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
	AL11967559	A. BUILDING: _____ B. WING _____	04/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA ASSISTED LIVING	220 N GROVE STREET MERRITT ISLAND, FL 32953

(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
CZ830 SS=D	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider	CZ830		

AHCA Form 3020-0001

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

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CZ830	Continued From page 1 is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database	CZ830		

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CZ830	Continued From page 2 approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility placed the resident community (18 residents) at-risk by failing to maintain a current Comprehensive Emergency Management Plan (CEMP) approval from the local county emergency management office annually. Findings: On , a record review was conducted on the facility CEMP letter. The letter of approval from the local emergency management office was dated . There was no other documentation of CEMP approval from the years 2024 or 2025. In an interview on at 10:30 am, with the administrator, she confirmed the findings and stated there was no approval for 2024 and 2025 was just sent into the local county management office in . Class III	CZ830		
A 000	Initial Comments A re-licensure survey and complaint (#2025003719) and generator monitoring was completed on at La Casa Assisted Living, Merritt Island. Deficiencies were found at the time of the visit.	A 000		

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A 025	Continued From page 3	A 025		
A 025 SS=G	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 or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . 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 . . 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. (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.	A 025		

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A 025	Continued From page 4 (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 reviews, interview and observation, the facility failed to provide adequate care and services to a resident who sustained a that was not reported and the resident endured , for 24 hours until his power of attorney arrived at the facility for 1 of 3 sampled residents (#1). Findings: In a review of resident#1's health assessment dated . The assessment listed a medical history of , , , , , history of , , , and , . alert with some and behaviors, and assistance with medications and bathing. In a review of resident #1's care plan dated , it states the residents need assistance with medications, and bathing, and not a risk.	A 025		

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A 025	Continued From page 5 In review of the facility notes it revealed the following: residents had an unwitnessed . He was found lying supine, red mark noted on the resident's forehead but denied hitting his . authorized. resident was unable to stand due to , in left . The resident was assessed by the wellness director with no or discoloration noted. The resident stated he had soreness, , ordered Resident transported to hospital, resident having surgery for on , . In review of the facility's internal investigation of the unwitnessed on it states: On resident in dining room at 6pm. Resident uses a walker when needed and the walker was not present. The resident was found on the dining room floor by staff A and the resident was unable to stand up. The resident was then escorted to his room by staff A. Staff A did not contact his supervisor regarding the . On the resident was unable to get out of bed and was complaining of , in his left area. It was reported to the Wellness Director by another staff member. A Analysis (UA) and X rays were ordered. The POA visited the community on at 2 pm and insisted emergency medical transport be called (EMT) to transport the resident to the hospital. Upon arrival EMT determined the resident did not need emergency transport. POA contacted coastal transport, and the resident was then taken to the hospital. At 6pm the hospital reported the resident had a . . Staff A stated the resident had the day before when he was trying to walk. He stated he picked the resident up and put him in the chair and laid him down. He stated he did not report the because	A 025		

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A 025	Continued From page 6 he was cleaning another resident and resident #1 is always walking on his own. In review of the facility's policy it states: a is defined as an incident as witnessed or unwitnessed. Staff to complete internal incident report and complete investigation of the occurrence. Staff shall notify the wellness director. Potential for risk if history of 3 in a 3-month period. In an observation on of the facility's staffing it was observed that only one staff member was working on the assisted living side for a census of 11 residents. On the memory care unit there was one staff member for a census of 7. Only one staff member was an unlicensed staff to pass medications for both buildings. In an interview on at 11am staff D She stated the policy for is to always report a to the nurse or supervisor on duty. She stated as an unlicensed staff we cannot determine how serious the is only the nurse can. She stated resident#1's should have been reported immediately. She stated the staff was unaware that he had as he did not mention he was in , at first and therefore no one knew he had . She stated there is usually one staff member on the assisted living side and one in memory care. She stated it has not been a problem caring for the residents with that ratio. She stated she was not aware resident #1 was a risk. She stated there is only one unlicensed staff on duty per shift and they pass medications in both buildings. In an interview on at 11:15 am Staff E who stated she is new to the facility but is aware	A 025		

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A 025	Continued From page 7	A 025		

that if a resident it is to be reported to the nurse or supervisor immediately. She stated she feels the supervision for residents is adequate as they are not at full capacity. She further stated she does not know if resident#1 is a risk or not. She stated she was not aware resident#1 had a or had an injury.

In an interview on at 1pm with the Wellness Director she stated resident #1 has a care plan. She stated he was not a risk due to the first was from bad shoes. She stated he did have a risk assessment on his 1823 at admission from the other facility but that was corrected on the updated 1823. She stated after the in , he was assessed to not be a risk. After the she assessed him, and he was not in distress and did not have . She stated the was not reported so she was unaware he had a and did not know why he was in . She stated she thought it was a , trac . She stated the power of attorney (POA) decided to have him go to the hospital. She started then we found out he had a after speaking with all the staff. She stated she was not informed about the until after the fact. She stated the POA signed off on a care plan in which he is independent with no assistance and no risk. The Wellness Director stated care plans are completed every 6 months or more if needed.

In an interview on at 2:15 pm Staff C, she stated she was not aware that resident #1 had a as she works in memory care and not on the assisted living side where he resides. She stated the facility policy for is to report the immediately tell the nurse or supervisor on duty and fill out an incident report. She stated it caused a delay in the resident getting treatment

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A 025	Continued From page 8 for injury. In an interview on at 2:45pm Staff B, he stated he did not know that resident#1 had a until it was report ed later. He stated he approached resident #1 to give him a shower and change his clothes and he was complaining of , in his . He stated the resident did not tell him he had the night before. He stated he did not see any on his body. He stated the resident could not stand up and could not walk. He stated at that same time the POA came to see the resident and wanted an ambulance to take him to the hospital as she saw he was in , . He stated came but stated it was not an emergency and could not take him to the hospital. He stated called another transport company to take him to the hospital. He stated unlicensed staff A should have reported the immediately that evening and filled out an incident report, but he did not, so the other staff had no idea he had a or why he was in , . In an interview on at 2:30pm with the POA, she stated that there is a lack of supervision for the residents. She stated even before the resident #1 was not being taken care of. She stated he was very rarely bathed and this caused on his . She stated the facility never advised her of the he had, and this delayed treatment for him. She said she happened to show up that day and saw he was in , and immediately called the emergency services. She stated stated it was not an emergency and called another transport company to take him to the hospital. She stated the was not reported until the following day after we found out he had a , . She stated he is not going to the facility due to lack of care and supervision.	A 025		

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A 025	Continued From page 9 Photographic Evidence Taken Class II	A 025		