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
	AL11969720	A. BUILDING: _____ B. WING _____	05/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICASA SENIOR LIVING	6021 DUVAL ST HOLLYWOOD, FL 33024

(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 Unannounced Relicensure, Complaints (#2021016450 and 2022002540) and Generator Monitoring surveys were conducted from [redacted] through [redacted] at Micasa Senior Living. The facility had deficiencies related to the Relicensure and Complaint (#2022002540) at the time of the surveys.	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 [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] or [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 accepted for admission to the facility.	A 025		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 (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 interview and record review, the facility failed to provide appropriate personal supervision of care and daily observation to ensure the general health, safety and well-being for 2 out of 14 residents (Residents #1 and 12) who were assessed to be at-risk for . The findings are: Review of the facility's undated " Risk &	A 025		

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A 025	Continued From page 2 Prevention" policies and procedures revealed that it included the following: "Monitoring Subsequent . . and . Risk The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. 1. If the interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (e.g., ... or) has resolved. 2. If the resident continues to . , staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. 3. The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to ." a)Review of Resident #1's most recent medical examination dated on . . . . . revealed that the resident was diagnosed with , ... , ... , gait . . . . . , , and , . Review of this medical examination indicated that the resident ambulated with a walker, was forgetful and had short term memory . . . . ., and needed special precautions with out-of-bed assistance. Further review of this medical examination indicated that the resident required assistance with ambulation, bathing, ... , toileting and transferring and needed supervision with grooming, and needed assistance with self-administration of medications. Review of the facility's incident report dated on	A 025		

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A 025	Continued From page 3 revealed that Resident #1 was found on the floor in the resident's bedroom. Review of this report indicated that the resident was transferring from walking to his chair inside his bedroom and the resident lost his balance and . Further review of this report revealed that the facility did not document any follow-up and did not implement any interventions for the resident so to prevent future or accidents. Review of the facility's incident report dated on revealed that Resident #1 was found on the floor in the bathroom. Review of this report indicated that the resident lost his balance while in the bathroom and and hit his on the wall. Further review of this report revealed that the facility did not document any follow-up and did not implement any interventions for the resident so to prevent future or accidents. b) Review of Resident #12's medical examination dated on revealed that the resident was diagnosed with endometrial and needed to ambulate with a device, supervision with problem solving, occupational and , and risk special precautions. Further review of this medical examination indicated that the resident required supervision with ambulation and transfers with risk, and needed assistance with self-administration of medications. Review of the resident's most recent medical examination dated on revealed that the resident was diagnosed with endometrial , and gait instability. Review of this medical examination indicated that the resident ambulated with a wheelchair, needed supervision with problem solving and had special risk precautions. Further review of this medical examination	A 025		

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A 025	Continued From page 4 indicated that the resident required supervision with ambulation and transfers with risk, and needed assistance with self-administration of medications. Review of the facility's incident report dated on revealed that Resident #12 slipped and from the toilet while she went to the bathroom. Further review of this report revealed that the facility did not document any follow-up and did not implement any interventions for the resident so to prevent future or accidents. Review of the facility's incident report dated on revealed that Resident #12 was found on the floor in her bedroom. Review of this report indicated that the resident while she was putting on her pants and hit her on the bedside table. Further review of this report revealed that the facility did not document any follow-up and did not implement any interventions for the resident so to prevent future or accidents. In an interview with the Administrator on at 2:35pm, he stated that Resident #12 on and , and the facility did not monitor or document the response to any interventions intended to reduce the resident's risk for future or accidents. He stated that he relied on the care coordinator to document and to ensure the implementation of each at-risk resident's interventions after every resident or accident so to prevent future occurrences. In an interview with the Care Coordinator on at 2:45pm, she stated that she was aware that Residents #1 and 12 were at-risk for with prescribed special precautions to prevent and each had recently in the	A 025		

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A 025	Continued From page 5 facility. She stated that she did not presently document the facility's monitoring efforts and responses to any interventions intended to reduce each resident's risk for future or accidents. She stated that she did not know how the daily care for each at-risk resident changed subsequent to their documented . . . Class III	A 025		