STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911395	07/14/2017
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 standard biennial survey was conducted on , 2017 and concluded on , 2017. Residential Plaza at Blue Lagoon with Limited Nursing Services and Limited Mental Health, license number 7551 had the following deficiencies identified at time of the survey:

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observation, record review, and interview, the Assisted Living Facility failed to update the health assessment (AHCA form 1823) for two (#5 and #6) out of 17 sampled residents.

Findings included:

Observation on at 11:54 AM revealed there was strong odor coming from Unit 908. Resident #5 observed in soiled sheets with browns stains with a feces odor and blue incontinence filled with was on the floor. Further observations at 12:04 PM revealed Resident #5 was covered with a dress with left shoulders uncovered. B had foul odors, a combination of and feces. Bed commode was in the and feces in. Bed sheets were piled up together.

In an interview on at 12:05 PM the Staff Member G stated, "She is the last one, I haven't done her morning care yet."

Review of Resident #5's record revealed that Health Assessment (AHCA form 1823) completed on showed that the Resident needed supervision for ambulation and transferring, independent for eating, self-care and toileting, and assistance for bathing and dressing.

In an interview on at 11:15 AM the Registered Nurse revealed Resident #5 received assistance with bathing, dressing and toileting.

In an interview on at 11:21 AM Staff Member G revealed that she assisted Resident #5 with bathing, dressing, self- . Stated "If she pressed the call I assisted with the toilet. She can transfer and eat, independently. She has days that she does it in that (Referring to toileting). Everyone knows here that she is a difficult resident, I don't know if the doctor is aware."

Review of Resident #6's Health Assessment (AHCA form 1823) completed on showed that the Resident needed assistance will all activities of daily living (bathing, dressing, ambulation, eating, self-care, toileting and transfer).

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Review of Resident #6's record revealed that the Resident #6 hospice's admission was on . Last reviewed of plan of care was dated , it showed that the Resident needed total assistance with activities of daily living.

In an interview on at 12:28 PM the Administrator revealed the facility will contact hospice company to get a new health assessment completed.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, interview, and record review, the Assisted Living Facility failed to provide the care and services appropriate for the needs of one (#5) out of 17 sampled residents.

Findings included:

Observation on at 11:54 AM revealed there was strong odor coming from Unit 908. Resident #5 observed in soiled sheets with browns stains with a feces odor and blue incontinence , filled with was on the floor. Further observations at 12:04 PM revealed Resident #5 was covered with a dress with left shoulders uncovered. B had foul odors, a combination of and feces. Bed commode was in the and feces in. Bed sheets were piled up together.

In an interview on at 11:58 AM Staff Member G stated, "I changed Resident 5 when I first came to see her at 10:00 AM, I changed her incontinence brief. I do my rounds every two hours. The problem is this resident is difficult to care for because I have to be constantly changing her."

In an interview on at 12:05 PM Staff Member G stated, "She is the last one, I haven't done her morning care yet."

Nursing observations on at 12:05 PM revealed Resident #5 had redness on the and on the inner aspects of thighs.

The facility's Registered Nurse assessment completed on revealed the Resident had blanchable on sacral area and inner thighs.

Review of Resident #5's record revealed that Health Assessment (AHCA form 1823) completed on

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showed that the Resident needed supervision for ambulation and transferring, independent for eating, self-care and toileting, and assistance for bathing and dressing.

In an interview on at 11:15 AM the Registered Nurse revealed Resident #5 received assistance with bathing, dressing and toileting.

In an interview on at 11:21 AM Staff Member G revealed that she assisted Resident #5 with bathing, dressing, self-. Stated "If she pressed the call I assisted with the toilet. She can transfer and eat, independently. She has days that she does it in that (Referring to toileting). Everyone knows here that she is a difficult resident, I don't know if the doctor is aware."

Class III

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

Based on observation, record review, and interview, the Assisted Living Facility failed to keep medications locked at all times.

Findings included:

Observation on at 02:02 PM during the facility tour revealed that there was a tube of - 1-0.05% cream unlocked on the Resident #4's dresser.

Review of Resident #4's record revealed the Resident's Health Assessment dated showed that the Resident needed assistance with Self-Administration of Medications.

During an interview on at 03:17 PM Staff Member A acknowledged that the medication was for the Resident and stated "it is an over the counter medication."

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record review and interview the facility failed to have documentation that 1 out of 12 sampled staff received the control training (Staff I).

Findings include:

A review of Staff I's employee file revealed there was no documentation that the staff had received the

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control training.

On at 2:30 PM the Administrator confirmed Staff I did not have control training.

Class III

0085 - Training - Nutrition & Food Service - 58A-5.0191(6) FAC

Based on record review and interview the facility failed to provide documentation that 1 out of 12 staff received training in Nutrition and Food service (Staff C).

Findings include:

A review of Staff C's (cook) employee file revealed there was no documentation that the staff received training in Nutrition and Food Service.

On at 2:30 PM Administrator confirmed Staff C did not have the Nutrition and Food Service training.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the Assisted Living Facility failed to provide a safe and decent living environment for facility residents.

Findings included:

On at 11:54 AM observed a strong odor coming from Unit 908. In Resident #5 observed with soiled sheets with browns stains with a feces odor and blue incontinence , filled with on the floor.

On at 12:15 PM observed in Resident #17's , there was a odor in ; there was a mini fridge with spoiled food, and garbage on the floor.

On at 9:53 AM Administrator stated "Resident #17 does not cooperate with keeping his , and I have informed his family about it."

Observation on at 8:59 AM revealed that one of the elevator was not working and had a signed

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in front of it of "Out of Service" and observed several residents sitting on their walker waiting a lengthy amount of time to get to their floor.

In an interview on . . . . . at 3:12 PM the Administrator revealed that the elevators' company came in person and explained that they will take long to fix.

Review of records revealed that elevator was in schedule to be repair on because of damaged hoist ropes.

In an interview on . . . . . at 7:33 AM the Administrator revealed just one elevator was working and elevator's maintenance were working on them for fixing it. There was a bad weather the night before.

Observation on at 7:36 AM revealed that there were two elevators out of services and just one elevator working. Further observation at 7:50 AM revealed that there was just one elevator working.

Class III

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

Based on record review and interview, the Assisted Living Facility failed to have documentation of the appointment of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney one (#6) out of 17 sampled residents.

Findings included:

Review of Resident #6's record revealed Resident #6's family member signed the informed consent to assist with medication by unlicensed personnel and centrally store medication. There was no documentation of guardianship/ surrogate/proxy in record.

In an interview on . . . . . at 1:15 PM the Administrator revealed that she called the Resident's family Member for copy the POA (Power of Attorney).

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and interview, the Assisted Living Facility failed to submit the incident report within 15 days of the incident to AHCA for one (Resident #2) out of 17 sampled residents when a resident eloped from the facility.

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Findings included:

Review of Adverse Incident Reports revealed that Resident #2 had an incident on [redacted] due to the Resident left the facility with authorization but did not return to sleep as usually. The Resident was [redacted] by the Guardian. The one day incident completed on [redacted]. The 15 day incident report has not filed at the time of the survey.

In an interview on [redacted] at 3:10 PM The Administrator stated, "wow, it was my fault, the Resident did not come back."

Class III