AGENCY FOR HEALTH CARE ADMINISTRATION

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Provider Type: Assisted Living Facility

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Select	Complaint	Statement of Deficiencies	08/04/2017	9	Deficiencies Cited
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Select	Complaint	Statement of Deficiencies	05/03/2017	1	No Deficiencies
Select	Complaint	Statement of Deficiencies	05/03/2017	1	Deficiencies Cited
Select	Monitor	Statement of Deficiencies	02/01/2017	1	Deficiencies Cited
Select	Complaint	Statement of Deficiencies	02/01/2017	9	Deficiencies Cited
Select	Monitor	Statement of Deficiencies	01/23/2017	1	Deficiencies Corrected
Select	Monitor	Statement of Deficiencies	01/23/2017	1	Deficiencies Corrected
Select	Complaint	Statement of Deficiencies	01/23/2017	1	Deficiencies Corrected
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Select	Monitor	Statement of Deficiencies	09/26/2016	1	No Deficiencies
Select	Monitor	Statement of Deficiencies	09/16/2016	1	No Deficiencies
Select	Monitor	Statement of Deficiencies	09/06/2016	10	Deficiencies Cited
Select	Complaint	Statement of Deficiencies	09/06/2016	35	Deficiencies Cited
Select	Monitor	Statement of Deficiencies	09/02/2016	1	No Deficiencies
Select	Complaint	Statement of Deficiencies	09/01/2016	2	Deficiencies Cited
Select	Complaint	Statement of Deficiencies	09/01/2016	2	No Deficiencies
Select	Monitor	Statement of Deficiencies	08/18/2016	1	No Deficiencies
Select	Monitor	Statement of Deficiencies	08/11/2016	1	No Deficiencies
Select	Monitor	Statement of Deficiencies	07/23/2016	2	Deficiencies Cited

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	Inspection Type	Document Type	Visit Date	Pages	Inspection Status
Select	Complaint	Statement of Deficiencies	05/31/2016	2	Deficiencies Cited
Select	Standard	Statement of Deficiencies	03/09/2016	2	No Deficiencies
Select	Complaint	Statement of Deficiencies	01/05/2016	2	Deficiencies Corrected
Select	Complaint	Statement of Deficiencies	10/13/2015	4	Deficiencies Cited
Select	Complaint	Statement of Deficiencies	06/30/2015	2	Deficiencies Corrected
Select	Complaint	Statement of Deficiencies	04/23/2015	5	Deficiencies Cited
Select	Standard	Statement of Deficiencies	04/16/2014	2	No Deficiencies
Select	Complaint	Statement of Deficiencies	04/16/2014	2	No Deficiencies
Select	Complaint	Statement of Deficiencies	02/28/2014	2	No Deficiencies
Select	Complaint	Statement of Deficiencies	07/09/2013	2	No Deficiencies

1 2 3 4

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	Inspection Type	Document Type	Visit Date	Pages	Inspection Status
Select	Complaint	Statement of Deficiencies	04/08/2013	2	No Deficiencies
Select	Monitor	Statement of Deficiencies	05/31/2012	2	Deficiencies Corrected
Select	Monitor	Statement of Deficiencies	03/28/2012	10	Deficiencies Cited
Select	Standard	Statement of Deficiencies	03/01/2012	2	No Deficiencies
Select	Complaint	Statement of Deficiencies	06/30/2011	2	Deficiencies Corrected
Select	Complaint	Statement of Deficiencies	04/26/2011	4	
Select	Complaint	Statement of Deficiencies	10/13/2010	4	No Deficiencies Cited
Select	Standard	Statement of Deficiencies	03/29/2010	4	Deficiencies Corrected
Select	Standard	Statement of Deficiencies	02/03/2010	9	Deficiencies Cited

1 2 3 4

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953432	08/04/2017
NAME OF PROVIDER OR SUPPLIER EDEN GARDENS ALF	STREET ADDRESS, CITY, STATE, ZIP CODE 12221 WEST DIXIE HIGHWAY MIAMI, FL 33161	

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

0000 - Initial Comments

A Complaint survey (CCR#2017008717) was conducted on , 2017. Eden Gardens ALF (8209) with a Limited Mental Health component, had deficiencies identified at the time of the survey:

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

Based on record review and interview, the facility failed to ensure the appropriateness of continued residency for one of 104 sampled residents (Resident #56). The resident appeared to be responding to stimuli, which caused him to walk through the facility screaming and being verbally toward staff and other residents.

Findings included:

Upon arrival to the facility on at 7:40 AM, Resident #56 was observed in the dining room and pacing the hallway, agitated and yelling at the staff and the other residents. The resident was screaming in Spanish and his speech was slurred and he was shouting obscenities and calling staff and peers derogatory names. He was also yelling repeatedly, "You will not do anything to me. I am me. I do what I want. You shut up. You will not send me to the hospital."

