STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967805	**02/19/2018**
NAME OF PROVIDER OR SUPPLIER **LITTLE HAVANA II**	STREET ADDRESS, CITY, STATE, ZIP CODE **8260 SW GRAND CANAL DRIVE** **MIAMI, FL 33144**	

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

0000 - Initial Comments

A Standard Biennial Survey was conducted on , , 2018. Little Havana II with Limited Nursing Services components had the following deficiencies identified at the time of the survey:

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

Based on observation and interview, the Assisted Living Facility failed to treat one of six residents with dignity and respect (Resident #3). The facility fed the resident using baby's bottles.

Findings included:

1. Observation on at 6:58 AM revealed that there were three baby feeding bottles with milk on top of the kitchen counter.

In an interview on at 6:59 AM, the Administrator stated, "Some residents drink too liquids and it is easier to drink like that." the administrator did not provide the name of the residents.

Observation on at 7:51 AM revealed that after Staff B administered medicine to Resident #3, s/he put the baby bottle with milk in Resident #3's mouth.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on interview, record review and interview, the Assisted Living Facility failed to have licensed staff to provide medication administration to one out of six sampled residents (Resident #3) .

Findings included:

In an interview on at 7:30 AM, the Administrator revealed that a Registered Nurse administered medicines to Resident #3.

In an interview on at 7:38 AM the Register Nurse (RN) stated, "I am the nurse for the Resident (referring to Resident #3); I am coming from the ALF."
- RN was asked how many times a day was going to give medicines to Resident #3 and stated, " I think

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twice a day for Resident #3".

Review of Resident #3's MORs revealed that the resident had two medicines (, and Carvidopa- ,) by mouth three times a day (8 AM, 2 PM and 8 PM) and one medicine (,) by mouth four times a day (8 AM, 12 PM, 4 PM, 8 PM). The rest of the medicines were schedule at 8 AM, 6 PM, 8 PM. Staff D and B initialed the MORs for Resident #3 from to .

Review of Resident #3's record revealed that admission date was on . Health assessment (AHCA form 1823) completed on showed that the Resident needed medication administration.

Observation on at 7:47 AM revealed that Staff B put an , tablet in Resident #3's mouth.

In an interview on at 7:51 AM Staff B revealed that s/he was not a licensed staff.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record review and interview, the Assisted Living Facility failed to ensure that Medication Observation Records (MORs) were updated immediately each time medicines were offered or administered for six out of six sampled residents (Residents # 1-6). The facility failed to ensure that MORs included Resident's for two out of six sampled residents (Residents #2 and #3) .

Findings included:

1. Review of MORs for six out of six sampled residents on at 7:13 AM revealed that medicines were initialed as given 8 PM, 12 PM, 3 PM, 4 PM, 6 PM and 7 PM doses on and 8 AM doses on .
In an interview on at 7:16 AM Administrator stated, "It was the weekend."

2. Review of Resident #2's MORs revealed that it did not identify the . Resident #3's MOR did not identify the .

Review of Resident #3's record revealed that health assessment (AHCA form 1823) completed on showed that the Resident had an to .

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In an interview on [redacted] at 7:16 AM Administrator did not answer about the as needed medication nor about the [redacted].

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on record review and interview, the Assisted Living Facility failed to obtain clarification order for a medication ordered as needed or notify the doctor of changes that needed with the orders for one (Resident #3) out six sampled residents.

Finding included:

Review of Resident #3's Medication Observation Record revealed that there was an order for [redacted] 10 gm/5ml solution- ake 15 ml by mouth daily as needed. Staff initialed it every day at 8 AM from [redacted] to [redacted]. There was no documentation why medicine was given.

In an interview on [redacted] at 7:16 AM Administrator did not answer about the as needed medication or about the [redacted].

Class III

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on record review and interview, the Assisted Living Facility (ALF) failed to appoint a Manager for each facility.

Findings included:

Review of the Florida Health Finder database revealed the Administrator supervised two Assisted Living Facilities (ALFs).

Review of facility's records revealed that Administrator did not appoint a manager for present facility.

In an interview on at 12:43 PM, the Administrator stated, "I will put a manager."

