STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967199	**12/01/2017**
NAME OF PROVIDER OR SUPPLIER **CASA BONITA ALF LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **931 NE 17 TERRACE** **HOMESTEAD, FL 33033**	

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

0000 - Initial Comments

A Standard Biennial Survey was conducted started on , 2017 and concluded on , 2017. Casa Bonita Alf Llc with the Limited Mental Health component and license #11281 had the following deficiencies identified at time of the survey:

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

Based on interview and record review, the Assisted Living Facility failed to ensure the appropriateness of continued residency one of six sampled residents (#5). Resident #5 had a gait imbalance and repeatedly, injuring himself and was hospitalized with a forehead . The resident continued to and obtain injuries in the hospital, but was accepted back for residence at the facility.

Findings included:

In an interview on at 7:54 AM Staff B revealed Resident #5 went to the hospital on because he lost his balance and .

A review of Resident #5 (admitted)'s record revealed the facility did not have any progress notes showing that the resident went to the hospital. The health assessment (AHCA form 1823) completed on showed, under physical or sensory limitations,: loss of balance. The health assessment also identified a need for precautions.

In an interview on at 8:22 AM the Administrator revealed that there was no progress note regarding the resident's or hospitalization.

On at 12:06 PM Staff B revealed Resident #5 needed assistance for bathing, dressing, ambulation, and self-care. The resident needed supervision for toileting and transferring.

Hospital records for Resident #5 revealed the resident was admitted to the emergency with the diagnosis of laceration without foreign body of other part of head, initial encounter. The admission note stated that the resident was sent to the emergency falling and hitting his/her head and the right side of the face. The resident also had a . Physical examination showed that resident had , (skin discoloration) to the right periorbital (around eye) area and right forehead . The resident had a 3 cm cut on the forehead, resulting in simple being placed. The hospital record further stated that the resident informed hospital staff that he sat in a wheelchair and felt , when he tried to get up, falling and hitting his head on a table and then on the floor. Further review of the hospital record showed photographs of other injuries including: an old skin

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discoloration under left eye (blackish/purplish), something resembling a on the left shoulder, scratches or on the right elbow, a or on the right wrist, on the ribs, scratches on the center of the back, above the , and right hip, on the left back and hips, on the left and right knees, a on the right heel. Additional review of the hospital record showed that the resident was of and feces, and that he had a gait , . Nurses continuously documented that the resident did not follow instructions to avoid self-injury. The resident obtained wounds including:
1-) Right eyebrow- laceration- ,
2-) Sacrum- maceration (softening of skin from prolonging exposure to moisture)- , (redness)
3-) Left shoulder (back)- 2 cm x 2 cm x 0.1 cm- Full thickness -
4-) Back of right arm lower arm- 1 cm x 1 cm x 0.1 cm- partial thickness
5-) Right heel- lateral- full thickness - 4 cm x 4 cm x 0.1 cm
6-) Front of left foot Medial area- full thickness- 3 cm x 2 .5 cmx 0.1 cm.

Further hospital record review showed that Resident #5 was restrained during hospitalization with mittens because the resident did not follow directions or cooperation with medical treatment. Skin circulation and integrity was checked. The resident was restrained during the hospitalization because he would not follow directions or cooperate with medical treatment. The resident was discharged from the hospital on and returned to the facility.

A review of the resident record at the facility showed a document that stated "Out of Control", then in Spanish, "He and hit the forehead; he does sleep."

Class II

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on record review and interview, the Assisted Living Facility failed to treat residents with dignity, free of and neglect. The facility flicked water on residents to wake them, and pushed them, yanked another other resident by the hair until she was back in her . The facility also posted only a Spanish version of the menu so that one out of six sampled residents could not understand (Resident #3).

Findings included:

1) In an interview on at 12:34 pm, Resident #4 stated "They don't change me during the night. They wake me up early in the morning by splashing water on my face. I don't say anything because I'm afraid of retaliation." Resident #4 further stated "They push the other resident and lock her in her

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when she asks for a cigarette. They mistreat her and pull her by her hair, but they treat her nice today because you are here."

On . . . between 7:30 am and 1:00 pm, observed that Resident #2 was unable to be interviewed.

2) A review of the available weekly menu posted on the refrigerator located in the dining and dated from " to " with no specific month revealed that it was written in Spanish.

During an interview on at 7:43 AM Resident #3 who is an English speaking Resident stated "I don't read Spanish."

