STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911395	10/28/2016
NAME OF PROVIDER OR SUPPLIER **RESIDENTIAL PLAZA AT BLUE LAGOON**	STREET ADDRESS, CITY, STATE, ZIP CODE **5617 NW 7 STREET MIAMI, FL 33126**	

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

0000 Initial Comments

A Complaint (2016010986) Survey was conducted on 11, 2016 and concluded on 28, 2016. Residential Plaza at Blue Lagoon had the following deficiencies identified at time of the survey:

0010 Admissions - Continued Residency

Based on observation and record review, the Assisted Living Facility failed to have accurate and completed health assessments for 2 of 28 (#2 and #5) sampled residents.

Findings included:

Observation on at 8:55 AM revealed that Resident #2 was using a cane while ambulating.

Review of Resident #2's record revealed that Health Assessment (AHCA form 1823) completed on showed Resident #2 was independent for all activities of daily living including ambulation, bathing, dressing, eating, self care, toileting and transferring. Difficulty to walk documented under physical or sensory limitations. Risk of documented under special precautions.

Record review of Resident #5's health assessment dated / did not have diet order.

Interview on at 3:30 PM the Administrator acknowledged Resident #2 and #5"s health assessment was no completed.

Class III

0025 Resident Care - Supervision

Based on observation, interview, and record review, the Assisted Living Facility failed to provide care and services appropriate to the needs of residents for 1 of 28 (#19) sampled residents. The facility failed to maintain a written record, accurately of numerous by appropriate staff for 3 of 28 (#3, 5, and 6) sampled residents.

Findings included:

Observation on / at 12:32 AM revealed that Resident #19 was resting in bed in D with half-bed rail up.
In an interview on at 12:32 AM Resident #19 revealed that she already ate and she fed herself

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as every day.
In an interview on 10/24/16 at 12:44 PM the nurse from hospice revealed that Resident #19 needed total for all activities of daily living. Hospice staff was supposed to feed the resident. Nurse confirmed that doctor order for puree diet and thicker liquid was valid at the time of the survey.
Observation on at 1:03 PM revealed that in D there was a bottle of water with a straw in a hospital bed next to Resident #19' s bed.
In an interview on at 1:03 PM Resident #19 revealed that water was the same one that Resident always took.
In an interview on at 1:05 PM the Staff J revealed that if Resident #19 requested water, staff gave to resident. Resident #19 took the bottle water brought by family member, caregiver just opened and pass to resident.

In an interview on / at 1:34 PM the Healthcare supervisor was revealed that resident on precaution needed eating assistance or supervision, one staff should be there. Resident under can if it is not catch in time.

Supplemental Interdisciplinary Note completed by hospice nurse on revealed that Resident #19 received assistance from hospice CNA(Certified Nursing Assistance) and Alf. Review of Plan of Care done on revealed that Resident #19 had precautions.

Record review revealed Resident #3 Resident #4 on / notes stated, "check head to toe & she has no evidence of cuts, or ."

Resident #5 on notes stated, "was check head to toe & has no evidence of cuts, and ." On / / notes stated, "check head to toe & has a in her back. The resident has no evidence of cuts, or ." On / notes again stated, "checked head to toe & she resident has no evidence of cuts, or ."

Resident #6 out of bed on notes stated, "checked from head to toe. She has no evidence of cuts, , or ." On found on floor notes stated, "check head to toe & she has no evidence of cuts, , or ." On / was found on the floor notes stated, "check head to toe & she has no evidence of cuts, , or ." On was found on the floor notes stated "check head to toe she did not hit her head. The resident has a on her face left. The resident has no evidence of cuts, , or ."

Interview conducted with team Leader at 2:11 PM. When I received a call I go to resident ' s I review their body. I contact resident ' s physician and family member. When the residents are

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their families took the decision for them. We also contact their primary physician. We followed their instructions. We do more rounds. We do not document what the physician said in each case. We do not document that the family was the one who take the decision in some cases. Each CNA take care of 12 residents.

Class III

0031 Resident Care - Third Partv Services

Based on observation, record review, and interview, the Assisted Living Facility failed to obtain documentation of changes made by third party in services provided to resident in order to meet resident's meet.

Findings included:

During medication reconciliation on at 11:03 AM showed that there were two in medication refrigerator for Resident #1. Medicines were labeled as: Lantus 15 units at bedtime and 6 units before meals.
Review of Resident #1's Medication Observation Record revealed that there was a doctor order for inject per sliding scale and hand written next to " by home health." Also there was a doctor order hand written for Lantus inject 15 units at bedtime and hand written next to "by home health."
In an interview on at 2:06 PM the Healthcare supervisor revealed that home health agency should informed facility about any change in medication orders.

Lunch observations on / at 12:09 PM found Resident #19 in her bed with a tray of pure food in front of her. Resident #19 was observed eating the meal but needed assistance because some of the food was falling from her mouth while she was trying to eat it. Observations found there were no staff members from the ALF or hospice present.

