Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ814 SS=C	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12(2) Care Provider Background Screening Clearinghouse.- (b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to update its employee roster in the Background Screening Clearinghouse (BGS) for 2 of 5 sampled Staff (Staff C and D). The findings included:	CZ814		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ814	Continued From page 1 Review of the facility's personnel files revealed, the following concerns: 1. On [redacted] and [redacted] Staff C, a Caregiver and Medication Technician (CG/MT) hired on [redacted], was observed providing direct care to residents of the facility throughout the survey. A Review of the BGS Clearinghouse on [redacted] at 3:12pm revealed, staff C was not listed on the facility's employee roster. 2. Review of the facility personnel files revealed, Staff D was hired on [redacted] as a Caregiver and Medication Technician. Staff D separated from the facility on [redacted]. Review of the BGS Clearinghouse revealed, Staff D's entry was not updated to reflect her "End Date" of [redacted]. This was discussed with the Administrator during a telephone interview conducted on [redacted] at 2:43 PM. Unclassified	CZ814		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced Complaint Investigation #2019014217 was commenced on . . . . . and concluded on at La Casa de Todos Inc. The facility had deficiencies identified at the time of the survey.	A 000		
A 010 SS=D	429.26(1&9) FS; 58A-5.0181(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (9) A . . . . , ill resident who no longer meets the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 010	Continued From page 1 physician who agrees that the physical needs of the resident are being met. 58A-5.0181 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a [illegible]-to-[illegible] medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 58A-5.0131, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days. (b) A resident requiring care of a [illegible] may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from the facility. (c) A [illegible] ill resident who no longer meets the criteria for continued residency may continue	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 010	Continued From page 2 to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C. This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to ensure a resident's Agency for Health Care Administration (AHCA) Form 1823 (health assessment) was updated as evidenced	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 010	Continued From page 3 by discrepancies between the health assessment and the resident's actual condition for 1 of 3 sampled Residents (Resident #1). The findings included: Review of Resident #1's medical records revealed, the resident was admitted to the facility on . . . . . Review of the residents health assessment dated on revealed, the assessment was done more than 60 days prior to her admission to the facility. The section titled, Medical History and Diagnoses included, " , severe ". The residents AHCA 1823 Section 1, Item A, documented the following information, To what extent does the individual need supervision or assistance with the following: "Assistance" with ambulation, bathing, . . , eating, self care, toileting and transferring. The form did not specify the extent and type of assistance needed. During an interview with the facility's administrator on . . . . . at 9:45 AM, the facility's Administrator reported, Resident #1 needed . . . . . with all activities of daily living and they had to feed her. The resident's AHCA 1823 revealed in Section 3 for Services Offered or Arranged by the Facility for the Resident, Needs identified from Sections 1 and 2, Services Needed, Service Frequency and Duration, Service Provider Name, and Initial Date of Service were all left blank. The resident's AHCA 1823 revealed in Section 1, Item D. In your professional opinion, can this individual's needs be met in an assisting living facility, which is not a medical, nursing or	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 010	Continued From page 4 facility? The answer was checked as "Yes". The comments included, "Need 24 [hour] Care". During a telephone interview with the Medical Doctor on at 3:23 PM, the Medical Doctor who completed the health assessment reported the resident had a history of . These concerns were discussed with the Administrator on at 2:43 PM. Class III	A 010		
A 027 SS=J	58A-5.0182(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making and remind residents about scheduled for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a health care provider. This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to facilitate resident health care services as evidenced by the facility staff failing to contact Emergency Medical Services ( ) when a resident was found , , for 1 of 3 sampled residents who are	A 027		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 027	Continued From page 5 (Resident #1). The findings included: During record review of the the facility's written policy titled, of Resident included (undated): "1- In case of the of a resident, the assistant administrator or nurses' aide supervisor is to contact "911" immediately. The administrator on call should then be contacted as well. 2- "911" will send the fire rescue squad; the paramedic will pronounce the official expiration. 3- Fire rescue will notify the police who will come to the facility and file a report. They will also notify the next of kin, the morgue and the attending physician. ..." Review of Resident #1's records revealed she was admitted to the facility on . Resident #1's Agency for Health Care Administration (AHCA) Form 1823 (health assessment) dated documented diagnoses of 's and severe . Further review of Resident #1's records revealed a yellow State of Florida DH Form 1896 ( ) dated , and signed by Family Members #1 and #2, and the resident's Medical Doctor. Review of Resident #1's Certification of revealed the time of as 6:30 AM on . Review of the county Emergency Medical Services ( ) report dated revealed, they were dispatched to the facility on at 9:07 AM. During an interview conducted on at 9:46 AM and 3:21 PM, the facility's Administrator provided the following information. Resident #1	A 027		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 027	Continued From page 6	A 027		

was very ill when she was admitted to the facility. She had been declining since the admission to the facility. The Administrator had recently discussed the possible use of hospice services with the family, but they declined the services. On around 7:15 AM, Staff C , one of the facility's caregivers, called her and told her Resident #1 was not breathing. Staff C was the only staff member on duty at the time. She told him to wait until she got there. She immediately came to the facility, in which she contacted the family members (#1 and #2). After family member #1 and #2 arrived, she told them they needed to call . The Administrator reported, it was the facility's policy that when a resident is found , , the staff member tries to wake the resident. If they can not wake the resident, they call the Administrator. She comes to the facility, calls the family, and they decide when to call . The Administrator reported, she did not instruct Staff C to perform on Resident #1.