On at 8:10 AM during the medication pass, Staff E stated, "He just came back from the hospital a few days ago and has been like that. We called the psychiatrist and he is coming to see him today."

A review of Resident # 56's record revealed that the resident was admitted to the facility on from a hospital; on the same day he had to be transferred back to the hospital under due to being and verbally aggressive with staff members and residents. On , he was hospitalized again under due to being verbally aggressive toward staff and other residents. The hospitalization records showed a diagnosis of Type in Acute Exacerbation. His health assessment was completed on and he had diagnoses of , hyperplasia, , chronic , dyslipidemia, and ; The resident was legally , alert and oriented times one with episodes of agitation; required supervision with bathing and dressing; required assistance with grooming and was independent with ambulation, eating, toileting and transferring.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
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0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, record review, and interview, the facility failed to provide a safe and decent living environment for a total of 104 residents. A state agency found that the site was infested with bedbugs, rodents and cockroaches. The facility needed to be closed down for the remediation of these conditions, and the residents were relocated.

Findings:

1)

During a tour of the facility on between 9:30 AM and 1:20 PM performed in conjunction with the representatives from another state agency, these conditions were observed:

A.

Live and dead bedbugs were found in rooms # 7, 28, 34, 35, 37, 38, 40 through 55, 62, 64, 66 and 67. Soiled mattresses with bed bug droppings and stains in rooms # 39, 67, 25, 26, 7 and 2.

On at 9:40 AM observed in room # 55 bed B a bed bug crawling on the bed. The insect was caught and placed inside a plastic bag with dead bed bugs shells.

According to the Centers for Control bedbugs are small, reddish-brown insects that bite the exposed skin of sleeping humans and animals to feed on their blood. They are not known to spread , but they can cause other public health issues. Some people have no reaction to bed bugs bites, while others experience an reaction that can include severe itching, or Sometimes the itching can lead to excessive scratching that can sometimes increase the chance of a secondary skin

On Resident #13 stated at 8:23 AM, "I used to have bed bugs about a month ago."

On at 7:45 AM Resident #54 stated, "We had bedbugs very bad. I had to go into the hospital for a large lump in my area. It turned out to be due to bedbug bites. I was moved to another room that didn't have handicap gear. I fell twice because there was no bar to help me get up. I hurt my bottom and got a new ."

On at 11:05 AM Resident #9 stated that she had seen bed bugs in the room the day before. The staff had not changed the mattress.

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SUMMARY STATEMENT OF DEFICIENCIES
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On . . . . at 8:56 AM the Administrator stated, "Before, we used another pest control company and we changed it. We are being treated for mice. The residents leave food in their rooms or leave the door open. We are doing it by sections (referring to pest control). Resident #1 was complaining of different ailments and went for a checkup. When they were examining her they removed the coat and the saw that the coat had a lot of bedbugs and they sent her to the hospital. When she came back they gave her new clothes and she came back yesterday with another jacket that was given to her at the hospital and when she got here she had a bed bug on her shoulder. We went to the room and did not see anything but there was one bed bug in the closet. She is the only one that has the bed bugs problem, nobody else has bedbugs. She is a hoarder and brings clothes and books from thrift stores."

On . . . . . at 8:37 AM Resident #1 stated that she did have bed bugs in her room, but that she had never been bitten. Her roommate Resident #82 stated, "I am being bitten." Then she showed two red . . . . . on her left . . . . .

A review of Resident #1's health assessment revealed the resident had the following diagnoses: Major , , , and , ; she requires encouragement and assistance for bathing. Record review of Resident #82's health assessment revealed the resident was diagnosed with . . . , , Parkinson, , , , non- . . . . . and , ... ; has tremors, poor balance, poor judgement and concentration, uses a wheelchair for ambulation; requires assistance and encouragement for bathing and assistance with dressing.

The American . . . . . Association stated that . . . . . can affect any part of the body including the skin making get , fungal and itching easier than people without . . . . . .

A review of 58 health assessments revealed that 13 sampled residents had a diagnosis of . . . . . (Residents # 4, # 37, # 38, # 65, # 70, # 76 # 78, # 82, # 88, # 92, # 97, # 100 and # 104.)

B.

Dead rodents and fresh rodent droppings were found in rooms # 63, 36, 37, 27, 21, 19 and 22.

According to the Centers for Control, rats and mice spread over 35 . These can be spread to humans directly, through handling of rodents, through contact with rodent feces, urine, saliva or through rodent bites.

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SUMMARY STATEMENT OF DEFICIENCIES
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On at 8:26 AM Resident #4 stated, "I have a mouse in my room. I saw it last night."

