STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968764	**12/20/2018**
NAME OF PROVIDER OR SUPPLIER **LA CASA ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **9318 MEMORIAL HWY** **TAMPA, FL 33615**	

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

0000 - Initial Comments

Assisted Living Facility

A Complaint Survey (CCR#: 2018015804) in conjunction with a Biennial Survey was conducted at La Casa Assisted Living Facility on . La Casa Assisted Living Facility had deficient practice identified at the time of the survey.

(License#: 12615)

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on record review and interview, the Facility failed to ensure one (Resident #6) met minimum admission criteria, which included performing the activities of daily living with supervision or assistance and being appropriate for admission as determined by the Facility Administrator based on a Medical Examination Report.

Findings Included:

A record review for Resident #6, conducted on , revealed that based on documentation, Resident #6 was not appropriate for admission to the Facility. Resident #6's Health Assessment Form dated stated that the resident required medication administration and total care with all activities of daily living, which included bathing, , eating, grooming, toileting, and transferring at the time of admission. Resident #6 was admitted in to the Facility on .

Resident #6's Medication Observation Record revealed that Staff B, an unlicensed Medication Technician signed for medications as given to the resident. .

During an interview with the Owner, conducted on , the Owner stated that prior to , the Owner had no role or responsibility with running the Facility. At 11:15am, the Owner stated that, "I don't know; I just started last week; [and], that is all on the [Former Owner]." At 11:30am, the Owner acknowledged and confirmed that the Facility had no licensed nurses to administer medications to Resident #6.

Class III

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

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Based on observation, record review, and interview, the Facility failed to obtain a -to- medical examination after a significant change in condition for two Residents (#3 and #5. Additionally, the Facility failed to discharge one Resident (#3) of one sampled resident to a higher level of care who no longer met criteria for continued residency.

Findings Included:

During an observation of Staff A's transfer of Resident #3 from the couch to a wheelchair, conducted on at 01:15pm, it was observed that Resident #3 appeared unable to bear and both were in a bent position. On that same date at 02:09pm, Staff A was observed feeding Resident #3.

A review of Resident #3's record, conducted on , revealed that Resident #3's Health Assessment Form had no date of examination and noted that the resident required assistance with all activities of daily living and had gait imbalance. There was no documentation in Resident #3's record regarding Resident #3's inabiitiy to bear or that both of the resident's were . During an interview with Resident #3's nephew, conducted on at 02:48pm, the resident's nephew stated that Resident #3 was not admitted to Hospice services and that the resident had gotten worse since the resident moved in to the Facility. There was also no documentation in Resident #3's record indicating the resident was admitted to Hospice.

A review of Resident #5's record, conducted on , revealed that Resident #5 had a significant change in condition that warranted the resident's admission in to Hospice services on . Resident #5 had a -to- Health Assessment Form (HAF) dated , which noted that the resident required supervision with all activities of daily living, which included ambulation, bathing, , eating, grooming, toileting, and transferring. Resident #5's HAF did not note the required nursing services of Hospice.

During an interview with the Owner, conducted on at 10:50am, the Owner stated that prior to that the Owner had no role or responsibility with running the Facility. At 11:15am, the Owner stated that, "I don't know; I just started last week; [and], that is all on the [Former Owner]." At 06:30pm, the Owner acknowledged and confirmed that Resident #3 and #6 both had declines in condition and should have received a -to- Health Assessment and that Resident #3 needed a higher level of care than what the Facility could provide.

Class III

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

Based on observation, record review, and interview, the Facility failed to ensure it could meet the needs for care and services required for two Residents (#3 and #6) of six sampled residents admitted to the Facility.

Findings Included:

During an interview with Staff A, conducted on at 12:19pm, Staff A said they were not aware that Resident #6 had a .

An observation of Resident #3, conducted on at 01:15pm, revealed that Staff A transferred the resident in a potentially unsafe manner, placing both the resident and the staff at risk for injury. Staff A had Resident #3 wrap the resident's arms around Staff A's and while the staff wrapped arms around the resident's area and then the staff swung the resident from the couch to the wheelchair. Resident #3 had both in a bent position and appeared unable to bear or straighten their during the transfer. Staff A appeared unable to support or protect Resident #3's and during transfer.

A review of Resident #3's record, conducted on , revealed that Resident #3 had an undated Health Assessment Form. Resident #3 had no documentation of the to both of the resident's . There were no care and services provided or arranged to meet Resident #3's care needs documented on the last page of the form, including for transfers.

A review of Resident #6's record, conducted on , revealed that Resident #6 required medication administration and total care with all activities of daily living, according to the resident's Health Assessment Form dated . There were no care and services documented provided or arranged to meet Resident #6's care needs for medication administration and total care with all activities of daily living needs.

During an interview with the Owner, conducted on , the Owner stated that prior to that the Owner had no role or responsibility with running the Facility. At 11:15am, the Owner stated that, "I don't know; I just started last week; [and], that is all on the [Former Owner]." At 06:30pm, the Owner acknowledged and confirmed that the Owner unaware of the care and services required by Resident #3 and #6 and stated that, "it's a mess but we will get everything put together."

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0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on observations and interviews, the Facility failed to post a copy of the Resident Bill of Rights and have telephone numbers for lodging complaints posted in an area accessible to residents. Additionally the Facility failed to provide a safe living environment for all residents admitted in to the Facility.

