Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969794	A. BUILDING: _____ B. WING _____	R 05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRABELLE	7400 SW 88TH ST MIAMI, FL 33156

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments A revisit survey was conducted at Mirabelle from through . Deficiencies were identified at the time of the survey. A Class I deficiency was found at tags A0010, A0025, and A0079. A Class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is neccessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, , , or to a resident receiving care in a facility. The Class I deficiency began on when Resident #28 was found on the bathroom floor after a and a second time on . There were multiple in the facility including Resident #40 who had a in , which resulted in a , , and three more times since then. Resident #30 Resident #35 but there was no documented report of the . . . Furthermore, Resident #30 was aggressive towards her husband and would entered residents' rooms. Resident #30 had multiple including one which resulted in a . In addition to multiple , the facility only had six employees with 89 residents when Resident #28 was found on the floor on . The facility's Administrator and Assistant Executive Director was notified of the Class I noncompliance on at 1:22 PM.	{A 000}		
{A 010} SS=K	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency	{A 010}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{A 010}	Continued From page 1 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving	{A 010}		

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{A 010}	Continued From page 2	{A 010}		

hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to:
a. Move, turn, or reposition without total physical assistance;
b. Transfer to a chair or wheelchair without total physical assistance; or
c. Sit safely in a chair or wheelchair without personal assistance or a physical .
2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days.
3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days.

(2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.

(3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility.

59A-36.006
(4) CONTINUED RESIDENCY. Except as follows

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{A 010}	Continued From page 3	{A 010}		

in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are:
(a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S.
(b) A resident requiring care of a , may be retained provided that:
1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner,
2. The condition is documented in the resident's record; and,
3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility.
(c) A ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:
1. The resident qualifies for, is admitted to, and

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{A 010}	Continued From page 4 consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to determine the appropriateness of continued residency for three (#6, #28, and #30) out of 48 sampled residents, including Resident #28 who needed a higher level of care and was found with an ( ) port and refused baths for an unknown period. Resident #30 had a	{A 010}		

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{A 010}	Continued From page 5	{A 010}		

history of physical aggression towards residents. Resident #6 remained in the facility after several documented , including an on Resident #48, which resulted in a police investigation.

Findings Included:

1)
A review of Resident # 28's progress note dated showed that facility had discovered an ( ) port, and it was unknown when it was placed. The progress notes also revealed that Resident 28's son was actively looking for a skilled nursing facility. Resident #28's progress revealed that as early as , there were changes in Resident #28's condition including frequent calls for toileting and resident (Resident #28) refusal to accept assistance.

During an interview on at 2:50 PM the Assistant Executive Director stated that Resident #28 was last at the facility on after being under hospice care for one day. The Assistant Executive Director stated that Resident #28 had an port and was being treated by a private nurse, but he (Assistant Executive Director) did not know for how long and when the port was placed on the resident.

During an interview on at 9:27 AM, Resident # 28's son stated that staff at the facility would not take care of his father and were not equipped to help him. He further stated that Resident #28 refused staff assistance with bathing and that his father only took a bath when he was present.

A review of data from The Cleveland Clinic

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{A 010}	Continued From page 6 showed that health care providers used , ports to give treatments and directly into ta . A port allows easy access to a for draws. People with , severe , , , and may need , ports. With the device, you need fewer needle sticks for certain treatments, like , , . Interviewed on at 12:58 PM Staff R (Resident Assistant) stated that Resident #28 never took off his shoes and always slept with them on. Staff R stated that Resident #28 would get upset if someone tried to take his shoes off, he (Resident #28) would get upset and curse. Interviewed on at 4:09 PM, Staff P (Resident Assistant) stated that she provided assistance with baths for Resident #28. Staff P stated that the resident never allowed her to shower him. A review of Resident 28's health assessment dated showed a diagnosis of Prostatic Hyperplasia ( ). The physical status showed unable to walk and wheelchair bound. The status showed normal. The resident had , prevention precautions. Resident #28 needed assistance in ambulation, bathing, , eating, self-care, toileting, and transferring. 2) During an interview on at 11:20 AM the Wellness Nurse stated that Resident # 30 was aggressive and her husband (Resident #31) repeatedly. The Nurse further stated that Resident #30 Resident #35. The Wellness Nurse stated that Resident #30 other residents, but she was unable to provide the names or documentation of those	{A 010}		

