STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967288	08/17/2017
NAME OF PROVIDER OR SUPPLIER **A TROPICAL PARADISE ALF LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **5228 23RD AVENUE SAINT PETERSBURG, FL 33710**	

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

0000 - Initial Comments

Assisted Living Facility

A complaint investigation, (CCR# 2017006104), was conducted at A Tropical Paradise on . A Tropical Paradise, Assisted Living Facility, had deficiencies at the time of the investigation.

(License # 11367)

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on records review and interviews, the facility failed to assess one of six sampled residents (Resident #1) for appropriateness of continued residency. Resident #1 had a pressure store staged at a or higher for more than 30 days. The resident's pressure sores worsened and became . The resident was finally transferred out of the facility by ambulance to receive a higher level of care more than 3 months after the facility was first made aware of the pressure sores. In addition, the facility failed to obtain updated documentation of face-to-face health assessment (AHCA form 1823) when Resident #1 experienced a significant change.

Findings included:

During a records review at 10:30 am on , it was revealed that Resident #1 was admitted to the facility on . Resident #1's health assessments (AHCA form 1823) were reviewed and none of the assessments stated that the resident had a diagnosis or a history of having pressure sores. According to the 1823 assessments in Resident #1's records, the resident's needs could be met in an assisted living facility. The most recent 1823 assessment, dated stated that Resident #1 had generalized and a gait disturbance and required physical , and nursing services. There was no 1823 after although, per the notes in Resident #1's record, Resident #1 developed a pressure on their heel in 2016 and a pressure on the in , 2017. In addition, Resident #1 had a weight loss of almost 20 lbs documented from , to 2016.

Resident #1's records further revealed that on , a healthcare provider's diagnosis of a of the right heel and a referral for care. The healthcare provider ordered a soft

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protective for the resident to be worn on the right foot to protect the heel from further pressure and home health to provide care treatment. Resident #1's record further revealed that on a healthcare provider assessed the resident and diagnosed a , on the resident's area and ordered home healthcare treatment for the new , .

It was confirmed in an interview with the home health nurse who provided the care treatment to Resident #1 (conducted during complaint survey #2017004133) that the home health agency began treatment of the resident's , on the heel in of 2016. The nurse revealed that the home health agency had instructed the facility Administrator on how to position the resident to prevent further pressure areas from developing as the skin was fragile and the resident was lying in bed or sitting in a chair most of the time.

Resident #1's record revealed that on , more than 3 months after the original diagnosis of the pressure on Resident #1's heel, the healthcare provider diagnosed the resident with and a , on the . At the time the resident received the diagnosis that the resident required nursing facility services, the resident was receiving treatment because the pressure on the had become and there was a full (skin) thickness on the and the heel had a , . (Photographic evidence obtained).

The facility Administrator made a notation in Resident #1's records on that during the last week of 2017, there was a strong odor from the on the tailbone ( ). It was brought to the attention of the home health nurses. The odor continued and the facility called the healthcare provider to check it.

The facility Administrator stated in an interview at 11:30 am on that they were aware that the Resident #1 had a , on the right heel in 2016. The home health care nurse instructed them to keep the resident off of the foot, so the resident stayed in bed more often and for greater lengths of time. Then the resident developed a on the from lying in bed or sitting in a chair. The Administrator confirmed knowledge that the resident was being treated for the , on the heel and on the . The Administrator denied knowledge that the , were staged and that they were not improving. Sometime in 2017, the , on the resident's became odorous and this was discussed with the healthcare provider and the home health care nurse.

Class III

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

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Based on records review and interviews, the facility failed to provide the care and services required to meet the needs of 1 of 6 sampled residents (Resident #1), who was accepted for admission to the facility. Resident #1 developed pressures sores, which worsened due to lack of oversight and care coordination by the facility.

