Resident # 64 told me she was feeling bad and her whole body hurt, her saturation was 95 and I asked her if she was hungry and she told me yes so I offered her yogurt and she ate it, I stayed with her until she went to sleep. She did not have any or and I stayed with her for a while to leave her calm and asleep. When it was time to change shifts, I told the nurse and the supervisor."

On at 4:03 PM, Staff DDD stated that staff completed rounds every hour and within rounds, they check if residents are sleeping and ensure their bed rails are up. She checks if they are breathing by observing their rising. Last time she saw Resident # 64 was around 4 AM. She got a call because the resident did not seem normal. She went and took her vital signs, which were normal. Resident # 64 had told her that her body hurt and she was not someone who complained a lot; however, she did love to eat. Staff DDD then gave Resident # 64 a yogurt and stayed with her until Resident # 64 asleep. After she went to sleep, Staff DDD checked two more times and stated that the resident was

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sleeping. Staff then explained that the resident did not show any signs or symptoms of or . During shift change, Staff DDD gave a written report to Staff EEE and Staff GG before leaving the facility. Staff DDD also stated that she is not a licensed nurse or healthcare professional.

Additionally, a second progress note dated stated: "The ALF nurse did an evaluation of Resident # 1 after she was called because the resident was weak and could not get up. Staff EEE performed an evaluation for all systems; the resident did not respond to verbal stimulation, there was no evidence of , distress at this time, normal pupils. Vital signs were take: , HR: 66, R 21 T: 95. No s/s (signs/symptoms) was observed. Supervisor Staff GG called 911. The resident was transferred to the hospital. The nurse will continue to follow up."

On at 10:19 AM, Staff EEE stated, "I arrived to my morning shift and was told that Resident # 64 wasn't feeling well. She was and wasn't responding when her name was called. She would mumble when I would call her name. Her vital signs were good, she was breathing and her , rates were 20-22 breaths per minute with no difficulty breathing. She didn't seem normal. I stayed there until the rescue got there and there was no significant change from the moment I called 911. When rescue arrived, I stepped to the side and allowed them to do their job. No was done. She had a and was still alive. At least to my knowledge, they didn't try to intubate her in her room. She was and responding , just not the way she typically responds. I don't think I worked the night before. I'm unsure if she took her medication because I wasn't the one that was providing medication to her."

On at 3:04 PM, Staff GG explained that during the morning of , Staff GG went into Resident # 64's room to get her ready to eat breakfast when Resident # 64 was found to not be responding to verbal stimuli. Staff GG described Resident # 64 as someone who always loved to talk and laughs; however, Resident # 64 was not saying hi that morning while her were open and she was breathing normally. Once Staff EEE arrived to Resident # 64's room to assess her, Staff GG followed to contact 911. Staff GG also explained that she had seen Resident # 64 leaving the facility in a gurney with rescue and stated "she did not have anything in her ".

Review of Resident # 64's Emergency Medical Services ( ) report showed that chief complaint was unresponsive. The resident was found unresponsive upon arrival with labored breathing on at 8 AM. At 8:02 AM, her saturation started to drop, had no audible , and a weak , while moaning and opening to painful stimulation. attempted to intubate the resident twice at 8:12 AM and was unsuccessful. Further review of the 's exam revealed that Resident # 64's / assessment consisted of decreased breath sounds on the left and right side. Resident's airway indicated agonal , . Resident # 64 remained with no audible , and weak

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, until arrived to the hospital on at 8:42 AM.

Review of Resident # 64's hospital records showed that the ambulance attempted to intubate the resident twice and suffered a on arrival. Hospital records documented that the resident had coffee ground in her upper airway and had lost her , . Resident # 64 received , , and before being moved to the .

Further review of Resident # 64's hospital records showed under history of present illness that the resident was found unresponsive in the ALF in the morning and last time seen in the baseline was the previous night. She had diagnoses of , , contents in the , tract part unspecified causing asphyxiation, acute , failure with acute hypercapnia and . She suffered anoxic , requiring .

Review of Resident # 64's progress notes dated stated "As per Resident # 64's niece, resident continues intubed with assisted breathing and medications in veins. Possibly the family today makes the decision to remove the tubing because the resident is . Nurse will continue to follow up." A second progress note dated stated "The niece of the resident was contacted regarding resident health condition. She let us know that on the night of Tuesday, resident was disconnected from the life support system and she , ."

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on record review and interview, the facility failed to follow the procedure outlined by the state for disposing of abandoned medications for one out of 65 sampled residents (#65).