In an interview on at 1:28 PM the hospice nurse revealed resident that is under precaution is at higher risk for , , , resident can decompensate. Resident can chock. Facility has been informed about residents changes.
Healthcare supervisor was interviewed on / at 1:34 PM and revealed that resident on precaution needed eating assistance or supervision, one staff should be there. Resident under can if it is not catch in time.
Supplemental Interdisciplinary Note completed by hospice nurse on revealed that Resident #19

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received assistance from hospice CNA (Certified Nursing Assistance) and Alf. Review of Plan of Care done on / / revealed that Resident #19 had , precautions.
Class III

0054 Medication - Records

Based on record review, interview, and observation, the Assisted Living Facility failed to ensure that staff assisting residents with self-administration of medication completed the Medication Observation Records (MORs) for 1 of 28 (#1) sampled residents. Facility failed to reported to the resident's health care provider and documented in the resident's record when residents noncompliance with medications ordered for 1 of 28 (#1) sampled residents.

Findings included:

During medication reconciliation on the 10 floor with Staff H (Certified Nursing Assistant/ Med tech) on at 10:05 AM revealed that in the medication cart there was no 2% shampoo for Resident #1. , Handihaler inhaler for Resident #1 was in the medication cart.

Review of Resident #1's Medication Observation Record (MOR) revealed that there was an order for 2% shampoo apply every other day for skin condition into hair. It was scheduled at 7 AM. It was initialed as assisted on , , , , / / , / / , / / . On / / the MOR was not initialed for that medicines. On / / , / , / and was documented that Resident #1 was at the hospital.
In an interview on at 10:09 AM the Staff H stated "he keeps it in his when he takes shower. I saw when he puts on just the days he has scheduled it."
Review of Resident #1's Medication Observation Record (MOR) revealed that there was an order for Handihaler inhale orally daily and it was schedule at 7 AM. It showed initialed and initials were circled since / thru / . There was no documentation in the back of the MOR explaining why the medication was hold.
Review of Resident #1's (MOR) revealed that there was an order for 160/4.5 mcg inhale 2 puff orally twice a day and it was scheduled 7 AM and 7 PM. It showed initialed and initials were circled since / thru / / except for / PM dose, PM dose, PM dose, AM dose, / AM dose and / / AM dose. It was documented that Resident #1 refused medicine on daily basis from / to .

Class III

0055 Medication - Storage and Disposal

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Based on observation and interview, the Assisted Living Facility failed to ensure that prescription and over-the counter medications for residents were centrally stored when facility assisted with self-administration of the medications for 2 of 28 (#1 and #15) sampled residents.

Findings included:

Observation on / at 9:50 AM revealed that in A Resident #1 had the following medications in his Eye Relieve (Eye wash, Eye irrigating solution), Instant Relief Neti Pot (Sinus wash system), (, solution). Resident #1 had a red box for sharp container, it had inside syringes; it was wide open and a hand fixed there.
Observation on at 9:51 AM revealed that 2% shampoo was in Resident #1's balcony and it was labeled by the pharmacy. There was an concentrator in the .
In an interview on / at 9:56 AM the Healthcare Supervisor revealed that Resident #1 liked to keep his medicines. "We usually keep them out of reach and closed. It is not safe. I come to this every 15 days and teach him. He is not supposed to have medicines here."

During medications reconciliation on the 9 floor with Staff H (Certified Nursing Assistant/ Med tech) on / at 10:33 AM revealed that in the medication cart there was no 2% shampoo for Resident #15.
Review of Resident #15's Medication Observation Record (MOR) revealed that there was an order for 2% shampoo apply to the scalp daily for skin condition. It was scheduled at 8 AM. It was initialed as assisted every day from / to / .
In an interview on / at 10:39 AM the Staff H stated "I do not assist him, that assistant does it."

Observation on at 12:32 AM revealed that there was a cream unlocked and it was labeled with Resident #19's name Silver Sulfa 1% cream, apply on affected area daily in D on the table next to the TV.

Class III

0056 Medication - Labeling and Orders

Based on record review, interview, and observation, the Assisted Living Facility failed to obtain clarification order for a medication ordered as needed or notify the doctor of changes that needed with the orders for 2 of 28 (#15 and #24) sampled residents.

Findings included:

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Review of Resident #15's medication observation records (MORs) revealed that there was an order for Ipratrop/ Inh Soln one vial via jet neb twice a day. It was scheduled at 8 AM and 8 AM. It showed initialed and initials were circled since / thru / . It was documented in the back of the MOR that resident refused.
In an interview on / at 10:38 AM the Staff H revealed that facility did medication monitoring and informed physician. Doctor usually stated that resident is allow to refuse.

In an interview on / at 2 PM the Healthcare supervisor stated "we don't document when resident refused medication until a month. After the third day we call the doctor."
Review of Resident #24's MOR revealed that there was an order for 0.5 mg tablets, take one tablet by orally at bedtime as needed for not to exceed 1-24 hrs. It was initialed daily from / to / . Documentation in the back of MORs revealed that at 8 PM 0.5 mg for completed from / to / except / which was initialed but no documented.
In an interview on / at 10:50 AM the Healthcare Supervisor stated "staff initialed , , and was not a licensed practical nurse (LPN) or registered nurse (RN). " Healthcare Supervisor referred to Staff K
In an interview on at 11:43 AM the Healthcare Supervisor stated about Resident #24 " She is able to make decision, nurses don't do med pass. "
In an interview on at 11:57 AM Resident #24 stated "yes, I took to help me sleep because they killed me a son. "
Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Residential Plaza At Blue Lagoon
5617 Nw 7 Street
Miami, FL 33126
RE: CCR #2016010986

Dear Administrator:

This letter reports the findings of a Complaint licensure survey that was conducted on 28, 2016 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

XG90

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