STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967037	**01/31/2019**
NAME OF PROVIDER OR SUPPLIER **BERMUDEZ SENIOR CARE INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **5301 SW 162 PLACE** **MIAMI, FL 33185**	

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

0000 - Initial Comments

A complaint inspection (CCR#2018018229) was conducted on . Bermudez Senior Care Inc. had deficiencies identified at the time of the survey:

0031 - Resident Care - Third Party Services - 58A-5.0182(7) FAC 429.255(1)(b). FS

Based on observation, record review and interview, the facility failed to ensure coordination of care with third party services (Home Health Agency) for one of six (#1) sampled residents.

Findings included:

Observation on at 7:55 am revealed a locked box on the premises containing prescribed for Resident #1.

A review of the resident record showed Resident #1 was admitted to facility on . Record review of medication logs for showed Resident #1 had received 100 units/ ml. On , Resident #1 did not receive , FUM 50 mg at 7 PM; 500 mg at 7 PM; , 10 mg at 7 PM. From through Resident #1 did not receive 10 mg for 7 AM. In resident was receiving 100 units/ ml to .

Review of the medication logs documented Resident #1 was in the hospital on to initialed as "H" on and on , to , . There was no notes documenting why Resident #1 was in the hospital. Review of the medication log showed from to/12/0/18 Resident #1 was in the hospital. The remaining month was initialed as given by staff.

The health assessment dated had Resident #1's diagnoses as Type 2 . resident #1 needed assistance with self-administration of medications. Attached with medication a list which includes b, glarine 10 unit/ ml injections 14 units 10 mks, and 50 mg tab 60 tablets test strips. The last health assessment dated missing page 1 had diet as diet.

Review of home health file documented that a home health agency had administered daily from , to , . No was logged as given from to . The log documented was given from to , , .

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On at 12:22 PM Administrator stated, "Resident #1 went to the hospital for . The rescue picked her up. She stayed in the hospital for 3 to 4 days."

On at 12:36 PM Staff A stated, "Resident #1 had a bad in . She went because of a . She was feeling bad we called rescue, but I think the daughter took her that night."

Class III

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

Based on observation, record review, and interview, the facility failed to assist the residents with self-administration of medications within one hour of the ordered time frame and failed to follow the procedure outlined by the state when assisting two out of six sampled residents with self-administration of medications (#1, 2, 3, and 4).

Findings included:

On at 8:32 AM observations of medication pass showed Staff A punched Resident #2's medication tablets into staff's gloved . One by one the tablets (7 tablets in total) were placed into a cup. The staff initialed the log as medications given. The medication tablets sat on the table next to the resident in cup. Staff A walked away to the kitchen and asked the Administrator for the key to put the medication bin into medication closet. Resident #2 sat at the dining table having breakfast then began taking the tablets one by one, chewing them without any staff supervision. Staff A returned at 8:38 AM with another bin of medication for another resident.

On at 8:41 AM Resident #3's medication tablets were punched into staff 's gloved . One by one the were placed into a cup. Staff A initialed the medication log as given. The cup placed with the medications in front of resident at dining table having breakfast. Staff left the resident's presence before the medication were taken.

On at 8:42 AM Residents #4's medications was punched into her one by one. The , 2 mg out of residents onto the ground. Staff A continued with the med pass and did not give resident the , 2 mg for 7 AM. After she initialed the medication log and returned bin to medication closet. The , was never replaced and given to resident.

On at 8:53 AM Staff A assisted Resident #5 with medications in the resident's room. The medication was punched into Staff A's and then poured into a cup. The medication log was

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initialed. Staff A exited resident room without ensuring her medications were swallowed.

On at 9:11 AM Staff A picked up tablet from the floor and discarded it.

Facility policy stated" Trained staff must observe the resident take medications as prescribed. All staff must adhere to the facility control policy and procedures when assisting with the self-administration of medication."

On at 2:45 PM the Administrator acknowledge Staff A did not follow the proper procedure in assisting with medication and would need to be retrained.

Class III

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

Based on observations, record review and interview the facility failed to ensure the medication log was maintained for two out of six (#1 and 2) sampled residents.

Findings included:

Review of the mediation sheet showed Resident #1 medications , FUM 50 mg at 7 PM; 500 mg at 7PM; , 10 mg at 7 PM were not given. The medication log showed from through resident #1 did not receive 10 mg for 7 AM.

Resident #2's medication sheet showed she refused Diphenydramine 25 mg for the entire month of and did not receive here tablet for , - on at 7 PM. There was no documentation of residents refusing medications for the month of and why they did not receive their medications on on those days. There was no documentation of the facility contacting the doctor.
.
On at 3:00 PM the Administrator could not verify why the medications were not given to the residents.

Class III

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

Based on observation, record review, and interview, the facility failed to have a written statement from a

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health care provider documenting that staff was free from communicable
result documented on an annual basis for out one of three (B) sampled staff.

Findings included:

Review of the facility's personnel files revealed that Staff B hired on 11/15/17 did not have statement from a health care provider documenting that staff was free from communicable

On ay 3:30 PM the Administrator, after review of the personnel files, acknowledged Staff B did not have proof of freedom from communicable

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 Resident #3 was not listed as discharged on. Resident #7 was listed on the log, admitted on and was not discharged from log. On at 10:12 AM the administrator stated, "She on hospice."

On 01/3019 at 3:00 PM the Administrator acknowledged the lack of an updated admission and discharge log.

Class III

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

Based on record review and interview, the facility failed to provide documentation of hospitalizations and orders for one of six (#1) sampled residents.

Findings included:

A review of medication logs for showed Resident #1 had received 100 units/ ml.
In resident as receiving 100 units/ ml to . Further review showed

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Resident #1 was in the hospital on to , with the log initialed as "H" on and on , , to , . There were no notes documenting why resident was in the hospital.

Resident Progress Notes review showed: -Now Resident #1 was informed about the future changes on long term care contract for 2019, family was also informed.
7:30 PM Resident was transferred to hospital by rescue she was complaining of spate she had with . Weak and confuse at times. Caretaker informed administrator and family.
Yesterday resident came from hospital-5:10 PM She is feeling better now, no complaints of , a change of medications at this time. * 500 * 250 mg

The health assessment dated showed diagnoses as Type 2 . Resident #1 needed assistance with self-administration of medications. Documentation attached to the medication a list which included , b, glarine 10 unit/ ml injections 14 units 10 mks, and 50 mg tab 60 tablets test strips. The last health assessment dated had diet as diet.

Review of the home health file documented that home health agency had given daily from , to , . No was logged as given from to .
The log documented was given from to , , .

Record review revealed Resident #1's file did not have a physician's order for the use of .
On at 2:50 PM with the Administrator stated, "The order for the was sent to the pharmacy."

Class III