STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967480	**01/30/2019**
NAME OF PROVIDER OR SUPPLIER **A PLACE LIKE HOME ALF, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1971 PORT MALABAR BLVD** **PALM BAY, FL 32905**	

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

0000 - Initial Comments

The re-licensure survey was conducted on . . . . . A Place Like Home ALF, Inc. (License#11499) had deficiencies at the time of the visit.

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

Based on resident record review and interview, the facility failed to obtain a new AHCA Form 1823 Health Assessment for continued residency completed by a healthcare provider as required when the resident had a significant change for 1 of 2 sampled residents (#2).

Findings:

Resident #2's record review revealed admission date . The 1823 Health Assessment on file dated . . . . . Further review revealed resident #2 was admitted to Hospice care on . . . . . (a significant change). There was no evidence of a new 1823 Health Assessment completed by the healthcare provider as required for the significant change.

On . . . . . at 2 PM, an interview with the Administrator confirmed the finding.

Photographic evidence obtained

Class III

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

Based on resident record review and interview, the facility failed to maintain written progress notes for updates as needed for significant changes and written documentation that residents' healthcare provider and family, legal guardian, health care surrogate, or case manager was notified for the significant change as required for 2 of 2 sampled residents (#2 and #3) requiring supervision in the assisted living facility.

Findings:
1. Resident #2's record review revealed an admission dated of . . . . . A significant change occurred on when resident the resident was admitted to Hospice care. There was no documented evidence or no written progress notes found in the record that the physician, family, or legal representative were notified of the significant change.

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2. Resident #3's record review revealed an admission date of with a Hospice interdisciplinary certification date of . The health assessment ACHA form 1823 was not dated. There was no written progress notes found in the record.

On at 2:20 PM, an interview with the Administrator confirmed the findings.

Photographic evidence obtained

Class III

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

Based on observation and interview, the facility failed to honor personal dignity and infringement on residents rights for 3 of 3 sampled residents (#1, #2 and #3) with being treated with consideration and respect for the need of privacy.

Findings:

Observation during tour on at 10:30 AM, revealed there were cameras up on the wall inside all residents' rooms. In resident #1's and resident #3's shared room the camera was located in the right corner upper wall of resident #1's side of the room; camera positioned to view any activity happening inside the entire room for both residents. In addition to the above, resident #3 did not have a closed closet but a rack with her hanging clothes. Further observation in resident #2's private room, the camera was located and positioned at the top center left side of her room to view specifically the rail hospital bed.

On at 11 AM, the administrator was showed the cameras inside the resident rooms'. It was explained to the Administrator that this is against residents' rights, dignity for privacy and cameras can only be up in common area spaces such as living room, dining room, and kitchen. The administrator stated that she was not aware and thought it was okay to have the cameras in resident rooms. She further stated that she had the cameras in the resident rooms for safety precautions, in fear that residents may .

The Administrator further commented that she ran out of room of closet space with all of resident #1's personal belongings so she thought it was a great idea with the hanging rack for resident #3's personal belongings. It was explained that this was not fair to resident #3 and against resident #3's right to privacy

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for her personal belongings, especially in a shared room.

On at 4 PM, observed the cameras being taken down in each of the resident rooms.

On at 12:30 PM, an interview with resident #1's family member who stated that she was absolutely okay with the cameras being up in her mother's room because it was extra safety measure to ensure her mother would not . It was explained to the family member that it was against regulations and that it is why the caregiver staff work at the facility with a 24 hour/7 days a week staffing pattern to visually check on residents while in there room and .

On at 2 PM, an interview with resident #2 who stated she was wondering about the cameras but did not say nothing because she thought it was okay. Unable to speak with resident #3's family member after several messages left. Resident #3 is , and unable to interview.

On at 5 PM during the exit conference, the Administrator confirmed the findings.

Photographic evidence obtained

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(I)

Based on observation, resident record review and interview, the facility failed to adhere to the elopement policies and procedures for 1 of 1 sampled resident (#3) that is an elopement risk by not having a photo identification in the record, and identification on their person that include name, facility's name, facility's address, and facility's telephone as required.

Findings:
Observation on at 10:30 AM, resident #3 did not have identification on person (room) or was not wearing identification as an elopement risk with required information including name of resident, facility's name, address and telephone number.

Resident #3's record review revealed the health Assessment form 1823 identified the resident as an elopement risk by the health care provider. Further review revealed there was no photo identification of the resident in the record.

On at 2:30 PM, an interview with the Administrator confirmed the findings.

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Photographic evidence obtained

Class III

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

Based on observation of the facility's posted menu and interview, the facility failed to follow the current dated and planned menu one (1) week in advance for both the regular and therapeutic diets that expired, approved, and signed by a registered dietician annually as required.

Findings:

Observation on at 10:20 AM an outdated and expired cycle 3 menu posted on the hallway's bulletin board with date in use of . The menu last signed and dated by the registered dietician last year on and valid thru .

On at 11 AM, an interview with the Administrator, who confirmed the finding.

Photographic evidence obtained

Class III

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

Based on observation and interview, the facility failed to ensure and maintain a clean living environment of facility's ceilings, walls and air conditioning vent be free of stains and free of dirt.

Findings:
During tour observation on at 10:30 AM, saw the air conditioning vent located in the hallway was very dirty. Also there were staining on the ceiling near the dining room and staining in resident rooms ceiling for #1, #2 and #3.

On at 11 AM, the dirt and stains was shown to the Administrator.

Class III

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0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS

Based on resident record review and interview, the facility failed to include the provision regarding that a 14-day written notice of claim for refund included in the contract agreement for 2 of 2 sampled residents (#2 & #3) as required.

Findings:

Resident #2's record review revealed a contract agreement signed on but no written documentation about the 14-day notice of claim for refund provided.

Resident #3's record review revealed a contract agreement signed on . . . . . but no written documentation about the 14-day notice of claim for refund provided

On at 2:30 PM, an interview with the Administrator confirmed the findings.

Photographic evidence obtained

Class

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c); 59A-35.090(2)(d)-(3)

Based on personnel record review and interview, the facility failed to obtain a copy of the Attestation of Compliance with Background Screening (BGS) requirements, Agency for Healthcare Administration (AHCA) Form 3100-0008 for 1 of 4 sampled staff (D) as required.

Findings:
Staff D's personnel record review revealed a hire date . . . and a copy of the Level 2 BGS eligibility date as of . However, there was no documented evidence of the BGS Attestation of Compliance Form signed and dated in the file.

On . . . . . at 4:30 PM, an interview with the Administrator confirmed the finding.

Unclassified