STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968485	**01/18/2018**
NAME OF PROVIDER OR SUPPLIER **ISA HOME CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **13316 SW 112TH CT** **MIAMI, FL 33176**	

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

0000 - Initial Comments

A Complaint Survey CCR# 2018000356 was conducted on & . Isa Home Corp. with Limited Mental Health component (AL#12367) had the following deficiencies identified at the time of the visit:

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on observation, record review and interview, the facility administrator, who was administrator of record for three facilities, acted as administrator for a fourth facility.

Findings Include:

A review of the Background Screening Clearinghouse Database and Florida Health Finder showed that the Administrator was as administrator of three facilities, and was also listed as staff at Facility B. During interviews conducted from at 10:25 AM through , the Administrator stated that, Acting as administrator for Facility B, the Administrator paid the bills, supervised staff and resident care, closed the facility and transferred the residents to other facilities without knowledge of the administrator/owner of record.

On , at 10:25 AM, spoke with the Administrator by phone. She said that she stopped working with Facility B in , and that there were no residents there. Stated that she took one resident to this facility. Resident #2. Later stated that she also took Resident #1 to this facility . Was asked if she could provide a resident roster, the files, an admission/discharge log or any other items that would identify who had been living at the facility. She said she didn't understand why she was being asked for these items since she had just been a staff person and she had nothing to do with the place.

During a visit to the facility, Staff B stated she transferred four residents from Facility B to her facilities. She only said two because the other residents were transferred before facility closure. Resident #4 was transferred to Facility C on , and Resident #3 to Facility 4 on . She further stated that Resident #5, who had been living at Facility B , , and Resident #6 never was admitted at Facility B because he only was at the facility for two days. He was living with his son. The Administrator stated that she helped the administrator of Facility B to manage the facility for three years. She paid all the utilities bills, managed the facility bank account, and gave $3000.00 monthly to the administrator to pay the rent. The Administrator told the Owner and Administrator of record that she would close Facility B and she needed to transfer all the residents. The Administrator told the Owner and Administrator of

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record for facility B that she did not need to give 45 days notices to the residents because the residents wanted to be transfer to another ALF.

During a facility visit to the facility on , observed Resident #1, , diagnosed with type II, , and . The record did not have documentation of the contract with the facility executed at or prior to admission, written informed consent for unlicensed staff assisting the resident with the self-administration of medication, Health Assessment completed within 60 days prior to admission into the facility or 30 days after been admitted in the facility, and a health care surrogate, health care proxy, guardian, or the existence of a power of attorney.

During a facility visit to the facility on , observed Resident #2, , diagnosed with , Incontinence was observed sitting in the common . The record did not have documentation of the Health Assessment completed within 60 days prior to admission into the facility or 30 days after been admitted in the facility and a health care surrogate, health care proxy, guardian, or the existence of a power of attorney.

Interview conducted on at 10:26 AM, Resident #2 said that she lived in another assisted living facility before but she did not remember why she was transferred to this facility, and Resident #1 said that she live in out of the country and she had been coming here since she was a little girl.

During a Monitoring visit to Facility C on . observed Resident #3, , diagnosed with , Parkinson's, , and . The record did not have documentation of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney. Resident #3 was observed in bed with a half bed rail raised. The staff stated that the resident was able to transfer with assistance, however she was not observed getting out of bed during the monitoring visit. She did not know how long she had been at the facility and that she didn't know where her identification or other papers were.

During a Monitoring visit to Facility D on , observed Resident #4, , diagnosed with , Hypolipidemia, , and , . The owner of facility D stated that the resident had a nephew who was her Power of Attorney (POA). He and his wife usually visited weekly but there had been an illness and other issues in the family, so they had missed a few visits. The owner further stated that she had spoken with the nephew since the resident had been transferred back to facility D when he called looking for his aunt, since he had not been informed that she was

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moved.

Class III

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

Based on observation, record review and interview, the facility failed to maintain an accurate written work schedule that reflected its 24 hour staffing pattern.

Findings Included:

Observation on . . . . . at 9:30 AM showed Staff A and B were caring for the residents and providing personal services to them.

Record review of the facility's staffing pattern showed that Staff B was not listed.

Interview conducted on . . . . at 11:30 AM, Administrator confirmed that the staffing schedule was inaccurate.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the facility failed to provide a safe and clean living environment to facility residents.

Findings Include:

Observation showed that there was a broken electric switch cover plate in # and there was water damage on the bottom of the double cabinet in the kitchen.

Interview conducted on . . . . at 11:30 AM, Administrator confirmed that the findings.

Class III