STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967975	**09/17/2018**
NAME OF PROVIDER OR SUPPLIER **HOGAR DULCE HOGAR**	STREET ADDRESS, CITY, STATE, ZIP CODE **5597 WENDY LN** **NAPLES, FL 34112**	

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

0000 - Initial Comments

An unannounced relicensure, limited mental health, limited nursing services, and emergency power plan monitoring survey was conducted on at Hogar Dulce Hogar, an assisted living facility (license #11937) in Naples, Florida.

The following is description of the deficiencies.

0004 - Licensure - Requirements - 58A-5.016 FAC

Based on observation, record review, and staff interview, the facility failed to notify the Agency for Healthcare Administration (AHCA) prior of change of space and subsequently obtain approval prior to the change. Failure to obtain approval prior to change of space is in violation of the physical plant standards provided in Rule 58A-5.023, F.A.C.

The findings included:

Observation during initial tour conducted on at 9:00 a.m., found Resident #6's bed in # . The resident's personal inventory was found in a dresser in # was not part of the licensed facility since it was utilized by the facility's staff only.

During an interview with the Administrator on at 2:45 p.m., it was confirmed that # was not part of the licensed area and was to be utilized only by the staff. The Administrator said they moved Resident #6 into Caregiver Staff A's she can better supervise him at night time. When the Administrator was asked if he notified AHCA prior to changing the use of space, he replied he was not aware of the regulatory requirement.

Class III

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on record review and staff interview the facility failed to follow appropriate admission criteria for one (Resident #6) of six residents admitted to the facility.

The findings included:

Record review for Resident #6 found he was admitted to the facility on . Further review found a

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health assessment (1823 form) dated .

Under nursing , , services the assessment indicated the resident needed administration of medications.

Under the medication section it indicated the resident needed administration of medications.

On at 3:45 p.m., the Administrator confirmed the facility does not have a full time nurse on payroll. The Administrator said the form was inaccurate and did not reflect resident's needs. He said he will call the resident's physician to clarify. He said if the resident still needs administration of medications a 45 day notice will be provided.

Class III

0009 - Admissions - Admission Package - 58A-5.0181(3) FAC; 400.0078(2)

Based on record review and interview, the facility failed to ensure a complete admission packet was available for new admissions to the facility. Failure to provide a complete admission packet leads to a lack of necessary information and may lead to misunderstanding between the resident or their representative and the facility.

The findings included:

Record review of the facility's admission packet revealed that the following information was excluded:

1. consumption policy;
2. Reporting resident , neglect and , policy.
3. Administrative and housekeeping schedules and requirements;
4. control, sanitation, and universal precautions; and,
5. The requirements for coordinating the delivery of services to residents by third party providers.
6. Facility's rules found visiting hours from 9 a.m., to 8:00 p.m. Per regulatory requirement described in Section 429.28, F.S., visiting hours must be 9:00 a.m., to 9:00 p.m.

During an interview with the Administrator on at 4:35 p.m., it was confirmed that the facility's admission package was incomplete since it did not include all required documents. It was also confirmed that the facility visiting hours were 9:00 a.m., to 8:00 p.m.

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Class III

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

Based on observation, record review, and staff interview, the facility failed to honor resident's rights by not properly utilizing half bed rails for one (Resident #6) of one resident with bed rails in the facility. The facility failed to obtain a consent prior to using bed rails for one (Resident #6) of one resident with bed rails in the facility. According to the Florida Statues 429.41 3. (k) The use of physical is limited to half-bed rails as prescribed and documented by the resident's physician with the consent of the resident or, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact. Failure to properly utilize half bed rails is in violation of resident's rights and has the potential of injury to the resident.

The facility also failed to provide a homelike environment for Resident #6 as he was housed with facility staff.

The findings included:

Observation during initial tour conducted on at 9:02 a.m., found Resident #6's bed in # . Resident #6's personal inventory was found in a dresser in # on the opposite side of the facility. # was not part of the licensed facility since it was utilized by the facility's staff only. Resident #6's bed was found to be placed against the wall. On the opposite side of the bed two half rails which were attached and were covering the whole length of the bed were observed.

During the course of the observation the Administrator was present and on at 9:04 a.m. said that Resident #6 had a tendency to get up in the middle of the night and urinate everywhere but the . To prevent him from getting out of the bed and everywhere, they moved him into caregiver A's . They placed the two bed rails on the bed so he could not get out of the bed.

Record review for Resident # 6 found he has admitted to the facility on . Further review found a blank consent form to be utilized prior to resident having half bed rails on his bed. On at 1:55 p.m. the Administrator confirmed he did not have a consent for the bed rails from Resident #6. The Administrator said he was unaware of the regulatory requirement. He said he did not know they needed consent before they used bed rails. He also said he was unaware that he can not use bed rails covering the whole length of the bed. He said no one ever told him.

On at 2:10 p.m., Caregiver Staff A (female) occupying # said that indeed she was

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with Resident #6 (male). Staff A verified that both bed rails were up during the night. She said the resident everywhere but the , and in order to prevent him from doing so they placed both bed rails up. She also confirmed they shared a better supervision.

An interview with the Administrator on at 2:45 p.m. confirmed that # was not part of the licensed area and was to be utilized only by staff. The Administrator said they moved Resident #6 in the staff A's she can better supervise him at night.

Class II

photos on file

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

Based on observation and staff interview, the facility failed to provide a safe and homelike environment to all residents.

The findings included:

Facility initial tour conducted on at 8:46 a.m., found the following:

1. In # accumulated dust on top of both dressers. Discolored stains of unknown origin on top of the dressers.
2. Two towels that were in distress and had holes on them found hanging in the in # . One more towel was found on top of the resident's bed. This towel had holes in it.
3. # : Mirror was in distress and parts of it were missing.
4. Ceiling light in the a hole in it.
5. Peeling paint off the wall in the hallway towards the second .
6. Leather sofa in distress and missing leather in different parts of the sofa. Interior material exposed.
7. Portable commode in Resident #2's rusted.
8. Accumulated dust and particles of unknown origin in Resident #2's dresser.
9. # commode had black stains of unknown origin.
10. Mirror in # was in distress and parts were missing.
11. The ceiling light in the a hole in it.
12. stain deposit on the faucet in # .
13. Drain in faucet in # was rusted.

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14. Two un-labeled sponges found in . . . . . # . Resident #4 and #5 said on . . . . at 11:00 a.m., they have been in the facility for more than a year and the sponges have been there in the same position for as long as they have been there. They said said they do not know who the sponges belong to.

15. Black stains on # 's door.

16. Facility refrigerators located in the garage had splatters of dirt on the exterior.

17. Inside the refrigerator, found an unlabeled bag of what appeared to be mango. On at 9:16 a.m., the Administrator said the mango was there for about a month.

18. Accumulated dirt on the ceiling air conditioning vent in the hallway toward # .

The Administrator said on at 4:00 p.m., he was working on the repairs and was planning to repaint. He also said the sofa was new and he did not understand why it was destroyed already.

Class III

photographs on file