STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969224	**01/15/2019**
NAME OF PROVIDER OR SUPPLIER **LITTLE HAVANA ALF INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **2600 SW 10 ST** **MIAMI, FL 33135**	

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

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on record review, and interview, the facility failed to maintain and update its background screening employee roster as required for one out of five (Staff E) sampled staff.

Findings Include:

Record review revealed Staff E was removed from the employee roster, but was still working at the facility. Staff E was hired on [redacted] and the end date, on the roster, was [redacted].

Interview conducted on [redacted] at 11:55 AM, Administrator stated the staff schedule was current and up to date.

Unclassified

AGENCY FOR HEALTH CARE ADMINISTRATION

PRINTED: 02/11/2019
FORM APPROVED

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0000 - Initial Comments

A Complaint Survey CCR# 2019000065 was conducted on & . Little Havana ALF Inc had deficiencies identified 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 ensure the staff were trained to perform their duties and honor resident rights, including the right to receive ( ) for one out seven (Resident #1) sampled residents. The facility failed to maintain contact with third party agency that provided services to facility residents for one out seven (Resident #1) sampled residents.

Findings included:

Resident #1 on . On the day of the incident, the facility had one staff member working (Staff B) with no and First Aid training caring for three bed bound hospice residents and four additional residents. The facility contacted a funeral service provider to initiated cremation. The facility left Resident #1's remains at the crematorium for nine days and didn't return to provide final payment and sign required documentation until the day of survey, .

On at 10:00 AM, observed Staff B alone at the facility caring for two bed bound hospice residents and four additional residents.

Staff record review showed Staff B did not have and First Aid training.

Review of the admission and discharge log showed that Resident #1 on . Facility record review showed that there was no policies and procedures in place.

Review of Resident #1's (admitted on) health assessment revealed the following diagnoses: , and . The health assessment dated indicated Resident #1 needed supervision with eating and assistance with the rest of the activities of daily living. The record documents emergency contact as a family friend. There was no documentation on file that a healthcare designee was appointed. The resident was enrolled in hospice care on . The ( ) was signed by an unauthorized individual who was later identified as the facility administrator's friend that was not listed as resident's family member or emergency contact. There was no documentation of legal guardianship or power of attorney on file.

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There were no written notes about circumstances surroundings the resident .

Attempted to interview Resident's #1 friend and health care designee on at 12:35 PM. The telephone numbers were disconnected.

Review of Resident #2's (admitted on) health assessment revealed the following diagnoses: , fecal impaction, , and . The health assessment dated indicated the resident required total assistance with the activities of daily living. Resident #2's daughter signed . There was an invalid power of attorney documentation on file.

Review of Resident #3's (admitted on) health assessment revealed the following diagnoses: , History of . The health assessment dated indicated total assistance with activities of daily living. Resident #3's granddaughter signed . There was an invalid power of attorney documentation on file.

Interview conducted on at 12:40 PM, the Administrator stated Resident #1 had labored breathing during the night on . Staff contacted hospice who told her to put the resident on until the hospice nurse arrived. Staff informed me that Resident #1 , next day on . We were unable to contact Resident's #1 friend because he was out of the country. Hospice staff contacted a crematorium after I told them that Resident #1 did not have any funeral arrangement. Crematorium owner's contacted me, and I accepted the fee services and requested to pick up the body. We had an with crematorium's owner to pay the fee services and sign the required documentation today. Administrator said the facility was the payee for the and two another residents and confirmed that the facility did not have a surety bond in place. In addition, she said the facility staff receive training and Staff B worked alone from 7: 00 AM to 5:00 PM from Monday through Friday since there were only six or seven residents in the facility.

Interview conducted on at 12:00 PM, Staff D stated he had an with the funeral service provider to pay the final balance owed for services and sign the required paper work. He stated, he told the provider he would pay for everything once the facility received the residents' payments.

Interview conducted on at 10:40 AM, Resident's #1 Hospice Social Worker Director stated when Resident #1 , Staff D called hospice to discuss arrangements because they weren't able to reached the individual listed in the resident's file as contact because he was out of the country.

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They informed facility's owner that they were unable to reach him as well. Staff D then stated that he would make the final arrangements for the resident and discussed options with them. They gave him a list of funeral service providers and he decided a crematorium. Staff D contacted the crematorium and had them come and pick up the remains. Staff D agreed assume responsibility to sign and pay for services for the resident. The crematorium began the process to complete services, but could not do it because, after several days, Staff D did not come in to complete the required paper work and pay for the services. After a week, a state agency contacted the crematorium to inquire why final documentation had not been completed. The crematorium contacted them and explained the situation. After several attempts, he reached the Staff B who he stated was very belligerent and told him he would pay for the cremation and sign all the paper work after the facility received its payments from residents.

Class II

0076 - ( ) - 58A-5.0186 FAC

Based on record review and interview, the facility failed to provide , , ( ) for one out of seven (Resident #1) sampled residents who did not have a properly executed ( ) for one out of seven sampled residents who became unresponsive and (Resident #1) sampled residents. The facility also failed to ensure that authorized individuals signed the for three out of seven (Residents #1, #2, and #3) sampled residents who were on hospice.

