| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11910671** | **04/09/2019** |
| NAME OF PROVIDER OR SUPPLIER<br>**FORT LAUDERDALE RETIREMENT HOME** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**401 SE 12TH COURT**<br>**FORT LAUDERDALE, FL 33316** | |

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

**0000 - Initial Comments**

An unannounced licensure complaint survey, Complaint Number 2019001239 was conducted at Fort Lauderdale Retirement Home on - . The facility had deficiencies at the time of the survey.

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

The facility failed to honor resident rights by failing to document resident grievances and showing how the grievances would be resolved. Specifically, regarding numerous food complaints filed with the facility management staff.

The findings included:

Record review revealed the menu dated for yesterday (Monday) was northern bean soup (8oz), turkey salad on (3 oz) with sauce (2 oz) lettuce and tomato. Lunch for today (Tuesday) was supposed to be tomato soup (8 oz), grilled cheese sandwich (3 oz), wheat bread (2 sl), celery sticks (1 cup). The menu was changed to green salad and bologna sandwich because they did not have enough bread to feed all the residents. The lunch menu for Thursday listed Vegetable soup (8oz), Turkey hamburger on a (3 oz), potato salad ( c).

An interview was conducted with designee on at 11:00 AM, at this time, she confirmed that she was aware of the residents complaints of only receiving pork and turkey. She referred to the dining room menu and stated they do have a variety of foods and at this time confirmed, they do substitute the menu. Six months of substitutions were requested to reflect the food variety in the facility. The designee was unable to provide the substitution log/list. The designee only presented original menus that was inaccurate, not reflecting the actual substitutions of the days. The facility was also unable to illustrate that they had addressed the food concerns of the residents. It was also noted, that the facility had not implemented any resolution to these problems.

An interview was conducted with the kitchen manager on at 11:02 AM, at this time, she confirmed that she has to substitute a lot because none of the ingredients to make the dish on the menu is in the kitchen. She cannot make shepherd's pie without mash potatoes, this results in a change to entire menu. She stated she prep, cook and serve all of the residents breakfast and lunch so she really don't have time to keep up with writing the substitutions as often as she have to substitute. She stated she is aware of the resident complaints but further stated that she only does the cooking and she has no say in the order of the food and that it is not coordinated with her.

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11910671 | 04/09/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **FORT LAUDERDALE RETIREMENT HOME** | **401 SE 12TH COURT FORT LAUDERDALE, FL 33316** |

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

An interview was conducted with the designee on _____ at 11:38 AM, the order log from the facility food supplier was requested, when the log was received there was only a quantity number and a total cash amount listed, the receipt did not reflect any food items (specifically meat). The facility was unable to provide receipts of the meat that was bought for the facility. The designee and the Administrator husband who was also present during the interview stated the Administrator buy what is on sale for the week and she go to different stores.

The designee confirmed the findings and provided no further explanation or documentation at the time of the survey.

Class III

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

Based on observation record review and interview, the facility failed to provide a clean, safe, decent living environment, free from pest. As evidence by failing to remedy and eradicate all bed bugs inside of both buildings (401 and 415).

The findings included:

During the observational tour on in bldg. 401 ( # ), a live bed bug was observed crawling on Resident #1. The resident was laying down fully dressed and the bed bug was crawling up her pants , the resident was unaware that a bed bug was on her. The resident stated sometimes she gets bit and other times she don't. She further stated she had not been bit in about a week. During an observational tour in bldg. 415 ( # ) black smeared dots, similar to bed bug droppings were observed on the mattress. The resident in this room stated the bed bug issues is a cycle sometimes, it is a lot of them, and other times there is a few of them but it never stopped completely.

During record review of the facility bed bug policy (not dated), it stated the facility would have biweekly treatment and inspection by a license pest control company. The policy and procedure for pest and rodent control stated the facility will contract with a pest control company that specializes in the treatment of bed bugs to monitor and inspect the facility on a biweekly basis and treat as needed. The policy further stated a pest management professional should inspect the suspect room, adjacent rooms, the resident new room, all furniture and equipment, and lunge and public areas the resident may have been using. The facility policy failed to address the ongoing maintenance protocol for the bedbug treatment and a prevention resource for the bed bug reoccurrence. The facility failed to provide a system

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11910671 | 04/09/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **FORT LAUDERDALE RETIREMENT HOME** | **401 SE 12TH COURT FORT LAUDERDALE, FL 33316** |

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

in place to monitor the effectiveness of the treatment plan and policy.

