AGENCY FOR HEALTH CARE ADMINISTRATION

PRINTED: 01/04/2019
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964762	**11/26/2018**

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

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

0000 - Initial Comments

A Complaint investigation (CCR2018016276)Was conducted at Lourdes Residence, Inc. survey on and completed on Lourdes Residences, In. with a standard license, had deficiencies at the time of the survey:

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on observation, record review and interview, the facility failed to provide at least 45 days notice of relocation or termination of residency from the facility to one of five sampled residents (Resident 1) who was transferred to a local hospital without any change of health condition giving the family a short time notice of termination of contract without reasons for relocation set in writing. In addition, the facility failed to provide a safe and decent living environment, free of and neglect for one of five sampled residents (Resident 3).

Findings included:

1) Review of Resident 1's record showed admission date . Last health assessment . Diagnoses, , walking , history of , track , gait, , of , , unable to perform personal care activity, , primary of . Assistance in all daily activities, regular diet. The record did not have any progress notes for the resident. The resident's record showed a contract signed by the facility and the resident's power of attorney including the required 45 notice of relocation or termination of residency from the facility.

A review of the admission and discharge log showed that Resident #1 was not listed. On , , between 5:30 am and 11:30 am, observed the Administrator adding the name on the log as the issue was discussed.

On , at 6:15 AM, the Administrator stated, "The resident left in , she was here since 2015." adding "Resident 1 left to another facility, she was declining. The family wanted hospice care but they would not give medications, so the family took her to another facility. She could not walk anymore." At 11:04 AM, the Administrator added, "I spoke to the daughter and told her that she was not walking and needed to be assisted by 2 people, she was declining and I suggested a nursing home or hospice; I told her verbally. Resident 1 left st to another ALF; her husband liked it. I

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am also the Administrator there. When I told the daughter about hospice, she spoke to an agency but they do not give medications."

On , at 10:04 AM during a phone interview, Resident 1's daughter stated, "She was at the facility until last week. We took her out because the owner told me that she had to be removed. I wanted her to put her in hospice. The owner did not give me any notice, it was verbally only; she told me a week before. I asked her to give me more time. I was happy with the facility, I never had any problems and I do not know what happened. 2 weeks ago, the owner sent her to the hospital. The doctor told me that she did not have anything, that they could not keep her there. He told me that they sent her because she was and constipated. They put a , and sent her to the facility. I have her now in another facility." The daughter contact the agency surveyor later at 2:19 PM and stated, "I forgot to tell you that they moved my mom last week on Monday or Tuesday without my authorization to another ALF. She told me that they had an available bed there and that she was going to be better there while I looked for another facility; that it was to my benefit. When I took her from that facility, I saw that she had a scab on her ; it looked like if it was healing but it was kind large. We did not take her to the doctor. She was always wearing long pants or long dresses. She was a whole week at the original facility and 2 days at the facility were she was sent. I asked for my money because I had already pay them for the month of and also for a letter stating why they wanted her out of the facility; they gave me a check for the money but never the letter and I assume that I am not going to receive one anyway."

2) Review of Resident 3's record showed an admission date of . The resident was observed in a shared room during the facility's tour. During the tour, there was a door locked outside on the left side of the facility, according to the staff the person who was living there was no longer renting the room. At 6:28 AM, the Administrator stated, "There is no one there, we have never rented it and we do not have the key; my husband does."

When the husband (Owner of the facility) arrived, opened the side door, it was observed furniture, wheel chairs, mattresses, women clothes inside a closet and personal items inside furniture drawers including a post card dated and posted by the post office on to Resident 3 from the niece who was traveling out of the country. The owner stated that no one was using the room and that the room had his own personal things.

In a phone interview with the Resident 3's son at 10:40 AM, he stated, "I have always been happy with the services; she used to have a private room; the room was going to the side of the house. I always saw maybe 8 or 9 people living in the facility."

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Class III

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observation and interview, the facility failed to follow the correct procedure as outlined by the state, when assisting 2 of 6 sampled residents with self-administration of medications (Residents # 2 and 6).