On at 7:45 AM Resident #54 stated, "We have roaches, flies, mice. People changed rooms several months ago due to mice."

According to the Centers for Control, an weakens a person's system by destroying important cells that fight and .

Record review showed that three sampled residents had a diagnosis of .

C.

Lives roaches were observed in rooms #17, 7, 28 and 20. Dead roaches and, roach eggs and roach droppings were found in rooms # 59, 63, 38, 31 and 28.

According to the Centers for Control, ( ) is a group of that cause airflow blockage and breathing-related problems. It includes , Chronic and in some cases . The main cause of is smoking and another cause is the exposure to air pollutants (Dust).

According to the Centers for Control the cockroach is considered an source and an trigger for residents; it has been demonstrated that they carry Typhimurium, Histolytica and the . The American Lung Association stated that roaches produce or that aggravate and cause reactions in people that are sensitive to those ; they are likely concentrated in their fecal matter and in fragments of their body parts; these tiny particles can become airborne and contaminate the air in your home.

A review of 58 health assessments revealed that 16 sampled residents had a diagnosis of (Residents # 1, # 4, # 5, # 28, # 39, # 54, # 74, # 76, # 77, # 82, # 89, # 93, # 94, # 95, # 96 and # 99.) Residents # 27 and # 28 had a diagnosis of Chronic .

Live ants were observed in storage room # 2. Dead insects were found throughout the rooms under beds, on floors and window sills.

A review of the health assessment of 58 residents showed the overall physical and vulnerability of the resident population due to their diagnosed health conditions:

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SUMMARY STATEMENT OF DEFICIENCIES
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-42 sampled residents had a diagnosis of (Residents #1, #5, #11, #26, #27, #28, #29, #37, #38, #39, #43, #58, #59, #60, #61, #65, #66, #67, #68, #69, #72, #73, #74, #77, #80, #82, #87, #88, #89, #91, #93, #94, #95, #96, #97, #98, #99, #100, #101, #102, #103 and # 104).

-35 sampled residents had a diagnosis of (Residents #1, #4, #5, #11, #26, #27, #28, #29, #38, #52, #53, #54, #56, #60, #61, #66, #67, #68, #72, #73, #74, #77, #82, #87, #88, #89, #93, #94, #98, #99, #100, #101, #102, #103 and # 104).

-12 sampled residents had a diagnosis of major (Residents #1, #4, #28, #66, #67, #68, #70, #89, #93, #96, #97 and #99).

-Three sampled residents had a diagnosis of type (Residents #64, #77 and #91).

- Nine sampled residents required wheelchair use (Residents #39, #43, #52, #54, 61, #72, #82, #95 and #96).

- 18 sampled residents required assistance with bathing (Residents #12, #39, #43, #51, #55, #58, #66, #70, #72, #72, #77, #78, #82, #90, #94, #95, #96 and #103) and five sampled residents required assistance with dressing (Residents #43, #55, #72, #95 and #96).

Class I

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

Based on observation, record review and interview, the facility failed to provide a safe living environment, free of hazards and failed to ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances were maintained in good working order for 104 sampled residents (Residents # 1-104). A state agency found the site's kitchen was unsuitable for food service due to a backup of gray wastewater. The facility needed to be closed down for the remediation of these conditions, and the residents were relocated.

Findings:

During a tour of the facility on between 9:30 AM and 1:20 PM performed in conjunction with the

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SUMMARY STATEMENT OF DEFICIENCIES
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representatives from another state agency, observed the following:

Furniture and fixtures throughout were accumulating dust, food residue and dead insects. Several windows were not screened and properly sealed. The doors leading to the outside on annex, northeast and northwest wing were not vermin proof. Several openings around the exterior of building needed to be sealed or screened to prevent vermin, rodent and insect harborage.

There was limited or no lighting in rooms and bathrooms in room #22, #24, #25, #26, #27, #30 and #31.

Observed the following:
In room # 53, there were old mattresses with stains, dead roaches and dead bedbugs on it.
In room # 50, some paint was missing from the wall.

Room # 45 was full of magazines, television, boxes, and other debris scattered on the floor, which belonged to a resident who had moved out a couple of months earlier. Observed the maintenance man remove a mattress and box spring with a soiled cover, taking it into room #7 to replace a mattress that may have been infested with bedbugs.