Review of Resident #1's monthly progress notes dated through revealed four entries, that repeated the same information to include, "[Resident #1] is a patient who is very cheerful, has a good , good appetite, and sleeps very well." The record review revealed no documentation showing the resident was very ill or in decline.

Review of the facility's , staffing calendar, revealed the following. Staff C was the only staff member on duty at the time of the incident regarding Resident #1. It was noted that Staff C works a 24 hour shift Monday through Friday and noted on the calendar as "Live-In". In addition, Staff B is noted to work with Staff C, Monday through Friday from 7 AM to 7PM. However, Staff B was not present at the time of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 027	Continued From page 7	A 027		

the incident. During an interview with Staff C on at 9:55 AM, he also confirmed he was the only staff member present.

During an interview conducted on at 9:55 AM and 3:21 PM, with Staff C, the only Caregiver on duty when Resident #1 was found unresponsive, revealed the following information. Staff C reported, he checked on Resident #1 on around 3:00 AM, the resident was sleeping, and everything seemed fine. Around 7:15 AM on , he went to wake her up and found she was not breathing. Her , were half-opened, her was open, her , were purplish-blue around the edges, and she was sweating. Staff C reported, he called her name and touched her multiple times, lifted her to a sitting position and rubbed her and she was not breathing. He located a stethoscope and listened to her , but he did not hear a heartbeat. Staff C reported, he attempted and demonstrated his actions by putting one over the other and making a motion. He reports, he did not attempt -to- . Staff C reported, he called the facility's Administrator and was told to wait until she arrived. He did not know she had a ( ). Further, he stated he had not received training in the facility's policies and procedures regarding 's. This was also confirmed during an interview with the Administrator on at 3:21 PM, that Staff C had not received training in the facility's policy.

During telephone interviews conducted on at 11:14 AM and at 11:46 AM, Family Member #1 provided the following information about Resident #1. The resident had five "mini " in the past, her was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 027	Continued From page 8 "weak", and she was not receiving hospice services. She received a telephone call from the facility's Administrator on [redacted] around 6:55 AM that the resident had [redacted]. She asked the Administrator not to call [redacted], and that they would call [redacted]. She called Family Member #2, and went to the facility. [redacted] was called by Family Member #2 while at the facility. The exact time [redacted] was contacted by Family Member #2 could not be determined. During a telephone interview conducted on [redacted] at 3:32 PM, the Medical Doctor who completed the resident health assessment reported, the resident had a history of [redacted] / [redacted] written in the health assessment. The resident required assistance with all activities of daily living and, was at risk for [redacted]. During resident record review, it was noted Resident #1's health assessment did not include information about the residents [redacted]. The health assessment Section 1, Item D. revealed, In your professional opinion, can this individual's needs be met in an assisting living facility, which is not a medical, nursing or [redacted] facility? The answer was checked as "Yes". The comments included, "Need 24 [hour] Care". During a telephone interview conducted with Family Member #2 on [redacted] at 1:15 PM, the family Member reported, she received a call from Family Member #1 on [redacted] around 7:05 AM informing her Resident #1 had [redacted]. She and her spouse arrived at the facility around 7:30 AM. At some point, the Administrator stated they needed to call [redacted]. Family Member #2 called [redacted] shortly thereafter.	A 027		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 027	Continued From page 9 Review of the report revealed, was dispatched approximately 1 ½ hours after the resident was found . Review of the County Sheriffs report dated revealed, an officer responded to the facility at 9:30 AM. Class I	A 027		
A 030 SS=J	58A-5.0182(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 58A-5.0182 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 58A-5.0181, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline,	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 10	A 030		

1(800)96- . . . . or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 58A-5.0181, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident . . . . , neglect, and
. ;
