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
	AL11910977	A. BUILDING: _____ B. WING _____	R 10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS MERCEDES BOARDING HOME	3418 SW 23RD TERRACE MIAMI, FL 33145

(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 Biennial 3rd Revisit Survey was conducted at Las Mercedes Boarding Home on 9/29/2020 & 10/09/2020. Deficiencies were identified at the time of the survey. One uncorrected deficiency was cited under Event ID YSBD13.	{A 000}		
{A 165} SS=D	429.23(&) FS; 58A-5.0241 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the	{A 165}		

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{A 165}	Continued From page 1 resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) [illegible], neglect, or [illegible] must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of	{A 165}		

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{A 165}	Continued From page 2 s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The Department of Elderly Affairs may adopt rules necessary to administer this section. 58A-5.0241 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1) above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to file an adverse incident report with the agency within one business day and fifteen days for two out of 21 (Resident #1 and #4) sampled residents. Findings included:	{A 165}		

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{A 165}	Continued From page 3 Review of the admission & discharged log showed Resident #1 [illegible] on [illegible]. Review of Resident #1 record showed he was admitted on [illegible]. The health assessment done on [illegible] the physician indicated the resident was diagnosed with [illegible]'s [illegible], [illegible] decline, [illegible]. The resident needed supervision with bathing and [illegible] and assistance with the rest of the activities of daily living. There was no documentation of a [illegible], COVID-19 test results and that he was under the care of a health care provider. Review of Resident #4 record showed she was admitted on [illegible]. The health assessment done on [illegible] the physician indicated the resident was diagnosed with medical history of [illegible], uncomplicated, [illegible], primary generalized [illegible], sleep [illegible], unspecified major [illegible], mild, [illegible], state. The resident needed assistance in all activities of daily living (eating, ambulation, bathing, [illegible], self-care, toileting and transferring). There was no documentation of a [illegible]. A review of the ambulance run record showed that Resident #4 was found on her bed at the facility. She had no [illegible] and was not breathing. Rescue staff-initiated [illegible] and continued it while transferring the resident to the hospital. A review of the hospital record revealed that the rescue efforts continued for about 45 minutes before they were discontinued, and Resident #4 was declared [illegible].	{A 165}		

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{A 165}	Continued From page 4 On at 8:35 AM, Staff E confirmed that she went to Resident's #1 room, saw him and observed Staff J check resident's On at 9:45 AM, Staff J stated he did not perform ( ) on Resident #1. He said that because he was a nurse in Cuba, he knew that the resident was , and was not necessary. He stated the resident was seen having dinner at around 5 pm on , then 20 or 30 minutes later, he saw unresponsive and pale. He stated he checked the resident's and his by using a PulseOx machine, and he determined the resident was already . On at 10:00 AM, Staff K stated she found Resident #4 panting, 'agitated' and unable to speak on at 4:30 AM. She stated she took Resident #4's temperature and and found those to be 'normal' (and the temperature was 97.5). She said she touched the resident's and called her by name, and the resident did not respond, then she called Staff I. She said they took resident's #4 again and found it low ( ), so went to the other building where the charts were kept, to get the demographic sheet, and called 911. She stated she returned to the room and pressed on the resident's a few times but the resident did not respond. She said resident's was not taken again and she was unable to express clearly whether or not the resident was breathing. She stated Resident #4 was alive when rescue removed her from the facility. She stated that she and Staff I performed by touching the resident's and pressing on it a few times. She states the resident was alive because her	{A 165}		

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{A 165}	Continued From page 5 body was moving during the . . Class III Uncorrected	{A 165}		