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	AL11910977	**01/18/2019**
NAME OF PROVIDER OR SUPPLIER **LAS MERCEDES BOARDING HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **3418 SW 23RD TERRACE** **MIAMI, FL 33145**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

A Standard Biennial Survey was conducted on . . . . . to . . . . . Las Mercedes Boarding Home, with a standard license, had the following deficiencies identified at the time of survey:

0004 - Licensure - Requirements - 58A-5.016 FAC

Based on observation and record review, the facility failed to provide proof of the annual fire safety inspection.

Findings included:

On . . . . . at 6:20 AM, on the hallway to the resident rooms, observed the main fire panel with the trouble light on. Staff H acknowledged the issue and stated she would let the management know.

Review of the facility's records showed an expired satisfactory fire inspection dated . . . . .

Class III

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

Based on record review and interview, the facility failed to provide documentation on one of 14 residents (Resident 10) who had a significant change. In addition, the facility failed to provide an accurate census, and failed to have knowledge of how many residents were at the facility during a survey.

Findings included:

1) Review of the facility's admission and discharge log showed Resident 10's admission date as . . . . . and discharge date as . . . . . .

Review of Resident 10's record showed no documentation stating the reason the resident was discharged nor where the resident was taken.

On . . . . . at 3:30 PM, a family member of the resident stated by phone , "I just removed her from the facility to be closer to me."

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2) On , , at 6:15 AM, Staff H, who started working at 6:00 AM and Staff J, who was working since the night before, did not know the current resident census for the facility; they stated that there were about 30 residents with one in hospice and one with .

Review of the facility's admission and discharge log showed 29 current residents. The tour confirmed the amount of residents.

Class III

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 honor the resident's rights to be free of for three out of 14 sampled residents (Residents # 3, # 12 and # 13). Resident # 13 had a ½ side rail in the center of the bed. Resident # 12 had a recliner chair that blocked an open space that restricted resident from exiting the bed. The facility failed to ensure that the use of physical did not restrict Residents to bed. The facility failed to treat residents with respect, personal dignity and privacy. Resident #3 used a in his room while his roommate was present, and there was no screen or other barrier for the resident to achieve privacy.

Findings Included:

1) On at 6:40 AM, observed Resident #13 with ½ side rail in the center of the bed. Resident stated he did not know how to put the rail down.

Review of Resident #13 record showed no physician order in file for the use of the side rail.

On at 11:48 AM, Staff H stated Resident 13 had the side rail in the center of the bed to prevent him from getting out of bed without assistance. Staff H stated the resident did not know how to put the side rail down.

On at 6:50 AM, observed Resident 12 lying in a bed that was against the wall and a recliner chair on the opposite side that blocked the open space.

On at 11:48 AM, Staff H stated Resident 12 gets agitated and move all over the bed. She stated the recliner chair was placed on the side of the bed to the open space to prevent resident from falling out of the bed.

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2) On , , at 6:25 AM, observed a container for Resident 3 on the floor next to the bed. The room is a shared room with another resident.

On , , at 6:25 AM, Staff H stated, "He uses it at any time of the night."

On , , at 9:30 AM, Resident 3 stated, "I use the container at night and in the morning also. I do not have any problems if my roommate is here when I use it."

Class III

0076 - ( ) - 58A-5.0186 FAC

Based on record review and interview, the facility failed to retrain all staff members and advise them which residents had a ( ). Staff was not aware that a fourth resident had a on record.

Findings included:

1) Review of Resident 6's record showed a yellow color document titled "State of Florida signed and dated by the physician and the resident's representative on .

On , , at 11:30 AM, Staff H stated, "We have two residents with , Resident 7 and Resident 8, then the hospice resident 2."

On , , at 10:20 AM, Staff G stated, "We have to check first if we can give them . I call 911 first. We have three residents with , Residents 8, 2 and 7."

On , , at 9:45 AM, Staff I stated, "We have three residents. Residents 2, 8 and 7."

On , , at 10:10 AM, Staff C stated, "There are three residents, 7, 8 and 2.

Class III

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

Based on record review and interview, the facility failed to provide the supervision and administration required to operate and maintain an appropriate care to all residents. The facility failed to request a

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change of owner to the agency when a third party individual made a verbal agreement with the facility to take over the business at least six years ago. The facility failed to review facility, residents and staff's records to assure accuracy. Original training certificates in Staff A's record, including for ( ) were dated, signed and filed in staff records without actual training being conducted.

