STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942941	R 11/20/2017
NAME OF PROVIDER OR SUPPLIER **CASA MARISA ALF INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **7435 SW 23 STREET** **MIAMI, FL 33155**	

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

0000 - Initial Comments

A Limited Mental Health Expansion Revisit Survey was conducted on 10/17/17 and concluded on 11/20/17. Casa Marisa ALF Inc. (license #8366) had the following deficiencies identified at the time of the survey:

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

Based on interviews and record review, the facility failed to provide adequate supervision for one out of six sampled residents who had precautions (Resident #3). Resident #3 at the facility, sustained injury to her right shoulder and was sent to the hospital days later for medical attention. The facility also failed to have precautions in place for Resident #3, and did not have any documentation regarding the resident who and went to the hospital.

Findings included:

1) On at 1:27 P.M. Staff C stated Resident #3 was in a rehabilitation center. At 1:35 P.M., Staff C further stated that Resident #3 was sent to a rehabilitation center because she and had an issue with her shoulder.

Hospital records received on revealed Resident #3 arrived at the emergency the assisted living facility (ALF) on at 3:38 P.M. by ambulance with diagnoses of and . The record stated that the injury occurred on on the resident's right shoulder, where she had pain and after a three (3) days earlier. The doctor's assessment documented that was dark purple, brown, on anterior aspect of right shoulder, right bicep and right area and said pain began two or three days before. The hospital admission note stated the resident had been walking when she tripped and onto her right side. The resident was evaluated by an orthopedic and the recommendation was that the "patient would need surgical intervention for a reverse shoulder . ". The resident was transferred on to another hospital for surgery with a diagnosis of closed of right hummers.

On at 1:50 P.M., the Administrator reported Resident #3 by herself in the was sent to the hospital, her diagnosis was a dislocated shoulder. The administrator stated, "I don't remember the day, it was before the hurricane. I'm going looked in the medication record (MORs) to recalled day and time, it was on , but we didn't know how it happened. The next day we saw the resident holding her shoulder and I contacted her sister over the phone to let her know about her sister's condition. She told us to send the resident to the hospital." The Administrator stated that after surgery, the resident went to a rehabilitation center.

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A review of Resident #3's record revealed the resident was admitted on . the resident 's health assessment dated had the diagnoses: , , , , and , (HBP). The resident needed precautions and was independent with eating; needed supervision with ambulation, dressing, self-care, toileting, and transferring and assistance with bathing. The resident needed assistance with self-administration of medications. The facility did not have documentation regarding Resident #3's or of any interventions in place to prevent Resident #3's . The facility's last progress note regarding the change in Resident #3's care was dated .

On at 1:41 P.M., Staff C reported Resident #3 must have on during night. The staff reviewed the medication observation records to recall the day of the incident. Staff C stated "I did not see her during the , I did not know how she . On the morning of , I was assisting her with bathing and she did not let me to touch her. I took her to the dining table and she couldn't hold the cup or bread."

A review of the facility's policies and procedures revealed staff of the assisted living facility (ALF) would monitor ALF residents on a 24 hours basis. The documents further stated that the purpose of monitoring of residents was to ensure safety and needs, to address any matter than could impact the safety and well-being of the resident or the care that they needed. The policy said that staff would make rounds at least every 2 hours or sooner if directed.

A review of records showed that there was no documentation that once staff observed Resident #3 not feeling well, the healthcare provider was contacted to assess the resident, or that the resident was immediately sent to the hospital.

Class II

0031 - Resident Care - Third Party Services - 58A-5.0182(7) FAC

Based on record review and interview, the facility failed to ensure that a Home Health Agency left documentation in the facility of the services provided to two out of six sampled residents (Residents #2 and #6).

Findings included:

A review of Resident #2's record showed that the resident was dependent. While the record contained a service agreement dated , there was no documentation of a plan of care from the agency or a daily administration log.

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A review of Resident #6's record revealed the facility did not have any documentation regarding home health services that were ordered. The resident agreement was dated .

On at 2:00 P.M., the Administrator stated, "I don't know why the agency does not leave documentation in the facility."

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview, the facility failed to keep medications locked and/or secured at all times.

Findings included:

On at 1:05 P.M. observed Resident #4's was unlocked. There was unlocked medication on top of the dresser.

On at 1:05 P.M., Staff B stated Resident #4 was independent with his medication, and for that reason he had his medication in his . He acknowledged that the door was unlocked.

Class III

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

Based on observation, record review and interview, the facility failed to maintain a written work schedule that reflected its 24-hour staffing pattern for a given time period.

Findings included:

Observation on at 1:27 P.M. revealed one staff alone caring for the residents (Staff C).

A review of facility's the staffing pattern posted on the bulletin board showed on , Staff B and Staff C were scheduled to work from 7 AM and 7 PM. The Administrator was scheduled from 7:00 PM to 7:00 AM.

On at 1:55 P.M., the Administrator stated Staff B went to the supermarket and he will be back soon. As of 2:30 P.M. on Staff B had not returned to the facility.

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On at 1:00 P.M. observed Staff B caring for a census of five residents. Staff B contacted Staff C by phone. Staff C arrived at 1:32 P.M.

A review of facility's records revealed that the staffing pattern posted was for 2017.

Uncorrected
Class III

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

Based on observation, record review, and interview, the facility failed to file an adverse incident report with the Agency within 1 day and a complete report within 15 days for one out of six sampled residents who and sustained injury (Resident #3).

Findings included:

On at 1:27 P.M. Staff C stated Resident #3 was in a rehabilitation center. During a further interview on at 1:35 P.M., Staff C stated Resident #3 was transferred to rehabilitation center because she and had an issue with her shoulder.

On at 1:50 P.M., the Administrator stated, "Resident #3 by herself in the we sent her to the hospital, her diagnoses was a dislocated shoulder. I did not file incident report with the agency because it was not an incident since we did not see the resident ."

Hospital records revealed Resident #3's arrived at the emergency at 3:38 P.M. from the assisted living facility (ALF) with an injury which occurred on on her right shoulder with pain and after a .

Class III