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
	AL11968271	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNE'S HOME ALF INC	955 TUSKAWILLA RD WINTER SPRINGS, FL 32708

(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 [redacted] to [redacted] conducted Complaint inspection #2013001960. The Allegations were substantiated. Anne's Home Assisted Living Facility had deficiencies found at the time of the visit.	A 000		
A 007	58A-5.0181(1) FAC Admissions - Criteria Admission Procedures, Appropriateness of Placement and Continued Residency Criteria. (1) ADMISSION CRITERIA. An individual must meet the following minimum criteria in order to be admitted to a facility holding a standard, limited nursing or limited mental health license: (a) Be at least [redacted] (b) Be free from signs and symptoms of any communicable [redacted] which is likely to be transmitted to other residents or staff; however, a person who has [redacted] may be admitted to a facility, provided that he would otherwise be eligible for admission according to this rule. (c) Be able to perform the activities of daily living, with supervision or assistance if necessary. (d) Be able to transfer, with assistance if necessary. The assistance of more than one person is permitted. (e) Be capable of taking his/her own medication with assistance from staff if necessary. 1. If the individual needs assistance with self-administration the facility must inform the resident of the professional qualifications of facility staff who will be providing this assistance, and if unlicensed staff will be providing such assistance, obtain the resident ' s or the resident ' s surrogate, guardian, or attorney-in-fact ' s written informed consent to provide such assistance as required under Section 429.256,	A 007		

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A 007	Continued From page 1 F.S. 2. The facility may accept a resident who requires the administration of medication, if the facility has a nurse to provide this service, or the resident or the resident ' s legal representative, designee, surrogate, guardian, or attorney-in-fact contracts with a licensed third party to provide this service to the resident. (f) Any special dietary needs can be met by the facility. (g) Not be a danger to self or others as determined by a physician, or mental health practitioner licensed under Chapters 490 or 491, F.S. (h) Not require licensed professional mental health treatment on a 24-hour a day basis. (i) Not be bedridden. (j) Not have any or 4 pressure sores. A resident requiring care of a pressure may be admitted provided that: 1. The facility has a LNS license and services are provided pursuant to a plan of care issued by a physician, or the resident contracts directly with a licensed home health agency or a nurse to provide care; 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 licensed nurse or physician, the resident shall be discharged from the facility. (k) Not require any of the following nursing services: 1. Oral, or suctioning; 2. Assistance with tube feeding; 3. Monitoring of gases; 4. Intermittent positive pressure breathing or 5. Treatment of surgical or wounds,	A 007		

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A 007	Continued From page 2 unless the surgical [redacted] or [redacted] and the condition which caused it have been stabilized and a plan of care developed. (l) Not require 24-hour nursing supervision. (m) Not require skilled rehabilitative services as described in Rule 59G-4.290, F.A.C. (n) Have been determined by the facility administrator to be appropriate for admission to the facility. The administrator shall base the decision on: 1. An assessment of the strengths, needs, and preferences of the individual, and the medical examination report required by Section 429.26, F.S., and subsection (2) of this rule; 2. The facility ' s admission policy, and the services the facility is prepared to provide or arrange for to meet resident needs; and 3. The ability of the facility to meet the uniform fire safety standards for assisted living facilities established under Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C. (o) Resident admission 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 record review and interview the facility failed to follow admission criteria and admitted 1 of 5 sampled residents (#2) who were harmful to themselves of others. Findings: Resident record review revealed an Assisted Living Facility health assessment form 1823 dated [redacted] with diagnoses of [redacted] and	A 007		

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A 007	Continued From page 3	A 007		

agitation. The 1823 stated the resident posed a danger to self or others due to agitation and punched the family. The resident was admitted on

The resident was observed on _____ at approximately 2:45 PM walking in facility. Attempted to interview the resident, who due to her _____ was unable to speak English anymore and reverted to her primary language.

Review of Altamonte Springs Police report #20122021923 dated _____ at 16:17 stated officer responded in regard to a disturbance near a restaurant in Altamonte Springs. Resident #2 was with the ALF caregivers on an errand for the first time and became upset when she could not get out of the car. The resident got agitated easily, due to _____ and hit the caregiver in the head. The caregiver placed her hand on the resident's arm to stop her. The resident and caregiver were sitting in the back seat of the car when the officer arrived. The resident was still attempting to hit the caregiver in the face. The resident had no visible signs of injury. The resident's family member was contacted and she confirmed the resident had _____ was with her caregiver from the ALF and became upset very easily and that she trusted her caregiver.

The resident was harmful to herself or others due to her agitation upon admission to the facility, was inappropriate for admission and was at risk of punching others.

Interview on _____ at 2:30 PM with the manager who stated she and her family member took the resident to the mall. When they got to their destination the resident stated I am almost home and was trying to get out of the car. There was a police not too far away. The police came and talked to her and told her she could not leave.

