STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967559	08/31/2015
NAME OF PROVIDER OR SUPPLIER **LA CASA ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **220 N GROVE STREET** **MERRITT ISLAND, FL 32953**	

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

0000 Initial Comments

Complaint Investigation #2015008906 was conducted from / / . La Casa Assisted Living Facility had deficiencies at the time of the visit.

0025 Resident Care - Supervision

Based on interview and record review, the facility failed to maintain a written record for 5 of 9 sampled residents who experienced a significant change in condition at the facility (#1, 3, 4, 5 & 6). The facility failed to document when the residents experienced , were admitted to hospice, and were diagnosed with a communicable .

Findings:

1. Resident #1 was admitted to the facility's memory care unit on with medical diagnoses including , , , and a history of recurrent and of the lower extremity. The resident requires assistance with all activities of daily living (ADLs) including eating. On , the resident was placed on hospice services for and functional decline with weight loss and immobility.

Review of resident #1's nurse's progress note, dated on / , indicated the resident was admitted to the facility on that day. The note indicated she had a dressing on the left lower extremity which was documented as dry and intact. On / at 2:45 AM, the nurse documented that resident #1's aide noted a moderate amount of bright red drainage from the left lower extremity, seeping through the dressing. The nurse removed the soiled dressing and observed an L shaped laceration with . The nurse cleansed the and reapplied a dressing but the continued to seep yellowish tinged drainage. The note indicated the resident had 2+ pitting ( ) with redness and heat at the site. The note further indicated the resident had complained of pain with touch. was given for the pain, and the physician was notified. On / , the registered nurse (RN) manager observed the along with the healthcare provider.

Review of resident #1's health care provider note dated on / indicated the resident had a non-healing left lower leg laceration/ from 2 weeks prior, and now had discharge and . The resident had received for 2 weeks without improvement. Review of the note indicated the resident was referred to the care clinic for evaluation. Also, a referral to the home health agency was made to provide care along with facility staff. The physician ordered the 100 milligrams (mg.) twice a day for 5 days for symptoms of ( ).

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In an interview with the care clinical coordinator on at 3 PM, she stated that resident #1 had initially been seen on / at the care clinic for a left lower extremity non-healing from / . The had multiple intact which were removed, and tissue was removed by the physician. She stated the resident was receiving and a culture was obtained at that time. She stated that the culture results indicated growth of , , ( ) in the . The culture results were sent to resident #1's health care provider for review. She indicated that the care physician orders had been faxed to the facility, requesting a home health nurse to change the resident's dressing on / .

Review of the home health nurse's note, dated / , indicated the home health nurse performed care on resident #1's leg as per the care clinic orders. The note indicated the nurse instructed the facility staff to keep the dressing clean and dry, to keep the resident's legs elevated at all times, and to monitor for signs of , increased temperature and complaints of pain. Review of the home health nurses' notes did not contain any documentation of in the resident's .

Review of resident #1's physician note, dated , indicated the culture results of in the leg . The note read, "Staff to be aware of contact precautions including hand washing and glove use every time touching the area." The note read that the resident was prescribed the DS twice a day for 7 days.

Review of resident #1's Health Assessment form (AHCA form 1823), dated , indicated the resident required home health nursing care for the left lower leg . Review of an updated health assessment 1823 form, dated , indicated the resident did not have any wounds and did not have a history of . The assessment indicated resident #1 was free from a communicable which could be transmitted to other residents or staff.

Review of resident #1's nurse's progress notes, dated , indicated the resident was evaluated and placed on hospice services. The nurse's progress notes from did not contain any documentation by the facility nursing staff regarding any assessments, observations or care provided to the resident.

In an interview with the RN manager on at 11:30 AM, she stated that she was aware of resident #1's history of in the left leg . The nurse stated that she could not recall when or how she had been notified of the culture results. She stated that she had not personally contacted either the health care provider or care clinic regarding the progress. When

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questioned if she had communicated the potential risks of to the facility staff and other residents, she stated she had not.

