Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968426	A. BUILDING: _____ B. WING _____	09/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA COLONIA II ALF INC	637-639 SE 12TH CT CAPE CORAL, FL 33990

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced complaint survey #2021005318 and #2021005962 was conducted on [redacted] at La Colonia II, an assisted living facility in Cape Coral, Florida. Complaint #2021005318 and #2021005962 were substantiated at A025. The following is a description of deficiencies. .	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making [redacted] for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents	A 025		

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A 025	Continued From page 1 accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review, and staff interview, facility failed to notify Hospice after an accident for 1 (Resident #1) out of 3 resident records reviewed. The findings included: Record review for Resident #1 found the following note dated , "Resident #1 got up to smoke	A 025		

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A 025	Continued From page 2 outside. When she was coming . . . she removed the door from the frame and the door . . on her. The staff examined her. The nurse from hospice was notified and she was assessed with no issues." Record review noted that Resident #1 , . . , on . Interview on at 9:08 a.m., Administrator stated, "She was a construction worker. She removed one of the two sliding door herself and placed it against the table in the lanai door. It was in the middle of the night. After she finished smoking she tried to come . . . and tried to place the door where it was. The door on her. She was under hospice care." He said they notified the hospice provider. They came for assessment the next day and no further action was needed. Interview on at 9:34 a.m., the Assistant Administrator said they notified hospice right away and the nurse was here the next day and found no issues. She proceed saying a record note indication notification of Hospice. Interview via phone on at 4:30 p.m., the Hospice Nurse, responsible for Resident #1's care, said she saw the resident on as a routine visit and the resident her self told her of the incident. She said she spoke to her supervisor and looked at their notification log and no notification was found on the record indicating the facility notified them of residents change in condition. She said it was a coincidence that she came the day after the accident as no one had called Hospice to notify them. Interview on at 9:55 a.m., the Hospice Nurse said when she arrived on . . . . in the morning (not exact time provided) Resident #1	A 025		

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A 025	Continued From page 3 told her that the night before she went out to the lanai to smoke. Resident #1's room had direct access to the lanai. Resident #1 was on her way when the sliding door came out the tracks and hit her on the left side of her body. Hospice Nurse said that Resident#1 had a on her left arm, around the left on her left lower , a on her left and a small in the left as a result of the accident that took place the night before. The Hospice Nurse said, "I know she was a strong woman, but there is no way she would have been able to take a sliding door of the tracks. I don't believe that." The Hospice Nurse confirmed once more that facility never notified Hospice. It was a coincidence that she came the next morning for a routine visit. The Hopice Nurse verified the resident's passing was not related to the incident, rather was health reasons. Class III .	A 025		