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation and interview, the Assisted Living Facility failed to follow the procedures outlined by the state when providing assistance with self-administration of medication to one out of six sampled residents (Residents #1).

Findings included:

On . . . at 6:56 AM Staff B was observed providing assistance with self-administration of medication to Resident #1. Staff B went to Resident #1 with the medication book and a medicine basket, asked for Resident #1's hand, and proceeded to punch the medication card, placing one pill after another into the resident's right hand, watched her swallowed the medication, and finished by signing the medication book. Staff B did not inform the resident of what the medications were.

During an interview on at 11:08 AM, Staff B stated "I forgot to read the medications."

Class III

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

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

Findings included:

On at 6:40 AM Staff B and Staff C were observed in the facility caring for a census of 6

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residents.

A review of the facility's staffing pattern revealed that Staff A was scheduled to work from 7 AM to 7 PM. However, Staff A walked in the facility at 8:07 AM. Also, the schedule stated Staff B lived in, however Staff C lived in.

During an interview on at 10:21 AM, Staff A stated "I made an arrangement with Staff C because I had to go to the social security administration today."

During and interview on at 10:43 AM, Staff B stated "I work from 7 AM TO 7 PM Staff C works during the night."

During and interview on at 10:55 AM Staff C stated "I work Monday to Friday from 7 PM to 7 AM. I live in."

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation and record review, the Assisted Living Facility failed to provide and serve therapeutic diet as ordered by the physician for one out of six sampled residents (Resident #2). The facility also failed to follow the menu and note substitutions prior to the meal being served. The facility failed to meet the residents' needs by offering a variety of meals adapted to the food preferences of the residents for one (Resident #4) out of six sampled residents.

Findings included:

1. On at 12:10 PM the residents, including Resident #2, were observed eating white rice with black beans, and whole pork chops (regular consistency) with a glass of juice. Resident #1 was served quinoa as substitution for white rice.

A review of the health assessment completed on showed that Resident #2 required a "Mechanical soft diet, with ground meat, pureed veggies, and soup." Resident #2 was not served a mechanical soft diet.

A review of the lunch menu for 11/ showed: "chuleta the Puerco 4 oz, arroz blanco 1 taza, frijoles ½ taza, petit pois ½ taza, ensalada mixta 1 taza, Aderezo 1 cu, fruta fresca." (pork chop 4 oz., white rice 1 cup, beans 1/2 cup, , 1/2 cup, mix salad 1 cup, dressing 1 t, fresh fruit). No substitution

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documented on the menu.

On at 12:34 PM Resident #4 stated, "The food is horrible. They don't give snack. For dinner they just give water and soup when you're not here."

Class III

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0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview, the Assisted Living Facility failed to have a completed health assessment for two of six sampled residents (Resident #5).

Findings included:

A review of Resident #5's record showed that health assessment (AHCA form 1823) completed on . Height and weight were blank. None of the activities of daily living were marked to identify the type of assistance needed. It did not show whether the resident's needs could be met in an assisted living facility. It did not show if resident needed help taking medications.

In an interview on at 12:06 PM Staff B revealed that Resident #4 received assistance with self-administration of medication. The resident needed assistance for bathing, dressing, ambulation, and self-care. The resident needed supervision for toileting and transferring, and was independent for eating.

Class III

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

Based on interview and record review, the Assisted Living Facility failed to submit an one day adverse incident report to the Agency after one out of six sampled residents in the facility , was injured, and was hospitalized (Resident # 5) .

Findings include:
On at 7:54 AM Staff B revealed that Resident #5 went to the hospital on /because he lost his balance and hit the floor.

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On at 8:10 AM the Administrator revealed that Resident #5 was going to be discharged from the hospital the night before. At 8:22 AM the Administrator stated that the facility did not complete the one day incident report because the Resident was not sleeping well and that's why he . She did not think that this needed an adverse incident.

A Review of Resident #5's record revealed that there was no progress note showing that Resident #5 went to the hospital and the reason why.

Class III

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(8) FAC

Based on record review and interview the facility failed to ensure that one out of three sampled staff who provided care for residents under its mental health license component received a minimum of three hours of continuing education of Limited Mental Health (LMH) Training (Staff B).

Findings included:

A review of Staff B's personnel file revealed that the last three hours of LMH continuing education was dated .

On at 10:21 AM Staff A acknowledged that Staff B did not have an updated three hours of LMH continuing education.

Class III