Class III

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0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview, the Assisted Living Facility failed to ensure that four of six sampled staff had a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable (Administrator, Staff D and E and Registered Nurse). Facility failed to have documented evidence of a negative examination on an annual basis for one (Registered Nurse) out of six sampled staff.

Findings included:

Review of Administrator's record revealed that hire date was on . There was not documentation of a written statement from a health care provider documenting that the individual did not have any signs or symptoms of communicable .

Review of Staff D's record revealed that hire date was on . There was not documentation of a written statement from a health care provider documenting that the individual did not have any signs or symptoms of communicable .

Review of Staff E's record revealed that hire date was on . There was not documentation of a written statement from a health care provider documenting that the individual did not have any signs or symptoms of communicable .

Review of Registered Nurse's record revealed that hire date was on . There was not documentation of a written statement from a health care provider documenting that the individual did not have any signs or symptoms of communicable and evidence of a negative examination.

In an interview on at 12:40 PM Administrator revealed that s/he did not know the statement of communicable was missing.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on record review and interview, the Assisted Living Facility failed to have currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding

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Orders( ) within 30 days after employment for one (Administrator) out of six sampled Staff.

Findings included:

Review of Administrator's record revealed that hire date was on . There was not documentation in record of straining.

In an interview on at 12:45 PM Administrator revealed that did not find the training.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the Assisted Living Facility failed to ensure that structural systems were maintained in good working order.

Findings included:

Observation on at 10:20 AM revealed that baseboard molding was off of the wall. A piece of it was in the hallway between the the dining , just next to the sink used by staff for handwashing.

In an interview on at 10:27 AM Administrator revealed that it happened due to the continuous passage of wheelchair.

Class III

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

Based on record review and interview, the Assisted Living Facility failed to have accurate health assessment (AHCA form 1823) for two out of six sampled residents (Residents #3 and #6) . The facility failed to ensure that one of six residents receiving assistance with the activities of daily living had their weight recorded semi-annually (Resident #3) . The facility also failed to have a signed consent to the use of half-bed rail by the resident nor legal representative for one (#3) out of six sampled residents.

Findings included:

1. Review of Resident #3's record revealed that admission date was on . Health assessment

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(AHCA form 1823) completed on showed medical history and diagnoses of , Parkinson's , history of , scoliosis, incontinence. Resident needed assistance with ambulation, bathing, dressing, toilet and transfer. Resident needed medication administration. It did not show that Resident received hospice services.

Review of Resident #3's hospice record revealed that admission date to hospice was on with a diagnosis of Parkinson's . Doctor order on for at 2 liters per minutes via nasal cannula as needed for .

In an interview on at 12:55 PM, the Administrator stated, "Resident #3 has changed."

Review of Resident #6's record revealed that admission date was on . Health assessment (AHCA form 1823) completed on showed that known section was blank.

Review of Resident #6's Medication Observation Records revealed that the Resident had , and as identified .

In an interview on at 12:55 PM Administrator revealed that Resident #6 had to but not to , probably Resident #6's sister reported , also as an .

2. Review of Resident #3's record revealed that the weight was not recorded in 2016, 2017 or 2018. Review of Resident #3's record revealed that admission date was on . Health assessment (AHCA form 1823) completed on revealed that Resident needed assistance with ambulation, bathing, dressing, toilet and transfer. Resident needed medication administration.

In an interview on at 9:38 AM Administrator revealed that it was hard to stand Resident #3 on the scale.

3. Observation on at 7:03 AM revealed that Resident #3 rested in bed with half-bed rail up.

Review of Resident #3's record revealed that consent to the use of half-bed rail was not signed by the resident nor legal representative. There was a doctor order for the use of half-bed rail signed on .

On at 9:46 AM, observed the administrator ask Resident #3's daughter to sign a consent for

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the use of half-bed rails and Resident #3's daughter did.

Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on record review and interview, the Assisted Living Facility failed to resubmit the emergency plan to the local emergency management agency within 30 days of receiving notification,

Findings included:

Review of Comprehensive Emergency Management Plan Approval Letter revealed that last approved was on . Facility received on informing that needed to send the updated Comprehensive Emergency Management Plan by . Facility submitted the payment on .

In an interview on at 12:48 PM Administrator stated, "I was under pressure with the generator. I was paying more attention to that."

Class III