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{A 010}	Continued From page 7 . The Wellness Nurse stated that Resident #30 was aggressive towards staff too. The Wellness Nurse stated that Resident #30 had been aggressive since she had been employed, and that recently the resident had gotten worse over the prior seven months. A review of Resident # 30's hospital records showed that on she was hospitalized under the for behavior changes and discharged on . A review of resident # 30's progress notes showed that on the resident pushed staff away after refusing medications. On Resident #30 after becoming verbally aggressive with staff and was hospitalized with a . During an interview on at 11:30 AM Staff R stated that Resident #30 chased her down the hallway because the resident was aggressive. 3) A review of Resident #6's progress notes dated showed Resident #6 demonstrated aggressive behavior towards staff and other residents. On , [Resident #6] "hit, shoved, and pulled the hair of staff. [Resident # 6] hit another resident [Resident # 48] where police had to be called. On , Resident #6 was noted to be and agitated, pushed the staff, and . On the staff noted that Resident # 6 was very agitated, aggressive, and was uncontrollable and fighting with staff. A review of facility's records showed Resident #6 remained in the facility. A review of the facility's continued residency policy showed that a resident would be discharged if the resident became a danger to	{A 010}		

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{A 010}	Continued From page 8 self or others. On from 6:30 AM to 1:00 PM during the survey Resident #6 and 30 were observed interacting with staff and other residents. Class I	{A 010}		
{A 025} SS=K	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident,	{A 025}		

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{A 025}	Continued From page 9 including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to have an awareness of the general health, safety, and physical well-being of three (#28, 30, and 40) out of 48 sampled residents. Residents #28 had an unwitnessed which resulted in the of four , the occurred while the resident was toileting and transferring. Resident #30 had an unwitnessed while ambulating and suffered a . Resident #40 who needed assistance with activities of daily living three times in less than a month, after having a	{A 025}		

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{A 025}	Continued From page 10	{A 025}		

previous last year, which resulted in a left , and .
Findings included:
1)
A review of the incident report dated showed that Resident # 28 was found on faced down on bathroom floor.

During an interview on at 11:30 AM Staff R (resident assistant) stated that on at around 2:00 AM she found Resident # 28 on the floor after responding to a pendant call. She stated that Resident #28 had scrapes on his and there was around the resident. Staff R stated that she called her supervisor when she found him on the floor.

A review of the facility's call pendant log showed that more than 20 minutes elapsed before staff responded to Resident #28's call for assistance. The first call was recorded at 2:04 AM and the wife also called at 2:13 AM. The wife's pendant call was answered 7 minutes after.

A review of Resident # 28's health assessment dated showed the resident had an inability to walk and that he was wheelchair bound as a physical limitation. The resident needed assistance with ambulation, bathing, eating, self-care, toileting, and transferring.

A review of Resident # 28's hospital record dated showed that the resident suffered a while walking to the bathroom unassisted. Resident # 28 was diagnosed with a closed injury and and was ordered to follow-up with his primary care doctor days after.
A review of Resident # 28's progress note showed that there was no documentation of the

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{A 025}	Continued From page 11 on or any subsequent care. During an interview on at 11:15 AM Staff J stated that the residents never complained of any , after the on . A review of Resident 28's individual service plan dated showed the staff would monitor transfers and provide two-person assistance as needed. Additionally, the resident would receive total assistance with bathing and showering by staff. During an interview on at 9:30 AM Resident # 28's son stated that his father complained of , and trouble breathing as early as two days after the , and that he eventually took his father to urgent care to get evaluated on . The son also stated that staff were not well suited to the task of caring for his father. A review of Resident # 28's urgent care records dated showed Resident #28 was complaining of and was diagnosed with of the fifth and sixth after diagnostic test. Resident was instructed to call 911 if his condition worsened but was also advised to follow up with his primary care doctor. A review of Resident # 28's progress note showed that there was no documentation of progress or subsequent care after . A review of the call pendant for Resident # 28 showed that between and there were eight (8) pendant calls during 11:00 PM to 7:00 AM. Between to there were twenty-nine (29) pendant calls during the 11:00 PM to 7:00 AM shift.	{A 025}		