2. Resident #4 was admitted to the facility on . Review of the Health Assessment form, dated , indicated diagnoses of debility with and lower legs wounds. The form indicated the resident required assistance with all ADL care, was non-ambulatory, required 2 person assistance to be transferred, and management. Review of nurses' progress notes indicated the resident was initially placed on hospice services for decline but was discharged from these services in 2014, when the resident 's medical condition improved.
Review of hospital laboratory results, dated /, indicated that resident #4's right leg wounds were cultured and heavy growth of was found.
Review of facility progress notes, dated , indicated resident #4 had leg wounds that had drainage and an unpleasant smell. Review of a progress note indicated the thigh was draining, and on /, the ' continued to drain and weep fluid. The progress note indicated resident #4 was evaluated and admitted to hospice services for decline in medical condition.
Review of the resident health assessment form, dated , indicated resident #4 was admitted to hospice services for ADL care. The form indicated the resident was free from communicable , did not have any wounds, and did not require care treatments.
Review of the progress notes indicated that resident #4 at the facility on .
In an interview with the nurse manager on / at 11:35 AM, she stated she was aware that resident #4 had been diagnosed with in her leg wounds and initially the facility staff and clinic were caring for the wounds. She stated that the facility did not keep detailed notes or observations of the wounds. She stated that the resident was placed on hospice services and the hospice nurse performed ' care. She stated that resident #4's was cultured and was identified but she had not shared this information with staff or other residents. She stated that the facility had not documented what steps were taken to protect other residents and staff. The nurse manager stated that she was the nurse in charge and supervised other nurses and unlicensed staff. She stated that she was responsible to assess, observe, and monitor all resident needs and care provided. When questioned if she had reviewed the updated health assessment form, dated / /, which did not have any documentation of any care requirements and a history of , she stated she did not routinely review the form for admission appropriateness. She stated that the licensed nursing staff was trained on control practices but she acknowledged that she had not conducted any control refresher training, specifically regarding and recommended precautions for the unlicensed staff caring for resident #4.
In an interview with a facility nurse on at 12:45 PM, she stated that she recalled that she was not informed that resident #4 had . She said she routinely performs resident care and used appropriate control practices. She stated that she did not recall any notice to the staff in general that resident #4 had wounds and if special procedures were implemented to protect

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the other residents and staff.
3. Resident #3 was admitted to the facility's memory care unit with medical diagnoses including . Review of the hospice nurses' notes indicated resident #3 was placed on hospice services on / for and ADL care. Review of the resident's current health assessment form, dated /, did not reflect the resident's change in condition and admission to hospice services. An updated health assessment form was not found in the record indicating the change in resident's condition which required hospice services.

In an observation on at 8:50 AM, resident #3 was sitting in a recliner wheelchair, asleep. The resident's lower extremities were and a dressing was not seen on either lower extremity. On at 10:15 AM, resident #3 was observed outside on the patio sitting in the recliner wheelchair. The resident's right lower leg had a quarter size, round pink open without drainage noted.
In an interview with the licensed practical nurse (LPN) on at 10:20 AM, she stated that she was aware that resident #3 had developed a on the right lower calf which was being treated by the hospice nurse. She stated that the care order was for care on Monday, Wednesday and Friday, and as needed. She stated that she had not been informed that the dressing had off the resident's leg. The nurse stated that the resident had been placed on the facility's Limited Nursing Services(LNS) to have the facility nurse provide care as needed.
Review of the hospice nurse's note, dated, indicated resident #3 had an open area on the right lateral calf, and that care was ordered. The care consisted of cleaning the with cleanser, applying triple ointment, and covering the area with a foam dressing 3 times a week and as needed until healed. Review of the hospice plan of care, dated, indicated hospice staff would assist with the coordination of all care needs for the resident.
Review of the facility nurses' progress notes did not contain documentation by the nursing staff of any observations, evaluation, and treatment of the right leg.

4. On, staff F was asked about residents of the facility with multiple . Staff F indicated that resident #5 had multiple .

Review of resident #5's record revealed that the resident's health assessment form, from her admission to the facility on , indicated that she was a risk. There was no documentation in resident #5's record of any at the facility.