Findings included:

A) Review of the Florida Health Finder in the system showed the facility's Administrator/Financial officer as the Owner (Staff A). Review of the State of Florida corporations showed, Las Mercedes Boarding, Inc. with an active status, filed and the registered agent as Staff A.

Review of the Background Screening Clearinghouse database showed, the Owner as the Administrator and Chief Financial Officer. Also, Staff B and K as Other Licensed Health Care Professionals.

On at 5:30 AM, observed 29 residents under the care of two staff who stated the person in charge would arrive at 6:00 AM and that the person over the facility was Staff K. When asked to speak to the Administrator, the staff stated they did not have the phone number for the Owner/Administrator, because the persons they always reported to were Staff H, B and K.

During an interview with the Owner/Administrator, he stated that he was the owner and administrator but he was renting the facility to a couple for $18,000/month. He further stated that they came one day and knocked at his door and discussed the possibility of taking over the facility and pay rent. A review of facility documents showed no Manager listed. At 5:55 AM, the Owner stated that he started the ALF in the 1980's. He said, "I started with 18 residents, then I increased to 32 and then to 39. Staff B and K rent the facility; the residents are theirs. I do not have access to the records or the residents; I hardly know their names. Staff K does not allow me to review the records; I do not even have access to the mailbox; they have the key and keep it locked; they never give me my correspondence. My attorney sent them a letter asking them to vacate the property as they are behind two months and they would not give me the agency's reports; I do not know if they have had fines. They are never here. They left Staff H in charge."

During an interview on at 11:06 AM, Staff K stated that she managed and served as assistant administrator for the facility since 2012 and to participate on all the agency's inspections. She stated that Staff A was the owner and administrator for the facility. She stated that she was interested from the beginning to act as the administrator, but the owner always wanted to be the administrator even though he did not want to help with anything. She stated the owner used to participate on the

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inspections, that he stopped going to the facility about two months ago when he installed cameras and see everything that goes on at the facility from his home. Staff K also added, that she had an with the owner's attorney on and was going to tell the attorney that if by of this year the situation of him being the administrator did not change, she would not continue to work there. Staff K further stated that she wrote checks from other facilities she owned to the owner/administrator to pay the rent, and confirmed that she had signature power on the facility's bank account, and that her husband Staff B did as well, but that Staff B did not sign for any checks. She added that the owner/administrator was also on the checking account and had access to do whatever he wanted. She concluded saying that the owner/administrator was not mentally well to be an administrator and was forgetful; that was the reason why she had the with the attorney.

During an interview at 11:30 AM, Staff H stated, "I have been working with them since the beginning, it's been 8 years. I used to work with them in another facility for a year. I am in charge of everything when they are not here. Staff K passes by here every day; she stays 2 or 3 hours. They both are the managers of the facility; the administrator is Staff A. He would pass by here at the beginning, maybe every 3 months; he would pass by the hallway outside, say hi and that was it. His wife would never come. He would never be worried and would leave right away. Maybe a month and an half ago, he started sitting outside only to see who was passing by and nothing else; if he would come inside, was to ask for something. They pay me more because I am in charge." In reference to the mailbox Staff H stated, "I have the key for the mailbox, it has always been locked; we received things from the ALF and things for the residents. The agency's papers and the electricity comes under the owner's name but I give everything to Staff K because she is the one who brought me here and I never see him anyway; I never speak to him. I report everything to Staff K, nothing to him but I know that he is the administrator. They have never told me that I need to report to him."

On at 9:45 AM, Staff I stated, "I report to the manager, Staff H. If she is not here, Staff K. She comes every day and stays few hours. At 10:10 AM, Staff C stated, "Staff H is always here. I report to her and if she has the day off, I contact the owners, Staff K or her husband. Staff K comes every day and stays 2 or 3 hours. I understand that the owner of the facility is Staff A but I report to Staff K."

Resident 3 stated on at 9:30 AM, "I know the owner, Staff K. She comes once a week."

B) Review of the Owner/Administrator's personnel record showed an original training ( ) document, signed , 12 hours continued education training signed , 4 hours medication training signed and Nutrition & Food Service training signed

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On , , at 9:15 AM, the Owner stated, "I have not done any type of training since they are renting the facility." The wife confirmed the statement. The Owner further stated that he had not taken any trainings in about eight or nine years.