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{A 025}	Continued From page 12 A review of Resident # 28's hospital records dated showed that Resident # 28 complained of , . Resident# 28 was diagnosed with right and was recommended follow-up with a and orthopedic surgeon. A review of Resident # 28's hospital records dated showed that fire rescue took the resident yet again to the hospital after he complained of . Diagnostic test reveal displaced right anterior of the third through sixth . The resident was recommended to follow-up with a , in days. A review of Resident # 28's progress note showed that there was no documentation of subsequent care after . According to the Mayo Clinic, a person with would not only experience , but would also be at risk of , , as poorly controlled , can affect , , mechanics and cause atelectasis. During an interview on at 2:00 PM Staff J stated that the resident was supposed to be bathed every other day but could not say if the resident was bathed. Staff J did not answer when asked if a log was kept showing when residents were bathed. A review of Resident #28's hospital records dated showed that he had another and that he was being treated for a , . Resident was diagnosed with closed injury, of the left and left and skin .	{A 025}		

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{A 025}	Continued From page 13 2) A review of the incident report dated showed that Resident # 30 had an unwitnessed and suffered and injuries. A review of the Resident # 30's hospital records dated / 2026 showed that she had an unwitnessed and suffered acute with and to her , . According to the Mayo Clinic, occurs when builds up in the space between the and the tissues that cover the . If left untreated it can lead to permanent damage or . A review of the Resident #30's individual service plan dated showed the residents would receive reminders for ambulation and transferring including instructions to use an assistive device. A review of Resident #30's health assessment dated showed that she had special precautions for . Resident #30 needed assistance with ambulation, bathing, , eating, self-care, toileting, and transferring. During an interview on at 11:20 AM Staff J (Wellness Nurse) stated that Resident # 30 was known for being aggressive toward staff. During an interview on at 11:30 AM Staff R (resident assistant) stated that when she worked on Resident #30's floor, she would avoid Resident #30. Staff R recalled that, on one of her shifts, she had to run away from Resident #30. 3) A review of an incident report dated	{A 025}		

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{A 025}	Continued From page 14	{A 025}		

showed that Resident # 40 and suffered a displaced left , and left pubic . On after the in , the residents had again this time suffering a hematoma on the right frontal area of her .

During an interview on at 10:45 AM Staff Q (Memory Care Director) stated that as part of the intervention plan increase rounding would take place every hour depending on the individual's service plan.

A review of the Resident #40's individual service plan dated showed the resident would receive total assistance with ambulation and staff would provide standby assistance while residents ambulate. Additionally, staff were to provide reminders and instructions for transferring.

A review of Resident #40's health assessment dated showed that she was diagnosed with , , , , and . Her physical and sensory limitation showed that he needed ambulation with a rolling walker. The residents had precautions for and pressure injuries. The residents needed assistance with ambulation, bathing, , eating, self-care, toileting, and transferring.

A review of the facility's reduction initiative protocol dated , showed that "resident that experiences a would receive the appropriate care and interventions necessary immediately after the ." The protocol also explained that "staff huddles" would happen to review interventions or new risk identified.

A review of Resident # 40's progress note

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{A 025}	Continued From page 15 showed that on , and had more . On she while there was an unassisted transfer out of bed. On / 2026 resident again when getting up from her walker without assistance. On while ambulating unassisted. According to the Center for and Control (CDC) are the leading cause of injury-related for adults ages 65. are common, costly, and preventable. Class I	{A 025}		
{A 079} SS=K	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 212 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416 66-75 457 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy	{A 079}		

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beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours.
3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.
4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night.
5. A staff member who has completed courses in First Aid and , , ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times.
a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement.
b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and .
6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least , , must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or

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{A 079}	Continued From page 17 manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents,	{A 079}		

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{A 079}	Continued From page 18 resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively.	{A 079}		

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{A 079}	Continued From page 19 This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide adequate staffing to meet the scheduled and unscheduled needs of three out of 48 sampled residents (#28, 32, and 47). Resident #32 swallowed unlocked medications left in a room when there was inadequate staffing, which resulted in a medication error and hospitalization for two days. Residents (#28, and 47) required staff supervision and assistance and had unwitnessed which resulted in , , 911 calls and hospitalizations. Findings included: 1) A review of the facility's incident reports showed that Resident #32 was administered medication intended for another resident [Resident #33] by an agency licensed practical nurse (LPN) on . During an interview on at 10:41 AM the Memory Care Director stated that on the night of the medication error an employee called out and the agency LPN was used to fill the absent position. She further stated that this was a common practice to use at temporary agency staff when they could get their own staff to cover the shift. A review of the hospital records dated showed that Resident #32 was sent to the hospital due to a medication error where she consumed 225mg of , , and had elevated , after the dosage. During an interview on at 11:20 AM	{A 079}		