5. Review of resident #6's medical record revealed that the resident was receiving hospice services. There was no documentation in the record indicating what services hospice was providing or the reason for hospice services.

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Class III

0030 Resident Care - Rights & Facility Procedures

Based on observation, interview and record review, the facility failed to provide a safe living environment, free of communicable , and failed to practice safe standards of control for 2 of 9 sampled residents who had a communicable (- resistant or), and did not disclose this to facility staff or take steps to protect the other facility residents from transmission (#1 & 4).

Findings:

1. Resident #1 was admitted to the facility's memory care unit on with medical diagnoses including , , , , and a history of recurrent and of the lower extremity. The resident requires assistance with all activities of daily living (ADLs), including eating. On / , the resident was placed on hospice services for and functional decline with weight loss and immobility.

In an observation of resident #1 on at 8:45 AM, the resident was observed sitting in a wheelchair with both of her feet resting on the floor. The resident's left lower extremity from her toes to below the knee had a thick padded dressing covered with meshing which was holding it in place. Both of the resident's legs and feet were .

In an interview with the facility's licensed practical nurse (LPN) on at 12:15 PM, she stated that resident #1 had a healing on the left lower calf and was scheduled weekly for care at the care clinic. The nurse stated that the resident had been admitted to the facility with the . The nurse stated that in the early morning of , she observed the resident's dressing soiled with a moderate amount of yellowish bloody drainage. The nurse stated that the surrounding tissue was " ", reddened, and the resident complained of discomfort with touch. The nurse stated that she notified the health care provider of her observations. The nurse stated that on / , the resident was evaluated by the health care provider who referred the resident to the care clinic for evaluation of the .

Resident #1's nurse's progress note, dated , indicated the resident was admitted to the facility on that day. She was observed to have a dressing on the left lower extremity which was documented as dry and intact. On at 2:45 AM, the nurse documented that resident #1's aide noted a moderate amount of bright red drainage from the left lower extremity, seeping through the dressing. The nurse removed the soiled dressing and observed an L shaped laceration with . The note further

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indicated the resident complained of pain with touch. was given for the pain and the physician was notified.

Resident #1's health care provider note, dated , indicated the resident had a non-healing left lower leg laceration/ from 2 weeks prior, which now had discharge and was .

In an interview with the care clinical coordinator on / at 30 PM, she stated that resident #1 had initially been seen on at the care clinic for a left lower extremity non-healing from / . She stated the resident was receiving and a culture was obtained at that time. She stated that the culture results indicated growth of ( ) in the , and the culture results were sent to the resident's health care provider for review. She indicated that the care physician orders had been faxed to the facility, requesting a home health nurse to change the resident's dressing on / . The resident was scheduled to return to the clinic on .

is a bacterium that causes in different parts of the body. It is more difficult to treat than most strains of or staph because it is resistant to some commonly used . Staph is one of the most common causes of skin but can also cause more serious problems like wounds. Some strains of staph like become resistant to that once destroyed it. is spread by contact with another person who has it on their skin. are common among people who have weakened systems and are in hospitals, nursing homes and other health care centers. (mayoclinic.org).

Review of the home health nurse's note dated indicated the home health nurse performed care on resident #1's leg as per the care clinic orders. The note indicated the nurse instructed the facility staff to keep the dressing clean and dry, to keep the resident ' s legs elevated at all times, and monitor for signs of , increased temperature and complaints of pain. Review of the home health nurse's notes indicated no documentation of in the resident's .

Resident #1's physician note, dated , indicated the culture results of in the leg . The note further indicated that "staff to be aware of contact precautions including hand washing and glove use every time touching the area." The note documented that the resident was to be prescribed , DS twice a day for 7 days.

Resident #1's Health Assessment form (AHCA form 1823), dated , indicated the resident required home health nurse's care for left lower leg . Further review of an updated health assessment form dated on / indicated the resident had no wounds and no history of . The assessment indicated the resident #1 was free from a communicable which could

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be transmitted to other residents or staff.

