STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964118	04/10/2019
NAME OF PROVIDER OR SUPPLIER **RESIDENCIA NUESTRA SENORA DE LA ESPERANZA**	STREET ADDRESS, CITY, STATE, ZIP CODE **11125 SW 48 STREET MIAMI, FL 33165**	

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

0000 - Initial Comments

A third revisit biennial survey and complaint investigation (#2019003381 and #2019004007) was conducted at Residencia Nuestra Senora De La Esperanza Home Care on , and concluded on . Deficiencies were identified at the time of the survey.

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

Based on observation, record review and interview the facility failed to provide appropriate care to all the residents. The facility failed to provide a safe and decent living environment, free from and neglect for one out of five (Resident #1). The facility failed to follow its elopement policy and procedures when one out of five (Resident #2) sampled residents eloped from the facility. The facility failed to file an adverse incident report to the agency within one business day and fifteen days for one out of five (Resident # 2) sampled residents. The facility failed to have the Medication Observation Records (MORS) immediately updated each time the medication is offered or administered. The facility failed to ensure that all medications were centrally stored and kept in a locked cabinet, locked cart, or other locked storage receptacle, room, or area at all times.

Findings included:

1) On at 6:40 AM, observed the Administrator's husband yelled at Resident #1 and called her a liar as Resident #1 explained when she received her medications.

On at 7:45 AM, Resident #1 stated on one occasion the man, meaning the administrator's husband, came to her room and yelled and accused her of turning down the thermostat. She stated she felt intimidated. Resident #1 stated the Administrator came to her room, gave her breakfast, and said "Are you happy now." Resident #1 stated she was afraid and did not want to be left alone with the Administrator or the Administrator husband.

On at 10:05 AM, the Administrator stated, "Resident #1 is a trouble maker and she need to go."

2) Review of Resident # 2's record showed an admission date of and progress notes explaining that the resident left the facility on and had not returned. Progress notes also revealed that this was not the first time the resident had eloped. The progress notes dated , showed the resident had yet to return to the facility and the Administrator had contacted the police. It was also documented that at approximately 8:00 PM on , the police contacted the Administrator to inform that they had found Resident # 2 in a different county around.

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Resident # 2's record did not have a completed health assessment on file since the date of admission to reveal if the resident is at risk for elopement.

On at 8:26 AM, the Administrator denied any of the residents eloping; however, she explained that Resident #2 was gone for a few hours and returned to the facility the same night. The Administrator also explained that the progress notes were written in error and was told by the resident that she had mistakenly taken the incorrect bus route and did not recall where she had gone. The Administrator stated that she was still within the 30 days to have had a medical professional conduct a health assessment for the resident.

Review of Resident # 2's record showed an admission date of and documentation revealing the resident went missing from through . There was no documentation of a completed health assessment that reflected the resident's risk for elopement.

A review of the Agency's Incident Reporting System (AIRS) database did not show a preliminary or an adverse incident report for Resident # 2's elopement.

On at 8:26 AM, the Administrator stated that she only filed a police report and forgot to file the incident report to the Agency.

3) On review of the resident medication observation records (MORS) showed Residents #1, #2, #3, #4, and #5 had scheduled medication times for 8:00 AM.

On at 7:00 AM, review of the Resident's MORS showed the Administrator had signed that she had given Resident's #1, #2, #3, and #4 their medications for 8:00 AM.

On at 8:08 AM, the Administrator stated she had given all the Residents their medications at 5:30 AM and 6:30 AM. She stated she put the medications at the Resident' bedside table for the Residents to take the medications on their own. She stated she signed the MORS for 8:00 AM.

On at 6:20 AM, observed syrup medication on top of Resident #2 night stand.

On at 6:20 AM, the Administrator stated Resident # 2 was able to take the medication on her own.

Class III