Findings included:

Review of the admission and discharge log showed that Resident #1 on .

Review of Resident #1's (admitted on) health assessment revealed the following diagnoses: , and . The health assessment dated indicated Resident #1 needed supervision with eating and assistance with the rest of the activities of daily living. The record documents emergency contact as a family friend. There was no documentation on file that a healthcare designee was appointed. The resident was enrolled in hospice care on . The ( ) was signed by an unauthorized individual who was later identified as the facility administrator's friend that was not listed as resident's family member or emergency contact. There was no documentation of legal guardianship or power of attorney on file. There were no written notes about circumstances surroundings the resident .

Attempted to interview Resident's #1 friend and health care designee on at 12:35 PM. The telephone numbers were disconnected.

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Review of Resident #2's (admitted on) health assessment revealed the following diagnoses: , fecal impaction, , and . The health assessment dated indicated the resident required total assistance with the activities of daily living. Resident #2's daughter signed . There was an invalid power of attorney documentation on file.

Review of Resident #3's (admitted on) health assessment revealed the following diagnoses: , History of . The health assessment dated indicated total assistance with activities of daily living. Resident #3's granddaughter signed . There was an invalid power of attorney documentation on file.

Facility record review showed that there were no policies and procedures on or in place.

Interview conducted on at 12:40 PM, Administrator confirmed unauthorized individuals signed the for Resident #1, #2 and #3. She said that Resident's #1 record did not have documentation of legal guardianship or power of attorney on file, and Resident #2 and Resident #3 had an invalid power of attorney on file. Administrator said Resident #1 had labored breathing during the night on . Staff contacted hospice who told her to put the resident until the hospice nurse arrived. Staff informed me that Resident #1 , next day on . We were unable to contact Resident's #1 friend because he was out of country. She said the facility staff receive training and Staff B worked alone from 7: 00 AM to 5:00 PM from Monday through Friday since there were only six or seven residents in the facility. Administrator provided "Resident Choice" form as facility's policies and procedures.

Class II

0077 - Staffing Standards - Administrators - 429.176 FS; 429.52( ),58A-5.019(1) FAC

Based on record review and interview, the facility failed to ensure that it was under the supervision of a qualified administrator who was responsible for the operation and maintenance of the facility, management of all staff, and provision of appropriate care. The administrator failed to ensure adequate staffing and that staff were trained to perform their duties and honor resident rights , including the right to receive ( ). The administrator failed to ensure maintenance of legally obtained and executed healthcare surrogate documentation and ( ) forms for three out of seven (Resident #1, #2, #3) sampled residents. The administrator failed to have

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policies and procedures for ( ) in place. The administrator failed to keep updated emergency contact records for one out of seven (Resident #1) sampled residents.

Findings included:

Observation on at 10:00 AM showed Staff B was working alone in the facility caring for two bed bound hospice residents and four additional residents requiring assistance with activities of daily living.

Review of the staffing scheduled posted showed the following: to was scheduled to work Staff B and Staff C from 7:00 A.M. to 5:00 P.M., and Staff F from 5:00 P.M. to 7:00 A.M.

Staff record review showed Staff B did not have and First Aid training.

Review of the admission and discharge log showed that Resident #1 on .

Review of Resident #1's (admitted on) health assessment revealed the following diagnoses: , and . The health assessment dated indicated Resident #1 needed supervision with eating and assistance with the rest of the activities of daily living. The record documents emergency contact as a family friend. There was no documentation on file that a healthcare designee was appointed. The resident was enrolled in hospice care on . The ( ) was signed by an unauthorized individual who was later identified as the facility administrator's friend that was not listed as resident's family member or emergency contact. There was no documentation of legal guardianship or power of attorney on file. There were no written notes about circumstances surroundings the resident .

Review of Resident #2's (admitted on) health assessment revealed the following diagnoses: , fecal impaction, , and . The health assessment dated indicated the resident required total assistance with the activities of daily living. Resident #2's daughter signed . There was an invalid power of attorney documentation on file.

Review of Resident #3's (admitted on) health assessment revealed the following diagnoses: , History of , . The health assessment dated indicated total assistance with activities of daily living. Resident #3's granddaughter signed . There was an invalid power of attorney documentation on file.

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Facility record review showed that there was no policies and procedures in place.

Attempted to interview Resident #1's friend and healthcare designee, by phone, on at 12:35 PM. The telephone number listed in the resident's record were disconnected.

Interview conducted on at 12:40 PM, Administrator stated Resident #1 had labored breathing during the night on . Staff contacted hospice who told her to put the resident on until the hospice nurse arrived. Staff informed me that Resident #1 , next day on . We were unable to contact Resident's #1 friend because he was out of the country. Hospice staff contacted a crematorium after I told them that Resident #1 did not have any funeral arrangement. Crematorium owner's contacted me and I accepted the fee services and requested to pick up the body. We had an with crematorium's owner today to pay the fee services and sign the required documentation today. Administrator said the facility was the payee for the and two another residents and confirmed that the facility did not have a surety bond in place. In addition she said the facility staff receive training and Staff B worked alone from 7: 00 AM to 5:00 PM from Monday through Friday since there were only six or seven residents in the facility.