In an interview with the registered nurse manager on at 11:30 AM, she stated that she was aware of resident #1's history of in the left leg . The nurse stated that she could not recall when or how she had been notified of the culture results. She stated that she had not personally contacted either the health care provider or care clinic regarding the progress. When questioned if she had communicated the potential risks of to the facility staff and other residents, she stated she had not. She stated that the facility did not have any written policy and procedure addressing or any other .

2. Resident #4 was admitted to the facility on . Review of the Health Assessment form, dated / , indicated the diagnoses of debility with and lower legs wounds. The form indicated the resident required assistance with all ADL care, was non-ambulatory, required 2 person assistance to be transferred and management. Review of nurses' progress notes indicated the resident was initially placed on hospice services for decline but was discharged in 2014, when the resident's medical condition improved.
Review of hospital laboratory results dated on / indicated that resident #4's right leg was cultured and results of heavy growth of was found.
Review of facility progress notes dated on indicated resident #4 had leg wounds that were draining and malodorous. Review of a progress note dated on indicated the thigh was draining and on the continued to drain and weep fluid. The progress note, dated , indicated resident #4 was evaluated and admitted to hospice services for decline in medical condition.
Review of the hospice initial admission nursing note, dated / , indicated resident #4 had medical diagnoses including , and .
Review of the resident health assessment form, dated , indicated resident #4 was admitted to hospice services for ADL care. The form indicated the resident was free from communicable , did not have any wounds, and did not require care treatment.
Review of the progress notes indicated that resident #4 at the facility on .
In an interview with the nurse manager on at 11:35 AM she stated she was aware that resident #4 had been diagnosed with in her leg wounds and initially the facility staff and clinic were caring for the wounds. She stated that the facility did not keep detailed notes or observations of the wounds. She stated that the resident was placed on hospice services and the hospice nurse performed care. She stated that resident #4's was cultured and identified but she had not shared this information with staff or other residents. She stated that the facility had not documented what steps were taken to protect other residents and staff. The nurse manager stated that she was the nurse in charge and supervised other nurses and unlicensed staff. She stated that she was responsible

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to assess, observe, and monitor all resident needs and care provided. When questioned if she had reviewed the updated health assessment form, dated / , which did not contain any information of care requirements or history of , she stated she did not routinely review the form for admission appropriateness. She stated that the licensed nursing staff was trained on control practices but she acknowledged that she had not conducted any control refresher training, specifically regarding and recommended precautions for the unlicensed staff caring for the resident #4.
In an interview with a facility nurse on at 12:45 PM, she stated that she recalled that she was not informed that resident #4 had but she routinely performs resident care and used appropriate control practices. She stated that she did not recall any notice to the staff in general that the resident had wounds and if special procedures were implemented to protect the other residents and staff.
In an interview with the administrator on at 3:10 PM, he stated that the facility did not have a written policy or procedures to address control care issues, including residents identified on admission and continued residency with any communicable process. He stated that he was not aware of any residents identified with any communicable in the past six months and "none with a diagnosis of ". He denied knowledge that resident #4 had been diagnosed with in her wounds.
Class III

N277 LNS - Resident Care Standards

Based on observation, interview and record review, the facility failed to provide nursing services in accordance with prevailing nursing standards. This is evidenced by the facility's lack of communication to address the prevention of known for 2 of 4 sampled residents (#1 & 4), and failed to ensure facility staff and residents were protected from potential for 2 of 4 sampled residents (#2 & 3).

Findings:

1. Resident #1 was admitted to the facility's memory care unit on / with medical diagnoses including , , , and a history of recurrent and of the lower extremity. The resident requires assistance with all activities of daily living (ADL) including eating. On , the resident was placed on hospice services for and functional decline with weight loss and immobility.

