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
	AL11964762	A. BUILDING: _____ B. WING _____	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOURDES RESIDENCE,INC	5770 SW 5TH TERR MIAMI, FL 33144

(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 AMENDED A biennial survey was conducted at Lourdes Residence, Inc on . . . . . and concluded . The provider had deficiencies identified at the time of the visit.	A 000		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident,	A 010		

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A 010	Continued From page 1 additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the	A 010		

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A 010	Continued From page 2 applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's	A 010		

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A 010	Continued From page 3 record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities	A 010		

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A 010	Continued From page 4 holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that one out of six sampled residents met the continuing residency criteria after a decline in activities of daily living (Resident #2). Findings include: A review of Resident #2 record showed progress notes dated translated from Spanish: "Today, the resident was down and did not eat well at lunch; for dinner, she had a nutritional drink. She was in bed when, at 8:00 PM, the staff approached her, and when calling her, and she was not responding. The resident began having sweats, and she called 911. They decided to take her to [hospital]." On at 2:03 PM, when asked about the resident's hospitalization, Resident #2's son stated that his mother, , in the hospital on . He said, "The owner called me on to tell me my mom was not well, and they called the rescue. She was transferred to [hospital]. She was admitted for ten days into intensive care and was intubated. She was declining, but she was still walking; recently, she went to the [hospital] twice for , ( ), the last time she was admitted for eight days." In an interview on at 4:07 PM, Staff C stated, "I worked during the day when [Resident #2] was taken to the hospital. I noticed she was down and not eating well. She was able to walk, though lately, she had been declining, and we	A 010		

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A 010	Continued From page 5 had to put the food in her ... because she was forgetting to eat." A review of Resident #4's health assessment dated ..... showed a medical history and diagnoses of ... 's ... with behavioral disturbance, hypertensive ... , ... degenerative disc ... , ... and unsteady gait. The resident was independent with eating and assistance with ambulation, bathing, ... , self-care, toileting, transferring and self-administration of medication. During an interview on ..... at 3:06 PM, the Administrator stated that Resident #2 was declining and her ..... was worsening. She further stated, "I noticed her ... was leaning to the side, and she seemed to have acquired a bad posture. During the last few weeks, she was not cooperating much, was walking very little and needed assistance from caregivers for bathing and ambulating." A review of Resident #2's ... notes dated ... showed the resident was "unable to ambulate and could only maintain a standing position for five seconds with a rolling walker and needed ..... of two for bed mobility and transfer process due to current condition. The patient has an exacerbation of ... in the lower ... , and ... that interferes with transitional movements such as sit-to-stand and functional activities." Class III	A 010		

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A 053	Continued From page 6	A 053		
A 053 SS=D	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record. (c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including [illegible] testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Chapter 483, Part I, F.S. A valid copy of the federal CLIA Certificate must be maintained in the facility. A federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the federal CLIA Certificate is available from the Laboratory and In-Home Services Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone	A 053		

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A 053	Continued From page 7 (850)412-4500. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that only licensed staff members administered medications to one out of six sampled residents (Resident #3). Findings included: On [redacted] at 12:20 PM, during medication pass, observation showed Staff B (caregiver) put the medication [redacted] TR 500 MG capsule] into a small container. Then, using a spoon, Staff B put the pill directly into Resident #3's [redacted]. On [redacted] at 12:20 PM, Staff B stated that she had to use the spoon because Resident #3 had tremors. A review of the personnel records found no documentation that Staff B was a licensed health care provider. Review of Resident #3's health assessment completed [redacted] showed medical history and diagnoses of atherosclerotic [redacted] of native [redacted] with unspecified [redacted] pectoris, non-[redacted] (non-ST elevated [redacted] ([redacted]), without behavioral disturbance, [redacted] degenerative disc [redacted], and [redacted] of [redacted]. The resident needed supervision with eating; and required assistance with ambulation, bathing, [redacted], self-care (grooming), toileting, transferring and with the self-administration of medication.	A 053		

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A 053	Continued From page 8 Class III	A 053		
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, 2. [illegible], 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 [illegible], 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 resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, [illegible], 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)(f), F.A.C. (f) A [illegible] record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents	A 162		

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A 162	Continued From page 9 receiving assistance with the activities of daily living must have their recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that not be taken. (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. (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	A 162		

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A 162	Continued From page 10 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. (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 a log listing the names of residents participating in this arrangement. (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 observation, interview and record review, the facility failed to maintain an accurate	A 162		

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A 162	Continued From page 11 and complete health assessment for two out of six sampled residents (Resident #1 and Resident #4). Findings included: 1) On at 9:08 AM, observation showed Resident #1 lying in bed with full bed rails in upright position. On at 9:18 AM, Staff C (caretaker) stated that Resident #1 was in hospice care and was bed bounded. Review of Resident #1's record showed that Resident #1 began receiving hospice services on . Resident #1's health assessment completed showed medical history and diagnoses of advanced , generalized (GAD), hypertensive diastolic ( ) , of , type II, degenerative disc (DDD), degenerative disc (DDD), and ( ). The resident required total care with all activities of daily living: ambulation, bathing, , eating, self-care (grooming), toileting, and transferring; and needed administration of medication. The health assessment indicated the resident was not bedridden. However, the physical or sensory limitations section indicated a bed confined status for the resident. 2) Review of Resident #4's health assessment	A 162		

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A 162	Continued From page 12 completed . . . . . showed that in the activities of daily living section, ,, was left unchecked. On . . . . . at PM, the Administrator stated that she would ask the physician to update the residents' health assessments. Class III	A 162		