STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966983	**05/18/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
OMEGA ASSISTED LIVING FACILITY	**1209 NW 35TH PLACE CAPE CORAL, FL 33993**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced Complaint Survey, CCR# 2015001690 was conducted on [redacted] at Omega Assisted Living Facility, an Assisted Living Facility (ALF) located in Cape Coral, Florida.

One of the allegations on this complaint was substantiated. The facility received citations as a result of this survey.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on resident record reviewed, facility record review, and staff interview, the facility failed to document a significant change in the resident's condition which resulted in the resident being discharged to the hospital for 1 (Resident #4) of 4 resident records reviewed.

The findings included:

1. A review of the facility's admission and discharge log showed Resident #4 was discharged to the hospital on [redacted]. A review of Resident #4's closed record showed there was no documentation in the record showing this hospital visit and being discharged from the facility.

An interview was conducted with the facility Administrator on [redacted] at 9:45 a.m. She said Resident #4 started [redacted] and [redacted]. She called 911 and the resident was sent to the hospital. She did not return to the facility. She reviewed Resident #4's closed record and confirmed there was no documentation of Resident #4's decline in health resulting in her going to the hospital and not returning to the facility.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on facility record review and staff interview, the facility did not provide an accurate staff schedule.

The findings included:

An interview was conducted with the Administrator on [redacted] at 11:20 a.m. She said that she went to visit her son on the east coast of Florida on [redacted] and [redacted]. She visits her son once a month.
A review of the staff schedule for [redacted] 2015 showed the Administrator working at the facility on [redacted] and [redacted]. Further review of past staff schedules showed her last day off was in [redacted] 2014.
An interview was conducted with Staff A at 11:30 a.m. She said that she works at the facility Monday through Friday and has Saturday and Sundays off. She was hired at the facility about one month ago.

A review of the facility staff schedule showed she has been working every day since [redacted] without any days off.

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0079 Continued From page 1

The Administrator said her staff schedule is not correct.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on resident record review, facility record review and staff interview, the facility failed to report an incident to the State Agency showing that 1 (Resident #3) of 4 residents broke her leg and was discharged to the hospital.

The findings included:

A review of the facility's admission and discharge log showed Resident #3 was discharge to the hospital on [redacted]. A review of Resident #3's closed record showed on [redacted] she was sent to the hospital due to her leg being in pain.

An interview was conducted with the Administrator on [redacted] at 9:30 a.m. She said that on [redacted] the staff working with Resident #3 tried to get Resident #3 up and Resident #3 complained of an increase of pain in her leg. The Administrator called 911 and the ambulance took Resident #3 to the hospital. The hospital x-ray showed Resident #3 broke her leg. The Administrator asked Resident #3 if she [redacted] at the facility and the resident stated No. The Administrator asked the staff if Resident #3 [redacted] and the staff stated No. The Administrator asked the staff what had happened. The Administrator said that the staff told her Resident #3 got up in the morning and ate breakfast. She complained of more pain while watching TV after eating breakfast. This is when Resident #3 went to the hospital and did not return to the facility.

The Administrator said she did not write an adverse incident report because Resident #3 always complained of leg issues. She did not do a thorough investigation as to how Resident #3 broke her leg to ensure the facility had no control of Resident #3's [redacted] a condition that required her to be transferred to the hospital for more acute care due to this incident.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Omega Assisted Living Facility
1209 Nw 35th Place
Cape Coral, FL 33993

RE: CCR #2015001690

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 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 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,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form

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