On at 8:45 AM, resident #1 was observed sitting in a wheelchair with both of her feet resting on the floor. The resident's left lower extremity, from her toes to below the knee, had a thick padded dressing covered with meshing holding the dressing in place. Both of the resident's legs and feet were

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In an interview with the facility's licensed practical nurse (LPN) on / at 12:15 PM, she stated that resident #1 had a healing on the left lower calf and she was scheduled weekly for ' care at the care clinic. The LPN stated that the resident had been admitted to the facility with the . The LPN stated that in the early morning of , she found the resident's dressing soiled with a moderate amount of yellowish bloody drainage. The LPN removed the soiled dressing and reapplied a new dressing but the continued to seep bloody drainage. The LPN stated the was an L-shaped laceration with 8-10 intact. The LPN stated that the surrounding tissue was , reddened, and the resident complained of discomfort when touched. The LPN stated that she notified the health care provider of her observations. The LPN stated that on , the resident was evaluated by the health care provider who referred the resident to the care clinic for evaluation of the .

Resident #1's nurse's progress note, dated , indicated the resident was admitted to the facility on that day. She was observed with a dressing on the left lower extremity which was documented as dry and intact. The following day, on at 2:45 AM, the nurse documented that resident #1's aide noted a moderate amount of bright red drainage from the left lower extremity, seeping through the dressing. The nurse removed the soiled dressing and observed an L-shaped laceration with . The nurse cleansed the and reapplied a dressing but the continued to seep yellowish tinged drainage. The nurse documented the resident had 2+ pitting ( ) with redness and heat at the site. The note indicated the resident complained of pain when touched, was given for the pain, and the physician was notified. On , the registered nurse (RN) manager observed the along with the healthcare provider.

Resident #1's health care provider note, dated / , indicated the resident had a non-healing left lower leg laceration/ from 2 weeks prior, and now had discharge and . The resident had been on a course of for 2 weeks without improvement. Review of the note indicated the resident was referred to the care clinic for evaluation. A referral to the home health agency was made to provide care along with facility staff. The 100 milligrams (mg.) twice a day for 5 days for symptoms of ( ) was ordered at that time.

In an interview with the care clinical coordinator on at 3 PM, she stated that resident #1 had initially been seen on at the care clinic for a left lower extremity non-healing ' from . She indicated that resident #1 had a medical history including and lymphedema in both lower extremities. "Lymphedema refers to that generally occurs in one of your arms or legs. Sometimes both arms or both legs swell." (mayoclinic.org).

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She reviewed the clinic notes and indicated that on the initial evaluation, resident #1's measured 2.9 centimeters (cm.) by 2.5 cm. by 0.1 cm. with moderate amount of red tissue and moderate amount of . tissue is " connective tissue forming projections on the surface of a healing , , or tissue surface." (mediLexicon.com). is " tissue separated from the living structure." (mediLexicon.com). The had multiple intact which were removed and tissue was removed by the physician. She stated the resident was receiving and a culture was obtained at that time. She stated that the culture results indicated growth of ( ) in the , and the culture results were sent to resident #1's health care provider for review. She indicated that the care physician orders had been faxed to the facility, requesting a home health nurse to change the resident's dressing on . The resident was scheduled to return to the clinic on / . The care order included Acticoat 7 day dressing moistened with sterile water applied to the bed with Qwick drainage dressing and Conform dressing to secure the 2 layer wrap to leg. She stated that the order also included instruction to have the resident's legs elevated to promote healing and reduce .

is a bacterium that causes in different parts of the body. It is more difficult to treat than most strains of , or staph because it is resistant to some commonly used . Staph is one of the most common causes of skin but can also cause more serious problems like wounds. Some strains of staph like become resistant to that once destroyed it. is spread by contact with another person who has it on their skin. are common among people who have weakened systems and are in hospitals, nursing homes and other health care centers. (mayoclinic.org).

Review of the home health nurses's note, dated , indicated the home health nurse performed care on resident #1's leg as per the care clinic orders. The note indicated the nurse instructed the facility staff to keep the dressing clean and dry, to keep the resident's legs elevated at all times, and to monitor for signs of , increased temperature and complaints of pain. Review of the home health nurses' notes did not find any documentation of in the resident's .

Resident #1's physician note, dated / , indicated the culture results of in the leg . The note read, "Staff to be aware of contact precautions including hand washing and glove use every time touching the area." The note documented that the DS was ordered twice a day for 7 days.