Administrator provided "Resident Choice" form as facility's policies and procedures during the interview.

In an interview conducted on at 1:20 PM, Staff D stated he had an with the crematorium to pay the fee to complete final services for the resident and sign the required paper work. He stated, he told the provider he would pay for everything once the facility received the residents' payments.

Resident #1 on . Crematorium picked up the body as requested. The body remained at the crematorium for 9 days. The crematorium was unable to reach the facility to obtain final payment and have the required documentation signed to complete services.

Class II

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

Based on observation, interview, and record review, the facility failed to have an accurate written work schedule that reflects its 24-hour staffing pattern for a given time period. The facility also failed to have qualified staff to meet the scheduled and unscheduled needs of the residents for seven out seven

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sampled residents.

Findings included:

Resident#1 , , on at the facility. On the day of the incident, the facility had one staff member working (Staff B) with no and First Aid training caring for three bed bound hospice residents and four additional residents

On at 10:00 AM, observed Staff B alone at the facility caring for two bed bound hospice residents and four additional residents.

Review of the Staffing scheduled posted showed the following: to was scheduled to work Staff B and Staff C from 7:00 A.M. to 5:00 P.M., and Staff F from 5:00 P.M. to 7:00 A.M.

Interview conducted on at 11:15 AM, Staff B stated she worked alone in the facility on . In addition, she said that there was a hospice staff taking care of Resident #1 that day.

Interview conducted on at 12:30 PM, Administrator stated Staff B worked alone from 7: 00 AM to 5:00 PM from Monday through Friday since there were only 7 residents in the facility.

Record review of Resident #1 admitted on was diagnosed with , and . The health assessment done on indicated Resident #1 needed supervision with eating and assistance with the rest of the activities of daily living. The record documented emergency contact as a family friend. There was no documentation on file that a health care designee was appointed. The resident was enrolled in hospice care on . was signed by an unauthorized individual who was later identified as the facility administrator's friend that was not listed as resident's family member or emergency contact. There was no documentation of have no legal guardianship or power of attorney documentation was on file.

Record review of Resident #2 admitted on was diagnosed with , fecal impaction, , and . The health assessment indicated the resident required total assistance with the activities of daily living. Resident's #2 daughter signed . There was an inavalid power of attorney documentation on file.

Record review of Resident #3 admitted on was diagnosed , , History of . The health assessment indicated total

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assistance with activities of daily living. Resident's #3 granddaughter signed . There was an inavalid power of attorney documentation on file.

Record review of Resident #4 admitted on was diagnosed with , Pulmonic , and . The health assessment indicated assistance with activities of daily living.

Record review of Resident #5 admitted on was diagnosed with , type II, and . The health assessment indicated assistance with the activities of daily living.

Record review of Resident #6 admitted on was diagnosed with , Right , and . The health assessment indicated supervision with eating and assistance with the rest of the activities of daily living.

Record review of Resident #7 admitted on was diagnosed with Controlled, , and . The health assessment indicated supervision with eating and assistance with the rest of the activities of daily living.

Class II

0083 - Training - First Aid and - 58A-5.0191(5) FAC

Based on observation, record review and interview the facility filed to have at least one staff present, trained in ( ) and First Aid at all times.

Findings Include:

On at 10:00 AM, observed Staff B alone at the facility caring for six residents.

Review of the Staffing scheduled posted showed the following: to was scheduled to work Staff B and Staff C from 7:00 A.M. to 5:00 P.M., and Staff F from 5:00 P.M. to 7:00 A.M.

Staff record review showed Staff B and First Aid training expired.

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Interview conducted on . . . . . at 12:30 PM, Administrator stated Staff B worked alone from 7: 00 AM to 5:00 PM from Monday through Friday since there were only 7 residents in the facility. She confirmed that Staff B's and First Aid expired.

Class III

0120 - Fiscal - Financial Stability - 429.17(3) FS: 429.275(1)58A-5.021(1) FAC

Based on record review, and interview, the facility failed to maintain accurate business records.

Findings Include:

Facility record review showed that there was no documentation of resident's income and expenses available for review during the survey.

Interviewed on at 11:30 AM, the Administrator stated that they received resident's checks and deposit them electronically in the facility's bank account.

Documentation of facility's expenses was requested by phone on . . . . . Documentation was not received within the requested timeframe.

Class III

0125 - Fiscal - Surety Bonds - 429.27(2) FS; 58A-5.021(3) FAC

Based on record review and interview, the facility failed to have a surety bond in place before acting as representative payee for three out of seven residents.

Findings Include:

Facility record review showed no documentation of a surety bond.

Interview conducted on . . . . . at 11:50 AM, the Administrator stated the facility acted as payee for Resident #1 and for two other residents.

Class III