6. Administrative and housekeeping schedules and requirements;
7. . . . . control, sanitation, and universal precautions; and,
8. The requirements for coordinating the delivery of services to residents by third party providers.
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 11 telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . . . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 12	A 030		

community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident ' s representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a room with his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making . . . . . for health care services, the provision of or arrangement of transportation to health care . . . . . , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.
(k) At least 45 days ' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 13 mentally , the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 14 resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident ' s access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27(1)(a), FS Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to ensure a staff member, who did not hold a certification in , ( ) and was left alone with residents, followed facility policies and procedures related to ( ); as evidenced by Staff C performing	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 15 on a resident who had a and failing to honor the resident rights to withold life-sustaining treatment , for 1 of 4 sampled Residents (Resident #1). The findings included: During record review it was revealed, the facility's written policy titled, & Advanced Directives Policy (undated) included: The facility will carry out the legal and medical wishes of a that has been completely filled out by resident / legal representing guardian and a physician. The facility will only honor a state of Florida ( ) that is on yellow paper and has been executed. A Resident has the right to have a third party assigned to the decision making, if he / she is not of capacity to do so. The facility will not administer , insert an airway, administer resuscitative drugs, defibrillate or , provide assistance, initiate resuscitative ( ) , or initiate monitoring. Purpose - This policy is intended to provide a guidelines for action, either when a resident (or surrogate) wants to limit unwanted interventions or when a patient (or surrogate) requests an intervention not recommended by the responsible physician. Residents or their legal representatives will be involved in all aspects of their care, including the decision whether to withhold resuscitative services and to forego or withdraw life-sustaining treatment. A patient has the right to refuse life-sustaining support, including ( ) . The purpose of this order is to direct the staff / administration of the facility what to do in the event of a resident's / stop operating	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 16 and they have a . Omission of the is to be only for the situation where it relates to the . For example, if a resident is choking and it is unrelated to their then appropriate care is to be rendered. A directs staff not to apply lifesaving skills (ex:). Procedure: 1. All prospective resident's, and / or their guardian, legal representative must read the policy, purposes, procedure & definition. 2. Complete the "", (either giving permission or refusing permission to), 3. File it in the resident's records and record on the resident binder cover, with an indication the resident is not to be . There is to be indication on the resident's binder if the resident is to be . 4. All staff are to be trained and or informed when a resident is not to be . (as they relate to this policy) Review of Resident #1's records revealed she was admitted to the facility on . Resident #1's Agency for Health Care Administration (AHCA) Form 1823 (health assessment) dated documented diagnoses of 's and severe . Further review of Resident #1's records revealed a yellow State of Florida DH Form 1896 ( ) dated , and signed by Family Members #1 and #2, and the resident's Medical Doctor. Review of Resident #1's Certification of revealed the time of as 6:30 AM on . Review of the county Emergency Medical Services ( ) report dated revealed, they were dispatched to the facility on at 9:07 AM.	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 17 During an interview conducted on at 9:46 AM and 3:21 PM, the facility's Administrator provided the following information. On around 7:15 AM, Staff C, one of the facility's caregivers, called her and told her Resident #1 was not breathing. Staff C was the only staff member on duty at the time. She told him to wait until she got there and notified the Resident's family member. The Administrator reported, it was the facility's policy that when a resident is found , , the staff member tries to wake the resident. If they can not wake the resident, they call the Administrator. She comes to the facility, calls the family, and they decide when to call Emergency Medical Services ( ). The Administrator reported, she did not instruct Staff C to perform on Resident #1. During an interview conducted on at 9:55 AM and 3:21 PM, with Staff C, the Caregiver on duty when Resident #1 was found unresponsive, revealed the following information. Staff C reported, he checked on Resident #1 on around 3:00 AM, the resident was sleeping, and everything seemed fine. Around 7:15 AM on , he went to wake her up and found she was not breathing. Her , were half-opened, her was open, her , were purplish-blue around the edges, and she was sweating. Staff C reported, he called her name and touched her multiple times, lifted her to a sitting position and rubbed her and she was not breathing. He located a stethoscope and listened to her , but he did not hear a heartbeat. Staff C reported, he attempted and demonstrated his actions by putting one over the other and making a motion. He reports, he did not attempt -to- . Staff C reported,	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 18 he called the facility's Administrator and was told to wait until she arrived. He did not know she had a . . Further, he stated he had not received training in the facility's policies and procedures regarding . . This was also confirmed during an interview with the Administrator on at 3:21 PM, that Staff C had not received training in the facility's policy. Class I	A 030		