Resident #1's Health Assessment form (AHCA form 1823), dated , indicated the resident

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required home health nursing care for the left lower leg . The updated health assessment form, dated , indicated the resident did not have any wounds did not have any history of . This assessment indicated resident #1 was free from a communicable which could be transmitted to other residents or staff.

Resident #1's nurse's progress notes, dated , indicated the resident was evaluated and placed on hospice services. The nurse's progress note did not contain any documentation by the facility nursing staff regarding any assessments, observations or care provided to the resident.

In an interview with the RN manager on at 11:30 AM, she stated that she was aware of resident#1's history of in the left leg . The RN stated that she could not recall when or how she had been notified of the culture results. She stated that she had not personally contacted either the health care provider or care clinic regarding the progress. When asked if she had communicated the potential risks of to the facility staff and other residents, she stated she had not. She stated that the facility did not have any written policy and procedure addressing or any other . The RN stated that the facility employs nurses on duty every day. She acknowledged that she was a professional nurse who carried responsibilities to prevent illness of residents and to provide supervision and teaching to other personnel about prevention. She stated that since resident #1 was placed on hospice services and was visited by a hospice nurse, she thought she did not need to document any nursing observations or progress.

Florida Statue 464.003(20) reads, " Practice of professional nursing " means the performance of those acts requiring substantial specialized knowledge, judgment, and nursing skill based upon applied principles of , , , biological, physical, and social sciences which shall include, but not be limited to: (a) The observation, assessment, nursing diagnosis, planning, intervention, and evaluation of care; health teaching and counseling of the ill, injured, or infirm; and the promotion of wellness, maintenance of health, and prevention of illness of others. (b) The administration of medications and treatments as prescribed or authorized by a duly licensed practitioner authorized by the laws of this state to prescribe such medications and treatments. (c) The supervision and teaching of other personnel in the theory and performance of any of the acts described in this subsection...."

2. Resident #2 was admitted to the facility memory care unit with diagnoses including . The resident health assessment, dated / , indicated the resident required assistance with all ADL care and was receiving hospice services.

On / at 8:45 AM, the resident was observed in the dining , sitting in a wheelchair asleep. The resident's left hand was resting on the dining . The resident's left hand had multiple reddened on the palm and between the index, middle and ring fingers. An open pinkish area was

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noted on the anterior thumb. The LPN on duty opened the resident's palm to provide further observation. A protective dressing was not seen covering the .

On at 8:50 AM, the LPN stated that she had been informed that the "suddenly blew up" on the resident's hand during the previous weekend. She stated that the hospice nurse had evaluated the resident's hand on and an antiviral medication had been ordered. She stated that she had not been notified of any specific diagnosis causing the . She stated that she was not aware of any treatment/dressing orders for the resident's hand.

On at 2:45 PM, resident #2 was observed in bed asleep. Her left hand was wrapped with gauze bandages. During an interview with the LPN at this time, she stated that the resident's hand should be wrapped to protect the and keep the areas clean and dry.

Resident #2's hospice nurse's note, dated , indicated the nurse was notified the resident had numerous fluid filled on her left hand. The note indicated numerous fluid filled were observed on the resident's palm and between several fingers on her left hand. The hospice nurse wrote that she had cleansed the left hand and wrapped Kling gauze dressing around the entire hand for protection and supplies were ordered for future care of the . The note indicated the resident did not complain of any discomfort during the care. An , the physician ordered the antiviral medication 800 mg. 4 times a day for 7 days for left hand with multiple .

In an interview with the hospice nurse on at 10 AM, she stated that she had not initially assessed resident #2's left hand and that the weekend hospice nurse had visited the resident, on or / . The nurse stated that she had visited resident #2 on Tuesday, , and requested the antiviral medication. She stated that on / / , the clear fluid filled were intact without drainage and without signs of or the hand. The nurse stated that she would recommend that the hand remain wrapped to protect the and keep the hand clean. She stated she had instructed the facility staff to keep the hand clean and call if any drainage was noted. She stated that she had recently seen the resident on and the were turning a brownish red color but remained intact without drainage noted.

