STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965853	**05/10/2018**
NAME OF PROVIDER OR SUPPLIER **BOSCH ALF, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **3060 NW 19 TERRACE** **MIAMI, FL 33125**	

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

0000 - Initial Comments

An abbreviated survey was conducted on . . . . . in conjunction with a complaint revisit inspection. Bosh Alf, Inc. with a Limited Mental Health component, (license # 10199) had the following deficiencies found at the time of survey:

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

Based on observation, record review and interview, the facility failed to determine the appropriateness of continued placement for one out of six sampled residents (Resident #2). The resident, who had been refusing to receive treatment, was diagnostic with . . . . on her toes. The resident had the condition for more than six weeks prior to obtaining hospice care.

Findings included:

On at 8:45 AM observed Resident #2 living the facility. Her left leg had a white bandage. Staff B stated that Resident #2 was receiving hospice care.

A review of Resident #2's record revealed that she was admitted on . . . . . A health assessment dated revealed diagnoses of Chronic , Left Leg; , ( ); , ... ; . . . . , ( ); . . . . . (ASCVD); , , ( ), and , . The resident had refusal behavior and poor compliance with treatment. Resident #2 needed supervision with ambulation, bathing, dressing, self-care, toileting, transferring and assistance with self-administration of medications. A progress note written by the administrator showed the following:

On . . . . "Resident foot continues black and . . . ."

On . . . . . , the Administrator called a physician to ask for a letter that explained the necessity of Resident #2's going to the hospital, stating "Her foot is worse every day." The next day on the progress note showed that a doctor was called and Resident #2 recognized that the doctor said that she would need a procedure on her leg, but she refused. She made a decision of not doing anything, only take pills. The doctor explained to the resident that the resident did not have circulation on that leg, her big toes and the next one were black and (left foot) and could finish with amputation for . . . . . The resident did not allow the doctor to take her . . . . , ... and she said that she would prefer to die before surgery or hospitalization.

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On , Resident #2 had 3 black toes.

On , the resident was refusing treatment to her foot. " It is totally black and her sister said that she should go to the hospital."

On 'The resident's toes are opening. The big toes already lost the nail, she refused treatment.'

On , Resident #2 'has not contacted any doctor and her foot is swallowed, with bad odor and liquid blooding water, is opening more.'

Two months later, on the Resident was admitted to received hospice care. An interdisciplinary plan of care revealed care to left foot toes due to and tissues 3 times a weeks as requested by patient care provided for status of type Un-stageable in left leg (in toes).

On at 10:52 AM, The Administrator stated, Resident #2 is giving me a hard time in the facility, she is having , , an sitting the entire day outside the facility at the front door, she get inside only to take her med and to slept. The administrator, stated I don't know what else to do with her. I gave 45 day letter and she did not move out, I called the rescue and the police and she refused to go the hospital for treatment she had in three toes and she is almost losing one toes and the other two are black. The resident did not want to bathe and during hot days (90 F) with needed to be running outside with ice pack and water because she refused to get inside.

Record review showed that a relocation letter from the administrator to Resident #2 was done on that gave the resident 45 days to move from the facility. The last day was to be on . The letter was signed by the administrator but was not signed by the resident, surrogate or legal representative person. There was no documentation that further legal action was pursued once the 45 day notice expired.

Class II

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on observation, record review, and interview, the facility failed to maintain a written work schedule that reflected its 24-hour staffing pattern.

Findings included:

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On . . . . . at 8:45 AM, observed Staff B alone, caring for a census of six residents.

A review of the posted staff schedule revealed that Staff C was scheduled to work along with Staff B from 7:00 AM to 7:00 PM on .

On at 9:12 AM, Staff C arrived at the facility.

On at 2:00 PM, the Administrator acknowledged the deficiencies found. She stated that she had Staff C scheduled to work from 7:00 am to 7:00 pm, but since she lived across the street from the facility, she worked flexible time. She came and went.

Class III