A 083 SS=J	58A-5.0191(5) FAC Training - First Aid and . (5) FIRST AID AND . . . . . ( ). A staff member who has completed courses in First Aid and . and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American . . Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by:	A 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 083	Continued From page 19 Based on observations, interviews, and record review, the facility failed to ensure one staff member with current certification of training in First-Aid and , ( ) was present in the facility at all times, for 1 out of 4 sampled staff members (Staff C) and the Administrator. This has the potential to affect all current residents of the facility. The findings included: On , from 9:24 AM to 9:41 AM, Staff C, a Caregiver and Medication Technician, was observed to be the only staff member present at the facility. He was observed providing direct care to residents of the facility. At 9:41 AM, the facility's Administrator arrived at the facility. She was observed providing direct care to residents of the facility. Both Staff C and the Administrator were observed providing direct care to residents on from 3:07 PM to 5:10 PM. Review of the facility's personnel files conducted on revealed the following concerns: 1. Staff C was hired on . Review of his personnel file revealed no documentation showing he held a current certification in first aid and . This was brought to the Administrator's attention on . She reported, he had training and they were waiting to receive his certification cards. As of the end of the day on , no certificate or other documentation was received for review. Review of the facility's staffing schedules for and , revealed Staff C was scheduled as a "Live In" caregiver, he was the sole staff member scheduled for Monday through Friday from 7:00 PM to 7:00 AM.	A 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 083	Continued From page 20 During an interview conducted on at 9:55 AM, Staff C provided the following information. On , Resident #1 was observed by Staff C (only staff member present in the facility) in her bed at about 7:15 AM. Her , were half-open, her was open, she was sweating, he could see she was not breathing. He located a stethoscope and listened to her , he could not hear anything. He attempted and demonstrated his actions with his overlapping the other and making a compressing motion. He reported, he did not attempt -to- . He called the facility's Administrator to report the condition of the resident and the administrator instructed him to wait until she got there (refer to A0025 and A0076). 2. Review of the facility's Administrator/Owner's personnel file revealed certifications for first aid and that expired on . Record review of her personnel file revealed no current certifications. Review of the staffing schedules provided shows the Administrator is on call 24/7; and scheduled to work on Mondays from 7AM to 7 PM with Staff C. Further record review revealed neither Staff C or the Administrator had documentation showing current certification in First-Aid and . These concerns were brought to the Administrator's attention on at 2:43 PM. As of the day survey on , no certificates or other documentation was received. Class I	A 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 090	Continued From page 21	A 090		
A 090 SS=J	58A-5.0191(11) FAC Training - . . . (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding . . within 30 days after employment. (c) Training shall consist of the information included in rule 58A-5.0186, F.A.C. This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to ensure staff received the required training in the facility's policy and procedures regarding . . . . . (. . .), for 3 of 4 sampled Staff (Staff B, D, C). As evidenced of Staff C, who lacked training in and not honoring a resident's when found unresponsive by performing . . . . , on the resident, for 1 out of 4 sampled residents (Resident #1). The findings included: During an interview conducted on . . at 9:55 AM and 3:21 PM, with Staff C revealed he had not received training in the facility's policy	A 090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 090	Continued From page 22 and procedures regarding ; and that he was the only Caregiver on duty when Resident #1 was found unresponsive. Staff C reported, he attempted , , ( ) on Resident #1 when she was found unresponsive and demonstrated his actions by putting one over the other and making a , motion. He stated he did not know Resident #1 had a . This was also confirmed during an interview with the Administrator on at 3:21 PM, that Staff C had not received training in the facility's policy. Review of Staff C's file, revealed no certificate of training or documentation showing he received the required training in the facility's policies and procedures. According to the Administrator, Staff C had recently started working at the facility and had not been employed more than 30 days. Staff C was the sole employee working on (day of the incident involving Resident #1), no other staff member present with training. Further record review also revealed two other staff members (Staff B and Staff D) had not received the required in-service trainings. 1. Staff B was a Caregiver and Medications Technician (CG/MT) hired on . Review of her personnel file on revealed no certificate of training or documentation showing she received the required training in the facility's policies and procedures. This was brought to the Administrator's attention on at 3:20 PM. As of the end of the day on , no certificate or documentation was received for the training.	A 090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 090	Continued From page 23 2. Staff D was a CG/MT hired on . . . . . . Review of her personnel file on revealed no certificate of training or documentation showing she received the required training in the facility's . . policies and procedures. This was brought to the Administrator's attention on . . . . . at 2:43 PM. As of the end of the day on , no certificate or documentation was received for the . . training. Class I	A 090		