Findings included:

Review of facility's admission and discharge log showed that on at 8:35 AM, the rescue transferred Resident #65 to the hospital with , and , .

Review of Resident #65's record showed that the progress notes dated on states that the resident was discharged on ; the resident's daughter wen to the facility for picking up her belongings on because resident , on .

On at 2:20 PM, the Registered Nurse (Staff N) revealed that the facility discarded Resident

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#65's medications. The facility had a chemical where they put the medications and it dissolved the medications. The facility followed the charting code in the of the Medication Observation Records.

Review of Resident #65's MORs showed staff initialed medications until at 8 AM. Medications on at 3 PM, 6 PM, 7 PM and 8:30 PM and on at 7 AM, 8 AM, and 9 AM were initial with "I". Medications on at 3 PM, 6 PM, 7 PM and 8:30 PM were initial with "C". The of the MORs showed that "I" was for Hospital and "C" was for patient out of facility. There was no documentation about disposal of medications for Resident #65.

On at 3:02 PM, the Administrator revealed that when a resident the facility discarded the medications at the time of the closed the case. The facility did not keep any record for the medications that the facility decided to were disposed.

Uncorrected
Class III

0058 - Pharmacy & Dietary; Uncorrected Deficiencies - 429.42( ) FS; 58A-5.033(3)(a) FAC

Based on record review and interview, the facility failed to correct deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, deliver, or administration during a survey. The facility has an uncorrected deficiency class III for storage and disposal of medications. The facility has been required to employ the consultant services of a licensed pharmacist or a licensed registered nurse who will, at a minimum, provide onsite quarterly consultation until an inspection by the Agency's personnel determines that such consultation services are no longer required.

Findings included:

1. Based on record review and interview, the facility failed to follow the right procedure for disposing the abandoned medications for one out of 65 sampled residents (#65).

Findings included:

Review of facility's admission and discharge log showed that on at 8:35 AM, the rescue transferred Resident #65 to the hospital with , and , .

Review of Resident #65's record showed that the progress notes dated on states that the resident was discharged on ; the resident's daughter wen to the facility for picking up her

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belongings on because resident , on .

On at 2:20 PM, the Registered Nurse (Staff N) revealed that the facility discarded Resident #65's medications. The facility had a chemical where they put the medications and it dissolved the medications. The facility followed the charting code in the of the Medication Observation Records.

Review of Resident #65's MORs showed staff initialed medications until at 8 AM. Medications on at 3 PM, 6 PM, 7 PM and 8:30 PM and on at 7 AM, 8 AM, and 9 AM were initial with "I". Medications on at 3 PM, 6 PM, 7 PM and 8:30 PM were initial with "C". The of the MORs showed that "I" was for Hospital and "C" was for patient out of facility. There was no documentation about disposal of medications for Resident #65.

On at 3:02 PM, the Administrator revealed that when a resident the facility discarded the medications at the time of the closed the case. The facility did not keep any record for the medications that the facility decided to were disposed.

2. There was a consulting agreement signed on with Staff QQ. It showed that consultation services would be performed quarterly. The last consultation note was dated on - finished with the 700's. The prior consult visits were on , , , (-), , (, , , , - , -).

On at 1:54 PM, the Administrator revealed that the nurse consultant visited the facility multiple times but on the last visit, she took the missing documentation with her by mistake.

Uncorrected
Class III

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

Based on record review and interview, the facility failed to have evidence of a negative examination documented on annual basis by the Florida Department of Health or a licensed health care provider for one out of forty four (Staff OO).

Findings as follow:

Staff record review showed no documentation of freedom from ( ) documented on annual basis for Staff OO.

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On [redacted] at 1:00 PM, the Administrator stated that she talked to the Doctor to request the statement and he said that he needed an statement from the Agency for Health Care Administration (AHCA) stating that the employee X ray was valid for 5 years.

Uncorrected
Class III

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

Based on observation, interviews and record reviews, the facility failed to correct deficient practices within 30 days after having been notified of them by the Agency for Health Care Administration.

Findings:

A review of inspection reports showed that the facility was cited for deficient practice regarding Medication Storage and Disposal on , , . Interviews and record review on showed that the facility had improperly documented medication disposal.

A review of inspection reports showed that the facility was cited for deficient practice regarding the need to obtain a licensed consultant to correct pharmacy deficiencies on , and . Interviews and record review on showed that the facility failed to provide documentation of consultant services.

A review of inspection reports showed that the facility was cited for deficient practice regarding Staffing Standards on , , and . Interviews and record review on showed that the facility failed to provide documentation of freedom from for one of 44 staff (OO).

Unclassified