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
	AL11969162	A. BUILDING: _____ B. WING _____	C 11/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BORMEY ASSISTED LIVING FACILITIES INC.	6416 AMBASSADOR DR TAMPA, FL 33615

(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 A complaint investigation (complaint number 2023014965) was conducted at Bormey Assisted Living Facilities, Inc. on . Deficiencies were identified at the time of survey.	A 000		
A 033 SS=D	59A-36.007(8) PHYSICAL (8) PHYSICAL . Residents for whom a physician has prescribed a physical must have a written care plan for the use of the physical . The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident. (a) The care plan must specify: 1. The device prescribed for use; 2. The maximum amount of time the resident is to have the applied each day; and, 3. In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of , , or decline in mobility or function related to the use of the prescribed . (b) Facility staff must ensure that the device is applied appropriately and safely. (c) The resident's physician must review the appropriateness of the continued use of the physical annually, and documentation of this review must be maintained in the resident's record. If the resident's ability to independently remove or avoid the device fluctuates, the device must be considered a physical and all requirements of this subsection apply. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to have a physician's prescription for a , and failed to have a written care plan for the safe use of the ,	A 033		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 033	Continued From page 1 for 1 of 1 resident (Resident #6), who was observed with the and whose records were reviewed. Findings Included: A record of an facility reported incident, involving Resident #6, was reviewed on . The record noted that on , Resident #6 was heard screaming in her room, and when the Administrator and Staff A came to see, they found her on the floor next to her recliner chair screaming that she was in , . They assessed her , to be coming from her right and a bump on her . She was sent to the hospital and was diagnosed with a . The facility's analysis of the incident revealed that the resident had been operating the remote control for her recliner chair and adjusted it so far that she tipped over out of the chair, causing injuries. The facility submitted a corrective action, to prevent another similar incident, which stated the facility staff would hide the remote control from the resident so that she would be forced to ask the staff for help, whenever she was in the chair and wanted to adjust the headrest or footrest. An interview was conducted with Resident #6 at 10:00am on . In the interview she stated that she sat in her recliner chair, in her room, everyday. She stated she did not operate the chair herself, since the accident. She learned her lesson. She always asked for help, and they came to help her. She could not get out of the chair without assistance. She stated she was not able to walk, even with a walker. An interview was conducted with the Administrator, and the Owner, at 10:30am on	A 033		

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A 033	Continued From page 2 . . . . The Administrator stated that Resident #6 had been told not to use the remote control on her recliner chair, that she was supposed to always ask the staff for assistance when she wanted her chair adjusted, or needed to get in or out of it. The facility staff kept the remote control hidden from the resident, so that she could not make any attempts to move the chair herself. She stated the resident was not capable of getting in and out of the chair without someone assisting her. She stated she was unaware that by removing the resident's ability to operate the chair herself meant that the recliner chair met the definition of a . They did not have a doctor's order for the , nor a plan of care for the safe use of the chair, which described the maximum amount of time the resident was to have the applied each day; and in what manner and frequency the staff would monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of , , or decline in mobility or function related to the use of the prescribed . . A review of the facility's policy and procedures for was conducted on . It stated that . . . . . would not be used on residents. In an interview with the Administrator at 10:55am on , she stated that they did not realize the resident's recliner would be considered a if the facility removed her ability to operate the chair by herself, and that they did not know that would be allowed in an assisted living facility if the facility followed the regulation's guidelines. Class III	A 033		