STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967542	**05/17/2017**
NAME OF PROVIDER OR SUPPLIER **HILDA BENGOCHEA CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **335 SW 22 ROAD** **MIAMI, FL 33129**	

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

0000 - Initial Comments

A Standard Biennial Survey was conducted on . Hilda Bengochea Corp. with standard license (AL11641) had the following deficiencies identified at the time of the survey:

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on interview and record review, the facility failed to provide adequate supervision by not maintaining a written record, updated as needed, of any illnesses that resulted in medical attention for 2 out of 6 facility residents (Residents #2 and #4).

Findings:

On at 10:15 a.m. Staff B stated Resident #2 was hospitalized due to low sugar level. Staff B also stated Resident #4 was hospitalized after falling at the day program, about 5 weeks earlier. Staff stated Resident #4 was actually in rehabilitation.

A review of Resident #2's and #4 's records review showed,that there was no documentation of the residents' hospitalizations.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation and interview the facility failed to honor 2 out of 6 residents rights by not treating them with respect and consideration of their privacy. The facility allowed a non- resident to sleep in a resident , using a residents' beds (Residents # 2 and #5) .

Findings:

On at 8:10 a.m. in # , observed Resident #5 sleeping in one bed and on the other bed, a man of about was sleeping. Staff D said that the man was the Administrator's nephew, who was not a facility resident. Staff D further stated that the nephew was using the bed of Resident #2, who was hospitalized.

On at 9:50 a.m. the Administrator stated that her nephew had his own liked to sleep in # .

Class III

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0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview the facility failed to have medications locked, where residents did not have access to them, at all times.

Findings:

On . . . . . at 8:10 a.m. observed an unsupervised, open plastic box with medication bottles, on the dining table.

On . . . . . at 8:10 a.m. Staff D stated those medications belonged to the Administrator, and then Staff D removed them from the table.

On . . . . . at 10:00 a.m., the Administrator stated the medications left on the dining table, where hers. She stated that leaves the medications there, to not forget to take the morning medications.

Class III

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

Based on observation, record review and interview the facility failed to have an accurate staffing schedule and failed to have the minimum staffing hours per week.

Findings as follow:

On . . . . . at 8:05 a.m. Staff D was observed working in facility.

Review of the staffing schedule posted for . . . . . showed Staff A was scheduled to work from 7 am to 7 pm. Staff D was not on the staffing schedule. Staffing schedule review also showed the facility had less than the required 212 working hours a week (144 hours).

Admission and discharge record review showed the facility had a census of 6 residents.

On . . . . . at 8:10 a.m. Staff D stated she that was not an employee and come to assist with residents because Staff B was coming later. Staff B arrived at 8:48 a.m..

On . . . . . at 11:50 a.m. the Administrator acknowledged the staffing schedule was not accurate and did not show the amount of staff working hours required. The Administrator added Staff D comes to

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the facility to assist with cleaning.

Class III

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. A dog without documented records was observed in a resident's .

Findings :

On at 8:10 a.m. a small dog was observed in # .

Record review showed the facility had no proof of the for the dog.

On at 10:00 a.m. Staff B stated the dog belonged to Resident #3, and that the dog had all the but she was unable to provide it.

Class III

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

Based on record review and interview the facility failed to have an up-to-date admission and discharge record.

Findings:

Record review showed the facility had no an admission and discharge log listing the names of all residents with the dates of admission and discharge from the facility.

On at 11:00 a.m. Staff B stated that there was no an admission and discharge record.

On at 12:00 noon, the Administrator stated, the facility had no admission/discharge record, because the admission date was in each resident's file.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

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Based on observation, record review and interview, the facility failed to have personnel records available for 1 out of 4 (Staff D) staff which contained at a minimum an employment application with references, documentation of freedom from communicable including , documentation of compliance with the level 2 background screening and copies of all certifications and trainings.

Findings:

On at 8:05 a.m. Staff D was observed in working in facility.

Staff record review showed the facility had none for Staff D.

On at 8:10 a.m. Staff D stated that he had no records because he was not a staff person. He said that he came and slept in the facility to assist with residents.

On at 12:00 noon the Administrator stated, Staff D comes to clean.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview, the facility failed to have the weight record initiated on admission for 1 out of 6 (Resident #3) facility residents.

Findings as follow:

Resident's #3 record review, showed, he was admitted on . Weight record review for Resident #3 showed, the facility did not have his weight on admission. His first weight recorded was on .

On at 12:00 noon, the Administrator acknowledged, Resident #3 was not weighed when he was admitted on .

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 two background screening for 1 out of 4 staff (Staff D) .

Findings:

On at 8:05 a.m. Staff D opened the facility door. In the living a sofa with linens and a pillow. Staff D pick up the linens and the pillow.

At 8:10 a.m. Staff D stated he slept on the sofa, and that he was not an employee but stays in facility to assist with residents. He said, the Administrator was in the staff C would arrive later. He said he had no staff records in facility.

Unclassified