

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910977	(X3) DATE SURVEY COMPLETED 02/01/2017
NAME OF PROVIDER OR SUPPLIER LAS MERCEDES BOARDING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3418 SW 23RD TERRACE MIAMI, FL 33145	

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

0000 - Initial Comments

An abbreviated biennial survey was conducted on _____, 2017. Las Mercedes Boarding Home with license number 5295 had the following 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, interview and observation, the Assisted Living Facility (ALF) failed to have a health assessment that accurately reflected the resident's medical condition for Resident #2.

Findings included:

Review of Resident #2's record revealed that admission to ALF was on _____. A health assessment (AHCA form 1823) completed on _____ showed: No known _____, medical history and diagnoses: _____'s _____, Recurrent _____, dyslipidemia, Decreased protein _____. Physical or sensory limitation: bedbound, unable to walk, _____/ bowel incontinence. _____ or behavioral status: Alert and orient times 0, Follow commands. Nursing/ treatment/ _____ service requirements: needs hospice care. Special precautions: _____. Needed total care for all activities of daily living (ambulation, bathing, dressing, eating, self-care, toileting, transferring). Puree diet. It also showed that resident was bedridden but did not have _____, 3 or 4 pressure sores. Further record review showed that Resident #2 was admitted under hospice services on _____. The last review of hospice's plan of care was done on _____ and it showed that the Resident had a _____ for _____ retention and was bedbound; the resident was dependent for all activities of daily living. There was a doctor's order on _____ for puree diet/ crush medicines and to add thickener to liquids. The resident had a sacral _____ A doctor's order on _____ by hospice described that resident had an unstageable _____ to the sacrum. Interviewed on _____ at 2:10 PM, the Manager agreed that Resident #2's health assessment needed to be updated.

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation and interview, the Assisted Living Facility's caregiver failed to follow the procedures outlined by the state while assisting Resident #1 with self-administration of medication. Caregiver A touched medicines directly with her hands before Resident #1 took them. The facility failed to have a licensed staff to administer medicines to Resident #2.

Findings included:

1. Observation on _____ at 8:09 AM revealed that Caregiver A stood next to Resident #1 with

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medication cards in the hand. Caregiver A did not wear gloves and she put medicines straight in her hand and passed them to Resident #1 's hand. Caregiver A waited until Resident #1 took all his medicines before washing her hands. Interviewed on at 10:32 AM the Caregiver A stated " I was nervous " . 2. Review of Resident #2's Medication Observation Records (MORs) for revealed that 8 PM medications were initiated by Home Health Agency's nurse. On at 9:29 AM , Caregiver A revealed that she gave medicines to Resident #2 but resident collaborated. Interviewed on at 9:31 AM, the Manager stated "Nurse will come in the morning and resident's daughter will come in the afternoon." Interviewed on at 9:32 AM, Caregiver A revealed that Caregiver D assisted with medicines previous night. Interviewed on at 9:40 AM, the Home Health Agency's nurse revealed that previous night around 7 PM he came to the facility and administered medicines to Resident #2. Interviewed on at 9:42 AM the Caregiver D stated "I mixed medicines after crush with puree to give the medicines, she did not open the mouth. Home health nurse came and checked on her and he wrote something down. He called the owner. I gave her the medicines. (Referring to Resident #2) " Interviewed on at 10:13 AM, the Home Health Agency's nurse stated "Caregiver D started administering the medicines and I finished." Class III 0054 - Medication - Records - 58A-5.0185(5) FAC Based on observation, record review and interview, the Assisted Living Facility failed to accurately record in the Medication Observation Record (MORs) immediately after the medication was offered or administered for one of 12 sampled residents (Resident #1). Findings included: Observation on at 8:10 AM revealed that Caregiver A did not assist Resident #1 with eye drops. Review of Resident #1 's MORs revealed that 0.2 % eye drop- instill one drop in both eyes twice a day was initialed as given on at 8 AM. Interviewed on at 8:40 AM, Caregiver A revealed that she has not assisted Resident #1 with his eye drops. Class III		

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

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

Findings include:

On at 7:33 AM Observed Staff F assisting Resident #12.

On at 7:38 AM Observed Staff G assisting Resident #14.

A review of the facility staff schedule did not reflect Staff F and G on the schedule.

On at 9:40 AM, Staff J said both Staff G and Staff F were not on the schedule because they are in training.

On at 10:17 AM, Staff J stated, "That's true, it is not updated."

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.019(5) FAC

Based on interview and record review, the Assisted Living Facility failed to ensure that unlicensed persons providing assistance with self-administered medications had annually a minimum of two hours of continuing education training on providing assistance with self-administered medications and safe medication practices.

Findings included

Interviewed on at 9:32 AM, Caregiver A revealed that Caregiver D assisted with medicines the previous night.

Interviewed on at 9:42 AM, Caregiver D stated "I mixed medicines after crush with puree to give the medicines, she did not open the mouth. I gave her the medicines. (Referring to Resident #2) "

Interviewed on at 10:13 AM, the Home Health Agency's nurse stated "Caregiver D started administering the medicines and I finished."

Review of Caregiver D's personnel record revealed that Caregiver D received 4 hours medication training on and on

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0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observations and record review, the facility failed to follow the posted menu. The substitutions

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were not noted before or when the meal was served. Findings included: On at 8:12 AM observed that the breakfast served to Resident #14 was coffee with milk, bread with butter, oatmeal, and a cup of water. Reviewed posted Menu for Tuesday 1, 2017. Menu included ¾ of dry cereal, 4 Cuban cookies, margarine, and 8 oz. of milk. The substitution was not made to menu prior or during meal being served. Class III 0162 - Records - Resident - 58A-5.024(3) FAC Based on observation, record review and interview, the Assisted Living Facility failed to have documentation of the appointment of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney for one (#3) of 12 sampled residents. Findings included: Observation on at 7:38 AM revealed that Resident #3's bed had a half-bed rail attached to it. Interview on at 7:38 AM, Caregiver A revealed that Resident #3 used the bed rail in the up position while in bed. Review of Resident #3's record revealed that admission date was on . The Resident's consent to the use of half-bed rails was signed by Resident #3's daughter on . Resident #3's did not have a power of attorney on record . Class III		

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Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS Based on observation, record review, and interview the facility failed to provide documentation of an eligible Level II background screening for 1 out 12 sampled staff (Staff L). Findings include: On at 7:52 AM Observed Staff L in the dining . . . , were residents were eating, and greeted the residents by name. On at 7:53 AM interview with Staff L stated he was a handyman and he was there for just 2 hours a day to make some repairs. A review of employee records revealed there was no documentation of an eligible level II background screening for Staff L. On at 9:08 AM Staff J Stated that Staff L did not have a background screening because he is just a handyman and he only goes to the facility when he is called for repairs. He mostly spends about one or two hours in the facility. Unclassified		