STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966505	10/21/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
La Paloma Alf	880 East Baffin Drive Venice, FL 34293	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0027 - 58a-5.0182(3) Fac - Resident Care - Arrangement For Health Care S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0082 - 58a-5.0191(3) Fac - Training - S-S= D
St - A - 0160 - 58a-5.024(1) Fac - Records - Facility S-S= D

Specific Tag Findings:
These are the results of an unannounced Complaint Survey, CCR# 2013009070 which was conducted at La Paloma an Assisted Living Facility (ALF) on .

The following is a description of non-compliance:

0025-Resident Care - Supervision 58A-5.0182(1) FAC

Based on record review and interview, the facility failed to provide care and services appropriate to the needs of residents accepted for admission to the facility for 2 (Residents #1 and #2) of 5 sampled residents.

The findings include:

1. On Resident #1 in the hit her head. The Administrator was on premises. She called 911 and Resident #1 was send to the Hospital. A was performed and the resident returned to the facility. Resident #1 did not experience a negative outcome due to the The Health Assessment for Resident #1 included the following wording: precaution. Assessment was completed on When the co-owner was questioned on at 10:34 a.m. as of what measurements the facility took to preventing Resident #1 falling, the co-owner could not provide an answer.

2. On at 2:30 p.m., Resident #2 slipped and on the floor and knocked her portable commode over. Resident #2 had a laceration to the back of her head and there was on the floor. Staff present called and ambulance. Resident #2 was transferred to the hospital. was performed with no negative result. Owner stated that as a precaution of resident frequent facility placed one half rail in resident's bed and moved all obstructions in the way. However, resident had 2 more after the preventive measures taken by the facility. On at 2:03 a.m. Resident #2 felt out of bed and hit her elbow and right side of her head. She was transferred to the hospital for ER visit. No negative outcome.

On Residentn #2 felt in her hit her back. The Health Assessment for Resident #2 included the following wording "frequent ' Facility's record review found no policies and procedures in precaution. Further review found no evidence of in service tra ning in resident behavior and needs and providing assistance with Activities of Daily Living (ADL) for Staff A.

At the end of 2013, (not specific date provided) Resident #2 was sitting outside at patio area, got up and went across the street and knock at the neighbors door asking for help. Neighbors called the facility and return the resident to the facility. Staff present were unaware of the resident's whereabouts for about 15 minutes. Record review for Resident #2 found no documentation of the incident. Further review found that Staff A lacked in service training in resident elopement response policies and procedures.

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Interview with Resident #2 on at 11:40 a.m., found that she recalled the day that the incident took place. She said it was few days after she was admitted to the facility. She said she was brought in the facility by her daughter in law in false pretenses. She was upset and wanted to go home. Resident #2 is alert oriented x 3.

3. Co-owner acknowledged on at 1:45 p.m., that facility failed to provide a system in place to prevent resident for Residents #1 and #2, to provide appropriate supervision to Resident #2 and to document incident that took place at the end of 2013 that involved the same resident.

Class III

0027-Resident Care - Arrangement for Health Care 58A-5.0182(3) FAC

Based on record review and interview, the facility failed to allow 1 (Resident #3) of 3 sampled residents to choose health provider of their choice.

The findings include:

Record review for Resident #3 found that she received care by a Home Health Agency.

When the co-owner was asked on at 11:30 a.m., who chose the Home Health Agency that provided the service he replied, "It's the one that we work with." He also stated, "I am pretty sure I notified resident family representative and he agreed to use the one we know." No notification of any kind was found at resident's record.

The co-owner acknowledged on at 1:45 p.m., that Resident #3 did not choose her own health care provider. He stated he was unaware of the requirement.

Class III

0078-Staffing Standards - Staff 58A-5.019(2) FAC

Based on record review and interview, the facility's staff failed to submit within 30 days of employment a statement from a health care provider, based on an examination conducted within the last six months, that the person does not have any signs or symptoms of a communicable including

The findings include:

Record review of Staff A (caregiver hired and Staff B (caregiver hired found not documentation of heath care provider examination indicating that were free of signs and symptoms of communicable including

The co-owner stated on at 1:45 p.m. that Staff A was scheduled to go to the physician that afternoon and Staff B the next day.

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Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC

Based on record review and interview, the facility failed to obtain the following in service training's within 30 days of employment for 1 (Staff A) of 3 sampled employees: reporting major incidents, reporting adverse incidents; facility's emergency procedure including chain of command and staff roles relating to emergency evacuation; resident rights in Assisted Living Facility (ALF); recognizing and reporting resident , neglect and . resident behavior and needs and providing assistance with Activities of Daily Living (ADL) and resident elopement response policies and procedures.

The findings include:

Record review for Staff A (caregiver hired found no evidence of the following in service training's: Reporting major incidents, reporting adverse incidents, facility's emergency procedure including chain of command and staff roles relating to emergency evacuation, resident rights in ALF, recognizing and reporting resident neglect and resident behavior and needs and providing assistance with ADL and resident elopement response policies and procedures.

the co-owner acknowledged on at 1:45 p.m., that Staff A lacked all in service training's mentioned above.

Class III

0082-Training - 58A-5.0191(3) FAC

Based on record reviewed and interview, the facility failed to obtain /AID training for 1 (Staff A) of 3 sampled employees.

The finding include:

Record review for Staff A, hired , found no evidence of /AID training.

The co-owner acknowledged on at 1:45 p.m. that Staff A lacked of /AID training.

Class III

0160-Records - Facility 58A-5.024(1) FAC

Based on record review and interview, the facility failed to obtain a major incident report for 1 (Resident #2) of 5 sampled residents.

The findings include:

At the end of 2013, (not specific date provided) Resident #2 was sitting outside at patio area, got up and went across the street and knock at the neighbors door asking for help. Neighbors called the facility and return

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resident to the facility. Staff present were unaware of resident's whereabouts for about 15 minutes. Record review for Resident #2 found no documentation of the incident.

Interview with Resident #2 on [redacted] at 11:40 a.m., found that she recalled the day that the incident took place. She said it was few days after she was admitted to the facility. She said she was brought in the facility by her daughter in law in false pretenses. She was upset and wanted to go home. Resident #2 is alert oriented x 3. Co-owner acknowledged on [redacted] at 1:45 p.m., that facility failed to provide to document incident that took place at the end of [redacted] 2013 that involved the Resident #2.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
La Paloma Alf
880 East Baffin Drive
Venice, FL 34293

Re: CCR #2013009070

Dear Administrator:

This letter reports the findings of a Complaint survey that was conducted on , 2013 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after , 2013 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

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Enclosure: State Form

Headquarters
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