On , , at 11:30 AM, Staff H stated, "I have received all the training; the trainer comes here. He came to do the but it has not been 2 years. All employees need to be here when he comes. The owner does not participate on the training, neither his wife."

On , , at 2:30 PM, the trainer who had provided the , Core update, and medication trainings stated in a phone interview regarding the validity of the training certificate, "I conduct the training as they need them. I conduct the training and they are all signed by me." In reference to keeping a log of participants to provide documentation that the Owner/Administrator or any staff had actually been trained, the trainer stated "Sometimes I do and sometimes I do not; for them I did not; an ID is not required for the trainings but they provide ID when they complete the applications. I know the owner for 35 years; he did the 12 hour continued education, the med training, food service/nutrition and . I do the training in both buildings. He is the owner and Staff B and K are managing the facility. If I issue a certificate, I gave the training; it is his word against mine." Record review showed all staff who had valid training at the facility had been trained by the same person.

Class II

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

Based on record review and interview, the facility failed to provide documentation of valid ( ) training for any staff, and provided falsified documentation of training for the Owner/Administrator (Staff A). The Owner/Administrator had a certificate of training dated and signed by an approved trainer who trained the entire staff although The Owner/Administrator said that he had not received this training in eight or nine years. The facility failed to ensure that a staff person who had completed training and held a valid verification of this training, was on site at all times.

Findings included:

Review of the Owner/Administrator's personnel record showed a training signed and dated by a trainer.

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On , , at 11:30 AM, Staff H stated she never saw the Owner/Administrator and that she reported to the person who is in charge of the facility and gave her the job. Staff H added, "The owner does not participate on the training, neither his wife." When asked if the Owner/Administrator had been present during the last training, dated the same day as Staff H's training, she stated that the Owner/Administrator had not been present.

On , , at 9:15 AM, the Owner/Administrator stated, "I have not done any type of training since they are renting the facility." He further stated that he had not completed training in eight or nine years. The Owner's wife confirmed the statement.

On , , at 2:30 PM, during a phone interview, the trainer stated that he was aware that the Owner/Administrator was assigning the use of his license to someone else. He further stated stated, "I conduct the training as they need them. I conduct the training and they are all signed by me." The trainer further stated that he kept no record of who had participated in trainings, and that he did not have a training log or sign in sheet. In reference to keeping a log of participants, the trainer stated "Sometimes I do and sometimes I do not; for them I did not; an ID is not required for the training but they provide ID when they complete the applications. If I issue a certificate, I gave the training; it is his word against mine."

Class II

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

Based on observation and interview, the facility failed to provide a safe living environment free of hazards and ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances were maintained in good working order.

Findings Included:

On at 6:20 AM, observed a black sofa that had peeling fabric in resident room two. Also, observed a closet in the corridor with a missing board.

On , , at 6:20 AM, in the hallway to the resident rooms, observed the main fire panel with the trouble light on. Staff H acknowledged the issue and stated she would let the management know.

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On at 11:45 AM, the administrator stated the chair with the peeling fabric would be replaced. He also stated the closet door would be repaired.

Class III

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

Based on record review and interview the facility failed to have a accurate health assessment for one out of 14 sampled residents. (Resident # 2).

Findings Included:

Review of Resident # 2 record showed that the health assessment (Agency for Health Care Administration form 1823) did not indicate resident known .

Review of Resident #2 Medication Observation Records indicated resident is to .

On at 11:48 AM, Staff H stated she would inform the doctor to update the health assessment.

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 14 sampled residents (Resident 1). The resident had to be transferred to the hospital after suffering a at the facility.

Findings included:

On , , at 7:05 AM, observed Resident 1 seated at the dining table; the resident had a black , and stated he few days ago.

Review of the incident reporting system for the agency did not show any incidents reported by the facility in the month of , 2019.

On , , at 7:05 AM, Staff H stated, "He few days ago." At 7:15 AM, Staff J stated, "I

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was in the kitchen and the resident was sitting right there at the dining table; the resident and we called the rescue; we put ice and they took him to the hospital. It happened not this Saturday but the other Saturday."

Review of hospital records for the resident showed an admission to the emergency room on with a diagnosis of 'injury of from , hematoma on the right side of forehead.'

Class III