STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966792	R 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA DE AMOR ALF INC	**10930 S W 143 COURT** **CROSSINGS, FL 33186**

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

0000 - Initial Comments

A Change of Ownership Revisit survey was conducted 02/08/2018. Casa De Amor ALF with License # 10984 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 observation, interview and record review, the facility failed to provide adequate supervision by not maintaining a written record of any incidents that resulted in medical attention for 1 out of 2 sampled residents (Residents #5).

Findings Included:

On at 9:33 AM observed Resident #5 had a large on the left side of her face.

On at 9:44 AM Staff B stated "Resident #5 suffered a yesterday, she trying to get up from her chair in the living . We called rescue and they assessed her. The rescue department determined she did not have any . I called 911, and they showed up. They did not leave any paperwork or anything else. They told me to not give her any food and not allow her to go to sleep for several hours."

On at 9:55 AM Resident #5 stated "I was trying to get up from the chair and I , I felt like my feet slipped. I did not have any , just the . I feel better now, I have been resting. The rescue came and they applied ice to my face."

A review of Resident #5's file revealed the resident was admitted on , health Assessment Dated , medical history and diagnoses: not documented. Physical or sensory limitations: or behavioral status: Alert, oriented x 2. Nursing/treatment/ , service requirements: As needed. Per health assessment the resident is not an elopement risk. The resident's type of assistance with daily living was not documented. The type of assistance the resident's needs with medication was not documented. No weights record. The last progress note on file was dated documented: The resident continues at stable condition at the moment. There was no documentation about the resident's on .

Class III

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

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966792	R 02/08/2018
NAME OF PROVIDER OR SUPPLIER **CASA DE AMOR ALF INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **10930 S W 143 COURT** **CROSSINGS, FL 33186**	

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

Based on observation, record review and interview, the facility failed to meet the minimum 168 staff hours per week requirement for the five residents in the facility.

Findings include:

A review of the facility staffing schedule from - had Staff B Scheduled from 7:00 AM-7:00 PM. Staff C 7:00 PM-7:00 AM, and Staff A was scheduled on call. The total of staff hours on schedule were 144.

On at 11:51 AM Administrator stated "I thought that the time I spend here when I am on call went towards the total hours. I do not document the time I am at in the home."

Class III

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

Based on observation, record review, and interview the facility failed to have a completed/updated health assessment done by healthcare provider after a significant change and failed to maintain weight records for 2 out of 2 sampled residents (Residents #2 and #5).

Findings included:

A review of Resident #2' record showed that the resident was admitted on . A Health Assessment Dated showed Medical history and diagnoses: , OA. Physical or sensory limitations: Needs Hospice care. or behavioral status: alert. Nursing/treatment/ service requirements: As needed, hospice care. Special precautions precautions. Per health assessment the resident was not an elopement risk. Per health assessment the resident did not require care. The resident required total help with all ADL. The type of assistance the resident's needs with medication was not documented.

A review of Resident #2's hospice file revealed Plan of Care in file dated . Medication Management. Care for left foot . Full bed rails order in file. Complete bath care.

A review of Resident #5's file revealed the resident was admitted on , Health Assessment Dated , medical history and diagnoses: not documented. Physical or sensory limitations: or behavioral status: Alert, oriented x 2. Nursing/treatment/ service requirements: As needed. Per health assessment the resident is not an elopement risk. The resident's

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966792	R **02/08/2018**
NAME OF PROVIDER OR SUPPLIER **CASA DE AMOR ALF INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **10930 S W 143 COURT** **CROSSINGS, FL 33186**	

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

type of assistance with daily living was not documented. The type of assistance the resident's needs with medication was not documented. No weights record. The last progress note on file was dated documented: The resident continued at stable condition at the moment.

Class III