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{A 079}	Continued From page 20 Staff T (Staffing Coordinator) stated that on the day that Resident # 32 was inadvertently administered the medication, he was working as a medication technician on another floor. Staff T stated that he had to go help the agency temporary LPN because she was three (3) hours behind. Staff T stated that there were only two medication technicians working that afternoon. A review of Resident #32's health assessment dated showed that she was diagnosed with , , , , , , , , of left , , , and , , . The residents needed assistance with ambulation, bathing, , toileting, and transferring and supervision with eating and grooming. Resident # 32 needed assistance with the self-administration of medication. A review of the facility census on the day ( ) of the medication error showed a census of 89 residents. A review of the facility's records relating to assistance with self-administration of medications showed 69 out of 89 residents needed assistance with the self-administration of medications. 2) A review of the incident report dated showed that Resident # 28 was found on faced down on bathroom floor. A review of Resident # 28's hospital records dated showed he was found down in bathroom after a . The hospital records dated showed Resident #28 arrived at the emergency room at 3:15 AM with right , and , following trip and while walking to the bathroom and was	{A 079}		

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{A 079}	Continued From page 21 admitted after hitting his with the floor Resident # 28 was diagnosed with a closed injury and . A review of Resident # 28's health assessment dated showed that he was diagnosed with high , . His physical and sensory limitation showed an inability to walk and that he was wheelchair bound. The residents had special precautions including pressure/ precautions. Resident # 28 needed assistance with ambulation, bathing, , eating, self-care, toileting, and transferring. During an interview on at 11:30 AM Staff R (resident assistant) stated that she was working two floors on the morning that Resident # 28 . Staff R stated that Resident # 28 had a call pendant and call for service the night he . Staff R stated that there were 6 staff working at the facility that morning. She stated that Resident # 28 was not a big person but was heavy because they had to lift his whole . A review of the overnight staff schedule from 11:00 PM to 7:30 AM on showed only six employees on schedule for 89 residents, including one employee covering two floors. A review of the staff schedules for showed six (6) staff on the 11:00 PM shift. During an interview on at 9:30 AM The son of Resident #28 stated that staff at the facility where not able to assist his father and were not well suited to the task. The son further stated that some of the staff were small in stature and would not be able to assist his father. A review of Resident # 28's individual service plan dated showed that staff needed to	{A 079}		

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{A 079}	Continued From page 22 monitor Resident # 28's transfers and provide a two-person assist when needed. A review of the facility's call pendant log showed that more than 20 minutes elapsed before staff responded to Resident #28's call pendant on the night he . During an interview on at 11:00 AM Staff B (The Assistant Executive Director) stated that minutes was the policy for responding to call pendant, and he did not know why the pendant took so long to clear the morning that Resident #28 . A review of Resident # 28's urgent care records dated showed that Resident #28 was complaining of and was diagnosed with of the fifth and sixth . According to the Center for and Control (CDC) are the leading cause of injury-related for adults ages 65. are common, costly, and preventable. 3) A review of the incident report dated showed that Resident #47 when assisting her husband (Resident # 28) with a transfer. The incident occurred at 9:00 AM. A review of the facility staffing scheduled showed that 13 staff were on the 7:00 AM shift on . A review of Resident # 47's hospital record dated showed that resident suffered a and acute hypoxic , failure. According to the Mayo Clinic, acute ,	{A 079}		

Agency for Health Care Administration

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{A 079}	Continued From page 23 failure can result from atelectasis or an injury that causes you to avoid taking deep breath. During an interview on at 9:30 AM The son of Resident #28 stated that Resident #47 was helping him with a transfer when she with him and a dresser on them. He further stated that he did not know exactly why Resident #47 aided Resident #28 instead of staff but also stated that staff were always busy with other residents. A review of the facility's records relating to activities of daily living for a census of 89 residents showed the following: 38 (43%) residents needed assistance with ambulation, 54 (61%) with bathing, 51 (57%) with ب, 25 (28%) with eating, 43 (48%) with toileting, 44 (49%) with self-grooming, and 43 (48%) with transferring. Residents needing supervision showed the following: 15 (17%) with ambulation, 12 (13%) with bathing, 10 (11%) with ب, 12 with eating, 21 with self-care, 13 with toileting, and 10 with transferring. Additionally, 71 (80%) residents of the 89 residents were at risk of falling. Moreover, seven residents needed total care with three or more activities of daily living. Class I	{A 079}		