Findings Included:

Observations of the Facility, conducted on at 10:52am during tour, revealed that the Facility did not have a Resident Bill of Rights and telephone numbers for lodging complaints posted in an area accessible to residents. Further observation revealed unsafe chemical storage (See Photographic Evidence3 - Frames 1, 3, and 12). Additional observation revealed portable not secured in a safe holder or rack in a resident's closet (See Photographic Evidence3 - Frame 2). Additional observation revealed medicated creams and stored in Resident #5's closet not secured or locked in a cabinet or cart (See Photographic Evidence 3 - Frames 7, 8, 9, 10, and 11). Another observation revealed that the Facility had a bed flush up to the resident's closet preventing the resident from accessing own clothes from the closet and creating a risk if the resident attempted to access the closet (See Photographic Evidence3 - Frames 13 and 14).

During an interview with the Owner, conducted on at 10:50am, the Owner stated that prior to that the Owner had no role or responsibility with running the Facility. At 11:15am, the Owner stated that, "I don't know; I just started last week; [and], that is all on the [Former Owner]." At 06:30pm, the Owner acknowledged and confirmed the aforementioned safety and resident rights issues and stated that, "it's a mess but we will get everything put together."

Class III

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

Based on record review and interview facility failed to maintain the minimum direct care staffing hours required for six residents who currently reside in the facility, and failed to maintain a written work schedule that reflects its 24-hour staffing pattern.

Findings Included:

A direct care staffing schedule was requested on during survey. The Owner produced a staffing schedule for that reflected one staff scheduled from 7am-3pm, one staff from 10am-7pm, and

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one from 3pm-11pm (photo evidence).

At 5:36pm on the Owner stated that Staff A works Monday-Friday 7am-7pm, Staff B works 7pm-7am seven days a week, and that she does not know who works 7am-7pm on Saturday and Sunday.

The written schedule listed six staff, the Owner stated four staff were currently employed, and the schedule was amended during survey to reflect three staff (photo evidence). Due to the conflicting information, it was not possible to establish how many staffing hours were being provided for the residents on the date of survey.

Class III

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

Based on record review and interview, the Facility failed to maintain documented twice yearly and maintain a Health Assessment form for six Residents (#1, #2, #3, #5, #6, and #7) of seven-sampled resident who required assistance with care or total care with activities of daily living.

Findings Included:

A review of Resident #1's record, conducted on , revealed that Resident #1 had three documented in the resident's record on , , and . There was no date noted on Resident #1's Health Assessment Form. There were no other documented in Resident #1's record.

A review of Resident #2's record, conducted on , revealed that Resident #2's record did not contain a Health Assessment or Medical Examination Report. Resident #2 admitted in to the Facility on and had no documented in the resident's record.

A review of Resident #3's record, conducted on , revealed that Resident #3 had two documented in the resident's record on and . There was no date noted on Resident #5's Health Assessment Form. There were no other documented in Resident #5's record.

A review of Resident #5's record, conducted on , revealed that Resident # 5 had two documented on and in the resident's record. Resident #5's Health

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Assessment Form dated noted that the resident required supervision with all activities of daily living. Observations during survey revealed that Resident #5 required total care with all activities of daily living and the resident admitted under Hospice services. Resident #5 had no other documented in the resident's record. Resident #5 admitted in to the Facility on .

A review of Resident #6's record, conducted on , revealed that Resident #6 had no documented on the resident's Health Assessment Form dated . Resident #6's Health Assessment Form dated noted that the resident required total care wit hall activities of daily living. Resident #6 admitted in to the Facility on . Resident #6 had no other documented in the resident's record.

A review of Former Resident #7's record, conducted on , revealed that Former Resident #7 had one documented on the resident's Health Assessment Form dated and the resident's Health Assessment Form noted that the resident required assistance with all activities of daily living. Resident #7 had no other documented in the resident's record. Resident #7 admitted in to the Facility on .

During an interview with the Owner, conducted on , the Owner stated that prior to that the Owner had no role or responsibility with running the Facility. At 11:15am, the Owner stated that, "I don't know; I just started last week; [and], that is all on the [Former Owner]." At 06:30pm, the Owner acknowledged and confirmed that the Facility did not take and record residents' twice yearly as required and stated that, "it's a mess but we will get everything put together."

Class III

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

Based on observations, record reviews, and interview, the Facility failed to submit an Adverse Incident Report to the Agency of Health Care Administration for one Resident (#7) for a in which the resident sustained a bone.

Findings Included:

A review of Resident #7's record, conducted on , revealed that Resident #7 sustained a from a on . Resident #7's Health Assessment Form dated stated that the resident was a risk. There were no documented interventions or prevention measures documented in Resident #7's record. Resident #7 required assistance with all Activities of Daily Living.

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Upon Resident #7's return to the Facility on , the Facility had no documentation of any interventions or prevention measures to keep Resident #7 from a reoccurrence.

A review of incident reports for Resident #7, conducted on , revealed that the resident's incident report was inaccurate and incomplete. According to Resident #7's Hospital report, the resident's occurred on and not on as the incident report indicated. There were no notifications documented that the Facility notified Resident #7's Physician and Representative of the .

During an interview with the Owner, conducted on at 10:50am, the Owner uwas nable to explain the events surrounding Resident #7's . At 06:30pm, the Owner acknowledged and confirmed the aforementioned findings.

Class III