STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968173	**05/09/2019**
NAME OF PROVIDER OR SUPPLIER **CASA SANTA MARTHA ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **1917 W MOHAWK AVE** **TAMPA, FL 33603**	

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

0000 - Initial Comments

A change of ownership (CHOW) survey was conducted at Casa Santa Martha Alf on . . . . . Deficiencies were identified at the time of survey.

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

Based on record review and interview, the facility failed to maintain an accurate Resident Health Assessment form, AHCA Form 1823 (1823) for 1 of 2 residents whose records were reviewed (Resident #3).

Findings Included:

A review of Resident #3's record, on , revealed the most recent 1823 form was dated . The resident's health care provider indicated on the 1823 assessment form, dated , that the resident required medication administration (photographic evidence obtained).

In an interview with the Administrator at 1:15pm on , the Administrator stated that Resident #3 does not require medications to be administered, that the resident only required assistance with medication self-administration. The Administrator stated the 1823 must have had an error on it and that it needed to be updated, or corrected, by the resident's health care provider.

Class III