Record review of the Department of Health (DOH) inspection that was conducted on revealed the following; An unsatisfactory report due to the findings of live bed bugs in building 415 ( # ) and observed live and bed bugs in building 401 ( # ). The facility was cited as having infestation/presence of bed bugs. An interview conducted with the DOH inspector on at 3:49 PM revealed the facility had live and bed bugs and bed bug fecal matter on the headboard, sides and corner of the mattress and inside the mattress covers in both buildings. DOH also furnish unsatisfactory reinspection reports from - due to the presence of bed bug infestation throughout the facilities, illustrating that the facility has had an ongoing problem with bed bugs.

Record review of the last 3 invoice statements revealed the bed bug company visited the facility on and conducted general pest control inside of the kitchen area and common area, the rooms were inspected for bed bugs but no mention of routine spray for bed bugs. The pest control company conducted another routine visit on . It was noted on the receipt that general pest control treatment in kitchen and common areas were conducted. It also noted that a bed bug inspection for the main bldg. was conducted but no mention of routine treatment for bed bugs. The receipt further stated an original bed bug treatment completed in 2018 eradicated 98% of bedbugs. Before initial treatment, the bedbug infestation was extreme. After inspection, completed , the previous infestation is now at a controllable level.

An interview conducted on at 9:01 AM with the Pest Control Manager, revealed they began treating this facility in . At this time, they stated the facility had a huge bed bug infestation; the worst ever seen in all of the years as an Exterminator. It was further stated bed bugs were observed all over the walls, encrusted all over the doors and bedbugs encrusted on the window panels. The Manager stated they are to go routinely to the facility on a monthly basis, treat the general areas (kitchen and all common areas), and spray the rooms that bed bugs were only observed in. The pest control company conducted another routine visit on . It was noted on the receipt that general pest control treatment in kitchen and common areas were conducted. The last treatment conducted at the facility by the Pest Control company was on in which the presence of bed bugs was confirmed throughout the facility.

Multiple resident interviews conducted on between 9:15 AM and 11:00 AM revealed that the facility still currently has a bed bug infestation. The residents reported observing bed bugs up to last week, the residents stated they are used to it and have realized it is a problem that won't go away.

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11910671** | **04/09/2019** |
| NAME OF PROVIDER OR SUPPLIER<br>**FORT LAUDERDALE RETIREMENT HOME** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**401 SE 12TH COURT**<br>**FORT LAUDERDALE, FL 33316** | |

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

A confidential interview was conducted on [redacted] (confidential time) stating the facility does currently have a bed bug infestation. The confidant stated they are having a pest control company treat the facility but the facility still has a bed bug issue. It was further stated the bed bug issue will never be gone completely because the owners are will not invest needed resources into the building, this building needs more than a bed bug treatment unless you are going to get behind every wall and under every floor in this facility.

An interview was conducted with the facility's designee on [redacted] at 10:01 AM regarding the bed bugs. The designee admitted the facility does have an ongoing bed bug issue. It was stated they have since hired a new pest control company that started services in [redacted] and the observation of bed bugs are decreasing but the presence of bed bugs are still present. It was further stated "a lot of the residents leave the facility and lay down in alleys, many of them don't bath and that is making the bed bug issue hard to get rid of; when we think got rid of them, we're starting all over again". The designee further stated the facility does have a bed bug policy in place but the policy does not seem to be effective due to the continuation of the bed bug findings between DOH , AHCA and the pest control company.

The facility failure to properly assess the bed bug protocol, DOH inspection reports and pest control documentation resulted in an extended period of bed bug infestation. This also resulted in a number of residents being bitten and created a large presence of bed bugs. According to the pest company, once treatment is used they are unable to implement retreatment until 30 days, even with new presence of bed bugs. Further discussion with the designee and pest control company revealed the facility has been unable to conduct an ongoing effective treatment plan due to the 30 day manufacture requirement in the bed bug spray used by the pest control company.

Class III