A 160 SS=D	58A-5.024(1) FAC Records - Facility The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a . . . . . ; and 2. Date of discharge, reason for discharge, and identification of the facility or home address to	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 160	Continued From page 24 which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 58A-5.025, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 58A-5.026, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 58A-5.021, F.A.C.; (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 58A-5.021, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 58A-5.0181, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 58A-5.0182, F.A.C. (j) All food service records required in Rule 58A-5.020, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 160	Continued From page 25 services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain an up-to-date admission and discharge log for 4 of 6 sampled Residents (Residents #1, 2, 3 and 6). The findings included: Review of the facility's admission/discharge log conducted on . . . . . at 9:48 AM revealed the following concerns: 1. Resident #1 was admitted to the facility on . . . . . and , ... , on . . . . . Her information was not added to the	A 160		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 160	Continued From page 26 admission/discharge log. Facility staff did not document her name, date of admission, where she was admitted from, and the date of . 2. Resident #6 was admitted to the facility on . His information was not added to the admission/discharge log. Facility staff did not document his name, date of admission, and where he was admitted from. 3. Resident #2 , , on . Facility staff did not update the admission/discharge log with the resident's date of . 4. Resident #3 , , on . Facility staff did not update the admission/discharge log with the resident's date of . This was discussed with the Administrator on at 9:52 AM. She stated the admission/discharge log was prepared by her consultant and she was waiting to receive it . Class III	A 160		
A 162 SS=D	58A-5.024(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name; 2. ; 3. Race; 4. Date of birth; 5. Place of birth, if known; 6. Social security number; 7. Medicaid and/or Medicare number, or name of other health insurance ; 8. Name, address, and telephone number of next	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 162	Continued From page 27 of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in Rule 58A-5.0181, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider ' s order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 58A-5.020, F.A.C., if applicable. (e) The resident care record described in paragraph 58A-5.0182(1)(e), F.A.C. (f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 58A-5.0181, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 58A-5.0185, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 58A-5.025, F.A.C.	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 162	Continued From page 28 (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No =Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 58A-5.0181, F.A.C. (o) The resident ' s , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 162	Continued From page 29 the discretion of the facility: 1. A log listing the names of residents participating in this arrangement; 2. The resident demographic data required in this paragraph; 3. The health assessment described in Rule 58A-5.0181, F.A.C.; 4. The resident's contract described in Rule 58A-5.025, F.A.C.; and 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to maintain documentation of resident [redacted] on a semi-annual basis for 2 of 3 sampled Residents (Resident #4 and #5). The findings included: Review of resident medical records revealed the following concerns: 1. Resident #4 was admitted to the facility on [redacted]. Review of her Monthly [redacted] and	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968625	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA DE TODOS INC	2364 WEST LAKEWOOD ROAD WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 162	Continued From page 30 . . Chart form revealed one entry dated . There were no other entries documenting the residents . . had been taken and recorded for 13 months. Further review of her file revealed no documentation of . . since /18. Review of the Resident#4's Health Assessment confirmed resident requires assistance with Activities of Daily Living (ADLs). 2. Resident #5 was admitted to the facility on . . . . . Review of her Monthly . . and . . Chart form revealed one entry dated . . . . . There were no other entries documenting the residents . . had been taken and recorded for 20 months. Further review of her file revealed no documentation of . . since . . . . . Review of the Resident#5's Health Assessment confirmed resident requires assistance with Activities of Daily Living (ADLs). This was brought to the Administrator's attention during a telephone interview conducted on . . . . . at 2:43 PM. Class III	A 162		