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
	AL11965711	A. BUILDING: _____ B. WING _____	R 05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA LUNA RETIREMENT HOME II INC	11511 SW 128 STREET MIAMI, FL 33176

(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 follow up survey was conducted on at Bella Luna Retirement Home. Deficiencies were identified at the time of the survey.	{A 000}		
{A 033} SS=D	59A-36.007(8) PHYSICAL (8) PHYSICAL . Residents for whom a physician has prescribed a physical must have a written care plan for the use of the physical . The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident. (a) The care plan must specify: 1. The device prescribed for use; 2. The maximum amount of time the resident is to have the applied each day; and, 3. In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of , , or decline in mobility or function related to the use of the prescribed . (b) Facility staff must ensure that the device is applied appropriately and safely. (c) The resident's physician must review the appropriateness of the continued use of the physical annually, and documentation of this review must be maintained in the resident's record. If the resident's ability to independently remove or avoid the device fluctuates, the device must be considered a physical and all requirements of this subsection apply. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to have a written care plan for the use of physical developed within 14 days of the device being prescribed and prior to use on the residents for three (#1, #4, #6)	{A 033}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{A 033}	Continued From page 1 out of six sampled residents prescribed ½ and full bedrails. The facility used devices that were not considered a physical . . . . . Findings: Observation during the tour on . . . . . at 6:33AM in # found Residents #1 and #4 with full bedrails. In addition to the tour of . . . # , observation at 6:38AM, found Resident #6 in . . . # with a ½ bedrail, a furniture . . . and a walker were braced up against his bed between the ½ bedrail. The furniture . . . . was on the side of the bed near the resident #6's . The walker was up against the side of the bed near his . . . . Photographic evidence obtained. A review of Resident #1's record showed no written care plan for the use of physical . . . . . developed within 14 days of the device being prescribed. Resident #1 health assessment completed on showed that the resident needed total care in all activities of daily living. A review of Resident #4's record showed no written care plan for the use of physical . . . . . developed within 14 days of the device being prescribed. Resident #4 health assessment completed on showed that resident needed total care in all activities of daily living. A review of Resident #6's record showed a prescription dated for a ½ bedrail. There was no written care plan for use of physical . developed within 14 days of the device being prescribed for the ½ bedrail. There was no documentation that the furniture and walker had been prescribed as physical . A review of the Resident #6's health	{A 033}		

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{A 033}	Continued From page 2 assessment completed on . . . . showed that the resident needed assistance in all activities of daily living including ambulation, bathing, , eating, self-care, toileting and transferring. Interviewed on . . . . . at 12:04PM, the Administrator stated that she was trying to prevent Resident #6 from falling out the bed, but she would not put the furniture and walker next to his bed anymore. She further stated that regarding the written care plans for use of physical . . . . ., she would contact her consultant. The Administrator further that that the physical . . . . . care plan was in the hospicefolder, however a review of the hospice record found no documentation of the plan. Interviewed on . . . . . at 12:24PM, the Owner stated that Resident #6 was ,and he was trying to stop the resident from falling out bed. The Owner stated further that he wanted to know if he could get the resident's son's permission to keep the furniture and walker next to the resident's bed. The Owner stated that both residents (#1, #4) were hospice residents and needed total care, and that the physical care plans were not needed due to their status. Uncorrected Class III	{A 033}		
{A 162} SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name,	{A 162}		

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{A 162}	Continued From page 3 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract.	{A 162}		

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{A 162}	Continued From page 4 (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No =Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C.	{A 162}		

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{A 162}	Continued From page 5 (o) The resident's . . . . . , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on Record Review and Interview, the facility failed to have a complete health assessment for four (#1, #3, #4, #5) out of 6	{A 162}		

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{A 162}	Continued From page 6 sampled residents. Findings: A review Resident #1's health assessment completed on showed the sections for and were left blank. Further review showed that Resident #1 needed total care in all activities of daily living. A review of Resident #3's Health assessment completed on showed sections for known and were all left blank. Further review showed the resident was independent in eating, but needed supervision in ambulation, bathing, , self-care, toileting and transferring. A review of Resident #4's health assessment completed on showed the sections for and were left blank. Further review showed the resident needed total care in all activities of daily living. A review of Resident #5's health assessment showed the sections for and were left blank. The resident needed assistance with , eating and self-care but supervision in ambulation, bathing, toileting and transferring. Interviewed on at 12:01PM, the Administrator stated regarding the deficiency, "I understand now." Uncorrected Class III	{A 162}		