3. Resident #3 was admitted to the facility memory care unit with medical diagnoses including . Review of the hospice nurse's note indicated resident #3 was placed on hospice services on / for and ADL care. Review of the resident's current health assessment form, dated , did not reflect the resident's change in condition and admission to hospice services. An updated health assessment form was not in the record to indicate the change in the resident's condition, requiring hospice services.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967559	08/31/2015
NAME OF PROVIDER OR SUPPLIER LA CASA ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 220 N GROVE STREET MERRITT ISLAND, FL 32953	

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

Review of the hospice nurse's note indicated that resident #3 had an open area on the right lateral calf and care consisting of cleaning the with cleanser, applying triple ointment and covering with a foam dressing, 3 times a week and as needed until resolved was ordered. Review of the hospice plan of care, dated , indicated the hospice staff would assist with the coordination of all care needs for the resident.

Review of the facility nurses' progress notes did not contain any nursing staff documentation of any observations, evaluation and treatment of the resident's right leg .

On at 8:50 AM, resident #3 was found sitting in a recliner wheelchair, asleep. The resident's lower extremities were and did not have any dressings on either lower extremity. On at 10:15 AM, the resident was observed outside on the patio sitting in the recliner wheelchair. Resident #3's right lower leg had a quarter size, round pink open without drainage noted.

On at 10:20 AM, the LPN stated that she was aware that resident #3 had developed a on the right lower calf and it was being treated by the hospice nurse. She stated that the order was for care on Monday, Wednesday, Friday and as needed. She stated that she had not been informed that the dressing was not on the resident's right leg. The nurse stated that the resident had been placed on the facility's Limited Nursing Services to have the facility nurse provide care as needed.

In an interview with the hospice nurse on at 11 AM, she stated that care had been ordered for resident #3 for a right lateral . The nurse stated that she had obtained a care order which included 3 visits a week and as needed until the was healed. She stated that resident #3 had restless legs and would rub his skin against the wheelchair, causing a . She stated that she had performed care on / and received a call from the facility nursing staff that the dressing had come off on / . As a result, she stated that she had added skin prep application to the peri- ' area, allowing the dressing to adhere better. She stated that she would expect the facility nurse to perform ' care and replace the dressing as needed. She stated that currently the was free of any signs of .

4. Resident #4 was admitted to the facility on . Review of the health assessment form, dated / , indicated diagnoses of debility with and lower legs wounds. The form indicated the resident required assistance with all ADL care, was non-ambulatory, required 2 person assistance to be transferred and ' management. The nurses' progress notes indicated the resident was initially placed on hospice services for decline but was discharged from hospice care in 2014, when the resident's medical condition improved.

Review of / hospital laboratory results indicated that resident #4's right leg was cultured and heavy growth of was found.

Review of the / facility progress notes indicated resident #4 had leg wounds that were

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

draining and had a foul odor. The progress note indicated the thigh was draining, and on / , the continued to drain and weep fluid. The / progress note indicated resident #4 was evaluated and admitted to hospice services for decline in medical condition.
Review of the hospice initial admission nursing note indicated resident #4 had medical diagnoses including and .
Review of the resident health assessment form, dated , indicated resident #4 was admitted to hospice services for ADL care. The assessment form indicated the resident was free from communicable , did not have any wounds, and did not require care treatment.
The progress note indicated resident #4 at the facility on .
In an interview with the nurse manager on at 11:35 AM, she stated she was aware that resident #4 had been diagnosed with in her leg wounds and initially the facility staff and clinic were caring for the wounds. She stated that the facility did not keep detailed notes or observations of the wounds. She stated that the resident was placed on hospice services and the hospice nurse performed care. She stated that resident #4's was cultured and identified, but she had not shared this information with staff or other residents. She stated that the facility had not documented what steps were taken to protect other residents and staff. The nurse manager stated that she was the nurse in charge and supervised other nurses and unlicensed staff. She stated that she was responsible to assess, observe, and monitor all resident needs and care provided. When asked if she had reviewed the updated assessment form, which did not contain any documentation of any care requirements and a history of , she stated she did not routinely review the form for admission appropriateness. She stated that the licensed nursing staff was trained on control practices but she acknowledged that she had not conducted any control refresher training, specifically regarding and recommended precautions for the unlicensed staff caring for resident #4.
On at 12:45 PM, the facility nurse stated that she said she was not informed that resident #4 had but she routinely performs resident care and used appropriate control practices. She stated that she did not recall any notice to the staff in general that resident #4 had an and if special procedures were implemented to protect the other residents and staff.
On at 3:10 PM, the administrator stated that the facility did not have a written policy or procedures to address control care issues, including residents identified on admission and continued residency with any communicable process. He stated that he was not aware of any residents that had been identified with any communicable in the past six months and "none with a diagnosis of ". He denied knowledge that resident #4 had been diagnosed with in her wounds.
Class II

