STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968118	**05/11/2019**
NAME OF PROVIDER OR SUPPLIER **BELLO HOGAR LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **3406 WEST CARACAS ST** **TAMPA, FL 33614**	

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

Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on observation, record review, interview, the facility failed to ensure 1 staff (Staff C) of four sampled staff that provided direct resident care and had access to residents' personal belongings and medications had an eligible level II background screening (BGS) as required.

Findings Included:

During an observation conducted on . . . . . beginning at 4:45pm Staff C was alone in the facility alone with four residents(Residents #1-#4) .

An attempted record review conducted on . . . . revealed there was no Level II Background Screening for Staff C at the facility.

During an interview with the Owner conducted on . . . . . at 8:50pm, they confirmed that Staff C works at the facility and assisted with cleaning and cooking. The Owner confirmed there was no Level II Backgrounds Screening for Staff C.

Unclassified

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0000 - Initial Comments

A complaint investigation (complaint number 2019004108) was conducted at Bello Hogar Assited Living Facility on . The facility had deficiencies at the time of the survey.

0008 - Admissions - Health Assessment - 429.26( ) FS; 58A-5.0181(2) FAC

Based on record review and interview, the Facility failed to obtain a -to- medical examination documented on the Agency for Health Care Administration Health Assessment Form 1823 (1823) after a significant change necessitated an admission to Hospice services for two Hospice Resident (Resident #2 and #4) of two records reviewed.

Findings Included:

A record review for Resident # 2, conducted on , revealed that Resident # 2's most current AHCA 1823 dated did not contain Hospice care information. The facility failed to obtain a new AHCA 1823 when Resident # 2 had a significant change-in-condition necessitating admission to Hospice.

A record review for Resident # 4, conducted on , revealed that Resident # 4's most current AHCA 1823 form dated did not contain Hospice care information. The facility failed to obtain a new AHCA 1823 when Resident # 4 had a significant change-in-condition necessitating admission to Hospice.

During an interview with the facility owner conducted on at 8:50 pm, the facility owner confirmed the missing information from Resident's # 2 and Resident #4's AHCA 1823 forms. No additional AHCA 1823 forms were provided for either Resident # 2 or Resident # 4.

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 obtain documentation that the resident's physician reviewed the use of ½ bedrails annually for 1 (Resident #4) of 2 residents sampled.

Findings Included:

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An observation was conducted on at 4:58pm of Resident #4 in their bed. During the observation, ½ bedrails were observed to be in the upright position.

Record review of Resident #4's recorded revealed there was no documentation that resident's physician reviewed the use of ½ bedrails annually.

An interview was conducted with Staff A on beginning at 7:25pm. Staff A stated Resident #4 cannot use or remove the ½ bedrails on their own and they require total assistance to do so.

Further observation of Resident #4 conducted on beginning at 7:48pm revealed Resident #4 cannot use or remove the ½ bedrails without assistance from staff.

Class III

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

Based on observation interview, the facility failed to provide assistance with self-administration of medications in accordance with procedures described in Section 429.256, F.S.; specifically, Staff A failed to remove medication from primary packaging in the presence of the resident and failed to read medication labels aloud for one (Resident #4) resident out of 3 residents observed during medication observation.

Findings Included:

An interview was conducted on at 7:13 with Staff A. Staff A stated they pre-pop the medications for Resident #4, crush them and then mix them in food prior to giving the medications to Resident #4.

During an observation conducted on at 7:48pm Staff A, unlicensed, removed medications from original packaging to store in plastic container, crushed the medications and mixed it in with yogurt for Resident #4. Staff A proceeded to enter Resident #4's room and spoon fed the resident their medications. Staff A failed to remove medication from primary packaging in the presence of the resident and failed to read medication labels aloud.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

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SUMMARY STATEMENT OF DEFICIENCIES
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Based on observation and interview, the facility failed to ensure that medications were secured for four (Resident #1-Resident #4) of four residents who received supervision or assistance with self-administration of medication, and failed to secure medication belonging to one (Resident #5) discharged resident.

Findings included:

While conducting the facility tour on at 4:50pm a white cabinet, identified by Staff C as medication storage, was observed to be unlocked. Further review revealed that the medication cabinet contained medications belonging to current residents, Resident #1, Resident #2, Resident #3, and Resident #4. The resident's medications were already popped out of their medication containers and were in medications cups that were labeled with each resident's name. Further observation, revealed a white pharmacy bag of medications for Resident #4 sitting on the counter.

An interview was conducted with Staff A on at 7:13pm. Staff A confirmed the medication cabinet was unlocked and they had locked it later in the evening.

An observation conducted on at 6:09pm revealed a brown cardboard box on top of the white medication cabinet full of resident medications.

An interview was conducted with Staff A on at 7:42pm. Staff A stated that the medications in the box were discontinued medications and should have been picked up by the pharmacy.

Observation conducted on at 8:09pm, revealed three medications bottles in the unlocked refrigerator labeled for Resident #5.

An interview was conducted with Staff A on at 8:09pm. Staff A stated that the Resident #5 no longer resided at the facility and they were unaware that his medications had to be locked up.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on record review and interview, the facility failed to ensure that prescriptions were filled or refilled in a timely fashion for one (Resident #2) out of 3 sampled residents that required assistance with self-administration of meds.

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Findings Included:

Record review of Resident #2's Medication Observation Report (MOR) was conducted on revealed there were no initials for the entire month of for 600mg, take two tablets by 2 times a day or Plus 50mg, take two tablets by two times a day.

An interview was conducted with Resident #2 on at 7:55pm. Resident #2 stated that their medications are not at the facility and they are waiting for them to be delivered.

An interview was conducted with Staff A on at 7:58pm. Staff A stated they are waiting for Hospice to deliver the medications.

Record review of Resident #2 file was conducted on revealed no documentation of Hospice being responsible for providing the medications.

Class III

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

Based on record review and interview, the facility failed to obtain an interdisciplinary care plan between Hospice and the facility for 1 (Resident #2) out of 2 residents receiving Hospice services.

Findings Included:

A record review for Resident # 2 conducted on revealed that Resident # 2's medical record chart did not contain all required information. Resident # 2's medical chart record was missing an interdisciplinary care plan between hospice and the facility for Resident #2 who started receiving Hospice Services on .

An interview was conducted on at 8:50pm with the Owner. The Owner confirmed there was no interdisciplinary care plan between hospice and the facility for Resident #2.

Class III