In room # 62, live and dead bugs and an old mattress.
In room # 64 the left side bar of bed A was broken and the box spring on bed A had some stains from bed bugs.
In room # 49 bed B the mattress was sunken.
In rooms # 22 the mattress was worn.
In rooms # 39, # 67, # 25, # 26, # 7 and # 2 the mattresses were soiled with bedbug droppings and stains.
In room # 2 an electric socket was missing.
In room # 38, on the front of the room, the roof was unfinished.
In room # 28 the bathroom paint was pealing.
In room # 22 and # 25 the window panes were broken. Also in room # 22 the window ledge was broken.
In room # 17 the ceiling was cracked close to the light fixture.
Live and dead bedbugs in rooms # 7, 28, 34, 35, 37, 38, 40 through 55, 62, 64, 66 and 67.
Dead rodents and fresh rodent droppings in rooms # 63, 36, 37, 27, 21, 19 and 22.
Live ants in storage room # 2.
Lives roaches in rooms # 17, 7, 28 and 20. Dead roaches and, roach eggs and roach droppings found in rooms # 59, 63, 38, 31 and 28.
Dead insects throughout the rooms under beds, on floors and window sills.

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SUMMARY STATEMENT OF DEFICIENCIES
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On at 8:38 AM the Administrator stated regarding whether or not the facility was under treatment for bedbugs, "They are doing regular pest control. If they identify a problem we do heat, vacuum, steam, and spray. The last pest control visit was on . We had a resident that found a bedbug, we replaced the mattress and the box spring as a preventive measure. We had a meeting with 6 or 7 residents that are hoarders on , . Any resident that bring things from the used items stores, and Resident # 1 is one of them, we check what they bring and treat it with heat."

On at 8:52 AM Staff D stated, regarding the in-house bedbug treatments he was applying, "I work outside the rooms and then when they had the problem Staff A told me to do the treatment and that was in , and ."

On at 8:56 AM the Administrator stated, "Before, we used another pest control company and we changed it. We are being treated for mice. The residents leave food in their rooms or leave the door open. We are doing it by sections (referring to pest control). Resident # 1 was complaining of different ailments and went for a checkup. When they were examining her they removed the coat and the saw that the coat had a lot of bedbugs and they sent her to the hospital. When she came back they gave her new clothes and she came back yesterday with another jacket that was given to her at the hospital and when she got here she had a bed bug on her shoulder. We went to the room and did not see anything but there was one bed bug in the closet. She is the only one that has the bed bugs problem, nobody else has bedbugs. She is a hoarder and brings clothes and books from thrift stores."

On at 11:30 AM the other state agency's inspectors went into the kitchen and stopped staff from serving lunch to the residents because 'gray water', which they described as waste water that was a part of the sewer system, was entering the kitchen through a floor drain, and the smell was very bad. The other state agency's inspector stated at 11:35 AM, "Once there is back flow on the sewer the facility's kitchen cannot be used; they need to discard all the food that is prepared and they are going to have to get food from the outside for the residents to have lunch."

In the room where the emergency food was kept, there was no light. The fryer had old, black and dirty oil; also a dead rat was found outside of the kitchen exit, amid multiple empty cans of cat food.

On at 9:10 am, records from of the pest control company were requested. The Administrator stated she was not able to provide any from , to , 2017. She stated at 9:15 AM that the pest control company had sent the reports to the corporate office, together with the ones from the other facilities that they manage, and that they would have to separate the records in order to provide it. She also stated that the facility had changed the pest control company recently in .

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Class I

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record review and interview, the facility failed to provide documentation of treatment by a pest control company from , to , 2017.

Findings included:

On at 8:38 AM, the Administrator stated, "We are doing our own regular pest control. If they identify a problem, we do heat, vacuum, steam and spray every 21 days. We got a new company. The last pest control visit was on . We had a resident that found a bedbug, we replaced the mattress and the box as a preventive measure. We had a meeting with 6 or 7 residents that are hoarders on , . Any resident that brings things from the used items stores and Resident # 1 is one of them, we check what they bring and treat it with heat."

On at 8:52 AM Staff D, the facility's maintenance and repair person stated, "I work outside the rooms, and then when they had the problem Staff A told me to do the treatment and that was in , and ."

On at 8:56 AM the Administrator stated, "Before we used another pest control company and we changed it. We are being treated for mice. The residents leave food in their rooms or leave the door open. We are doing it by sections. Resident # 1 was complaining of different ailments and went for a checkup. When they were examining her they removed the coat and the saw that the coat had a lot of bedbugs and they sent her to the hospital. When she was to come back they gave her new clothes and she came back yesterday with another jacket that was given to her at the hospital and when she got here she had a bed bug on her shoulder. We went to the room and did not see anything but there was one bed bug in the closet. She is the only one that has the bed bugs problem, nobody else has bedbugs. She is a hoarder and brings clothes and books from used items stores."

Pest control records were requested from the Administrator and she was not able to provide any from , to , 2017. She stated on 9:15 AM that the pest control company had sent the reports to the corporate office. She also stated that the facility had changed the pest control company recently in ,; she was not able to provide the documentation from the previous company dated later than of 2016.

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SUMMARY STATEMENT OF DEFICIENCIES
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Class III