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

September 1, 2015

Keith Krodel
Executive Administrator
La Casa Assisted Living
220 N Grove Street
Merritt Island, FL 32953

Dear Mr. Krodel:

This letter reports the findings of a complaint investigation survey conducted on - /, by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **five business days** of receipt of this hand delivered report.

The inspection resulted in findings of non-compliance in the following areas:

A 277- Limited Nursing Services- Resident Care Standards- Class II- the facility failed to ensure nursing services were provided in accordance with prevailing nursing standards. As evidenced by the facility's lack of communication to address the prevention of known and the failure to ensure facility staff and residents were protected from potential risks.

Your facility must comply with the following:

1. The facility must have a complete record of each resident of the facility, including an updated complete health assessment for each resident (AHCA form 1823) completed by a medical provider. The resident record must also contain documentation of all significant changes in the resident's status, including any identified and correspondence with all medical and service providers and responsible parties. Any care services provided by the facility nursing staff or 3rd party providers should be documented and maintained in the resident's medical record. The facility nursing staff will follow established nursing treatments as defined in the Florida Practice Act 464.003, (18) - "the establishment and implementation of a nursing regimen for the care and comfort of individuals, the prevention of illness, and the education, restoration, and maintenance of health."

This shall be completed by , 2015

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com

2. ALL staff providing care and services to the residents must be re-trained in the prevailing community control standards, universal precautions and facility sanitation procedures, including appropriate handling of residents with wounds and residents with wounds that are at risk for potential development of . The training shall be conducted by an outside registered nurse, or health care provider.

This shall be completed by , 2015

3. Your facility must develop a detailed written policy outlining your facility's practices for control and facility sanitation procedures. The policy must include specific documentation of each staff's role in the assessment, observation, treatments, evaluation and reassessment of resident's identified with and address environmental concerns identified as control risks. The policy will address that compliance with the facility's control practices will be mandatory and any noncompliance with the policy will result in immediate disciplinary action by the Administrator. The control policy will be included in the orientation training of all new unlicensed staff prior to direct resident care and also to staff providing nonclinical services to the resident, such as housekeeping/laundry services.

This must be completed by , 2015

4. Your facility must develop a written policy outlining your facility's practices and controls related to the documentation of any identified communicable with a resident and the step by step process of informing staff, other residents and family of the potential risks and the implementation of the facility plan for reduction of the risks. The facility must establish a policy/procedure for outlining the ongoing monitoring of the control processes for the facility when communicable are identified, the plan should identify who will be responsible for the monitoring of the compliance.

This must be completed by , 2015

5. The Administrator of the facility is expected to participate in the development of the facility control plan and attend any training noted above. Also be actively involved in the monitoring of any residents identified with currently residing in the facility and being evaluated for admission. It is expected that the Administrator will demonstrate active involvement in ensuring that residents are receiving adequate care, and maintaining a safe environment for all facility residents and staff.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact Laura Manville, Survey and Certification Support Branch, at (727) 552-1955 or Lorraine Henry, Health Facility Evaluator Supervisor,at [illegible]-2534.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LM/be

D7JR

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[redacted], 2015

Administrator
La Casa Assisted Living
220 N Grove Street
Merritt Island, FL 32953

RE: CCR #2015008906

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on [redacted], 2015 by representative(s) 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than [redacted], 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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(s). Should you have any questions please call Lorraine Henry at [redacted]2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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