Findings included:

During a records review at 10:30 am on , it was revealed that Resident #1 had resided in the facility for more than 5 years. Resident #1's health assessments (AHCA form 1823) were reviewed and none of the assessments stated that the resident had a diagnosis or a history of having pressure sores. The most recent 1823 assessment, dated , stated that Resident #1 was diagnosed with generalized and a gait disturbance and required physical , , and nursing services. There was no documentation found in Resident #1's records that physical , , was ever offered or given to the resident after the assessment stating that the resident required it.

Resident #1's records further revealed that on , a diagnosis of a of the right heel and a referral for care was documented in Resident #1's records, by the resident's healthcare provider. The provider ordered a soft protective for the resident, to be worn on the right foot to protect the heel from further pressure and home health to provide care treatment. Resident #1's record further revealed that on a healthcare provider diagnosed a new , on the resident's and ordered home healthcare treatment for the new , . (Photographic evidence obtained).

It was confirmed in an interview with the home health nurse who provided the care treatment to Resident #1 (conducted during complaint survey #2017004133) that the home health agency began treatment of the resident's , on the heel in of 2016. The home health nurse stated during the interview that the facility Administrator would sometimes watch the resident's care treatments being done. The home health agency nurse verified they had instructed the Administrator on how to position the resident to prevent further pressure areas because the resident's skin integrity was fragile and the resident was lying in bed or sitting in a chair almost all the time. The agency also instructed the Administrator to provide prompt incontinence care to Resident #1 and avoid letting moisture stay on the damaged skin, as that would aggravate that problem. The home health nurse stated that the resident was of bowel and and that on several occasions witnessed the resident lying in feces and . The home health agency would then have to clean the resident in order to provide care. The home health nurse confirmed that the assisted living

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facility was responsible for providing incontinence care, but that it seemed they were not providing it often enough and sometimes the bandage over the on the would become soiled and off.

The facility Administrator stated in an interview at 11:30 am on that they were aware that the Resident #1 had a on the right heel in 2016 and then the home health care nurse instructed them that the resident should stay off the foot, so the resident stayed in bed more often and for greater lengths of time. Then the resident developed a pressure on the . The Administrator confirmed knowledge that the resident was being treated for the on the heel and on the by a home health agency nurse. The Administrator denied knowledge that the were staged and that they were not improving. The Administrator stated that the home health care nurse kept telling the facility that the wounds were getting better, but sometime in 2017, the on the resident's became odorous.

The facility Admission and Discharge log revealed that Resident #1 was discharged on to a hospital via an ambulance with .

Class III

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

Based on records review and interview, the facility failed to ensure that direct care staff members completed required training to provide care for residents, for 1 of 1 sampled staff members (Staff A).

Findings included:

A record review of Staff A's records at 12:30pm on revealed that Staff A did not have any training certificates for the staff in-service training that is required within a direct care staff person's first 30 days of employment. Staff A started working at the facility in of 2017, according to a job application in the record. The required training documents that were missing included training on reporting major incidents, reporting adverse incidents, facility emergency procedures, resident's rights, recognizing and reporting , neglect and , resident behavior and needs, providing assistance with activities of daily living, and elopement response policies and procedures. Staff A would have been required to have received the staff in-service training by the end of 2017, based on the date of the job application reviewed.

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In an interview at 12:45pm , the Administrator stated that Staff A was a family member and the exact date that Staff A began employment at the facility is not known. Earlier in the day, the Administrator had stated that Staff A was the only other employee in the facility. The daily schedule of the facility was that the Administrator worked the day shift and Staff A worked the night shift, 7 days a week. When asked how long Staff A had worked at the facility, the Administrator wasn't sure, but probably about a year. Subsequent to Staff A's record review, the Administrator stated the facility had been had been training Staff A for "a while" and admitted that the facility had failed to print out any of Staff A's certificates of the in-service training required by the State. The Administrator stated that the training had occurred, however there was no evidence in the record and that was something that needed to be corrected.

Class III