Findings included:

On at 8:10 am, observed Staff D assisting residents with self-administration of medication. Staff D washed her and put on gloves, went to the locked cabinet, took the medication out, went to the resident and took the medication out of the medication card, put it into in her , put it on a small box, gave water and turned around and went to look for the medication observation record and signed all the medication.

On at 8:15 AM Staff D stated: "I always do this with the residents because I give them their time to take their medication, I did not know that I had to wait for them to swallow them."

Class III

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

Based on record review and interview, the facility failed to have an updated admission and discharge log.

Findings included:

Review of the admission and discharge log showed that the dated admitted, and place from which admitted were not listed for Resident some residents who had been discharged recently.

On at 11:00 AM, the Administrator stated that the reason why the admission and discharge log was not up to date was because she just updated everything and she forgot to list the residents who had been discharged recently.

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

Based on record review and interview, the facility failed to maintain an accurate admission and discharge log for the facility. In addition, the facility failed to provide progress notes on three of five sampled residents (Residents 1, 2 and 3) and a resident record for one resident who was not longer at the facility (Resident 4).

Findings included:

Review of the facility's admission and discharge log showed that Residents 1 and 4 were not listed.

On , at 6:18 AM, observed the Administrator adding the information for Resident 1 on the log and stated, "She left to another facility, she was declining. The family wanted hospice care with a company but they would not give medications, so the family took her to another facility. She could not walk anymore." The resident's admission date was .

On , at 10:04 AM during a phone interview, Resident 1's daughter stated, "She was at the facility until last week. We took her out because the owner told me that she had to be removed. I wanted her to put her in hospice. The owner did not give me any notice, it was verbally only; she told me a week before. I asked her to give me more time. I was happy with the facility, I never had any problems and I do not know what happened. 2 weeks ago, the owner sent her to the hospital. The doctor told me that she did not have anything, that they could not keep her there. He told me that they sent her because she was and constipated. They put a , , and sent her to the facility. I have her now in another facility." The daughter contact the agency surveyor later at 2:19 PM and stated, "I forgot to tell you that they moved my mom last week on Monday or Tuesday without my authorization to another ALF. She told me that they had an available bed there and that she was going to be better there while I looked for another facility; that it was to my benefit. When I took her from that facility, I saw that she had a scab on her ; it looked like if it was healing but it was kind large. We did not take her to the doctor. She was always wearing long pants or long dresses. She was a whole week at the original facility and 2 days at the facility were she was sent. I asked for my money because I had already pay them for the month of and also for a letter stating why they wanted her out of the facility; they gave me a check for the money but never the letter and I assume that I am not going to receive one anyway."

In addition, the facility did not have a record for Resident 4 and the resident was not listed on the log. At 11:14 AM, the Administrator stated, "Resident 4 is in the other ALF because he wanted to go there; I just cannot find his record."

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On , at 10:24 AM, Resident 4 'son stated, "My father used to be with my mom at the facility but asked to be changed to another facility because he could not see her in that condition."

Review of Residents 1 and 2's records showed no progress notes indicating significant changes. Resident 1 was removed from the facility without notice and Resident 2 had been transferred to the hospital and put in hospice by the doctor.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(&) FS; 58A-5.0241 FAC

Based on record review and interview, the facility failed to report within 1 business day after the occurrence of the adverse incident and a full report within 15 days to the agency including the results of the facility's investigation into the adverse incident for one of five sampled residents (Resident 2).

Findings included:

Review of the hospice documents for Resident 2 stated on that the patient had a history in the prior six months of multiple . Review of Resident 2's record showed an admission date of . The resident was under hospice care on admission. The resident needed precautions, and presented no elopement risk. The record did not contain progress notes reflecting any .

On , at 9:30 AM, Staff B stated, "The last time Resident 2 was like a month ago."

Class III

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

Based on record review and interview the facility failed to provide documentation of an updated Emergency Management Plan submitted and approved by the local agency.

Findings included:

Record review revealed the facility had an approved Emergency Management Plan available for review dated -Expired.

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On at 10:00 AM the Administrator stated that the consultant had done this already and she did not know why she had not provide the new one for the facility.

Class III