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A 007	Continued From page 4 The police called the family member, who stated the manager was the caregiver and she knew I was the caregiver. The resident was not being restrained or held back when the police came. She also stated she was not aware the 1823 stated the resident was a danger to self or others and did not state there were concerns with the resident's behavior at that time. Class III	A 007		
A 008	58A-5.0181(2) FAC Admissions - Health Assessment (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a face-to-face medical examination completed by a licensed health care provider, as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days prior to the individual ' s admission to a facility pursuant to Section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations; 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living; 3. Any nursing or services required by the individual; 4. Any special diet required by the individual; 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication; 6. Whether the individual has signs or symptoms of a communicable which is likely to be transmitted to other residents or staff; 7. A statement on the day of the examination that, in the opinion of the examining licensed health care provider, the individual ' s needs can be met	A 008		

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A 008	Continued From page 5	A 008		

in an assisted living facility; and
8. The date of the examination, and the name, signature, address, phone number, and license number of the examining licensed health care provider. The medical examination may be conducted by a currently licensed health care provider from another state.
(b) A medical examination completed after the resident ' s admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, 2010. The form is hereby incorporated by reference. A faxed copy of the completed form is acceptable. A copy of AHCA Form 1823 may be obtained from the Agency Central Office or its website at www.fdhc.state.fl.us/MCHQ/Long_Term_Care/ <http://www.fdhc.state.fl.us/MCHQ/Long_Term_Care/> Assisted_living/pdf/AHCA_Form_1823%.pdf. The form must be completed as follows:
1. The resident ' s licensed health care provider must complete all of the required information in Sections 1, Health Assessment, and 2, Self-Care and General Oversight Assessment.
a. Items on the form that may have been omitted by the licensed health care provider during the examination do not necessarily require an additional face-to-face examination for completion.
b. The facility may obtain the omitted information either verbally or in writing from the licensed health care provider.
c. Omitted information received verbally must be documented in the resident ' s record, including the name of the licensed health care provider, the name of the facility staff recording the information and the date the information was provided.
2. The facility administrator, or designee, must

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A 008	Continued From page 6 complete Section 3 of the form, Services Offered or Arranged by the Facility, or may use electronic documentation, which at a minimum includes the elements in Section 3. This requirement does not apply for residents receiving: a. Extended congregate care (ECC) services in facilities holding an ECC license; b. Services under community living support plans in facilities holding limited mental health licenses; c. Medicaid assistive care services; and d. Medicaid waiver services. (c) Any information required by paragraph (a) that is not contained in the medical examination report conducted prior to the individual ' s admission to the facility must be obtained by the administrator within 30 days after admission using AHCA Form 1823. (d) Medical examinations of residents placed by the department, by the Department of Children and Family Services, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.426, F.S., and this rule. (f) Any orders for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility issued by the licensed health care provider conducting the medical examination may be attached to the health assessment. A licensed health care provider may attach a order for residents who do not wish to be administered in the case of or	A 008		

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(g) A resident placed on a temporary emergency basis by the Department of Children and Family Services pursuant to Section 415.105 or 415.1051, F.S., shall be exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement shall be entered on the facility ' s admission and discharge log and counted in the facility census; a facility may not exceed its licensed capacity in order to accept a such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission.

This Statute or Rule is not met as evidenced by:
Based on record review and interview the facility failed to ensure the AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, 2010 included the required information for 2 of 5 sampled residents (#2 & #5).

Findings:

1. Resident record review for #2 revealed an Assisted Living Facility health assessment form 1823 dated with diagnoses of and agitation. Review of the 1823 did not indicate what type of assistance the resident needed with medications.

2. Resident record review for #5 revealed an Assisted Living Facility health assessment form 1823 dated with diagnoses stated and The 1823 did not indicate what type of assistance

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A 008	Continued From page 8 the resident needed with medications, that the resident was appropriate for placement in the ALF and that the resident did not have communicable Interview with the manager on [redacted] at approximately 3 PM who stated she was not aware the 1823's did not include the required information. Class III	A 008		
A 025	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual. (c) General awareness of the resident ' s whereabouts. The resident may travel independently in the community. (d) Contacting the resident ' s health care provider and other appropriate party such as the resident ' s family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection	A 025		

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58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.

This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to: 1. Provide adequate supervision and have general awareness of resident whereabouts at all times 2. Have implemented a plan to prevent the resident, who was eloped from the facility 3 times, the last elopement the resident was found 6 miles away from the facility on a busy highway, from continued elopements 3. Document significant changes for 1 of 5 sampled residents (#1).

Findings:

Resident record review for #1 revealed an Assisted Living Facility health assessment form 1823 dated with diagnoses of and and indicated the resident used a walker, was a l risk and had difficulty with recall. The resident needed assistance with all activities of daily living.

Interview on at approximately 3:15 PM with Staff A who stated: She was a home health aide, had worked in the facility for 2 weeks and had worked in another facility for 1 month, where she got her ALF training.

On resident #1 told me he wanted to go home, I told him he needed to wait for my manager, as I could not leave. He stated I don't feel good, I feel like I am in jail. His family did not come to see him. He ate breakfast and stated he

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wanted to go outside for a little bit. I told him it was ok, the manager stated he could go sit outside in a chair. I could see him through the kitchen window. I went to help a resident to the [redacted] I went to check on him. I did not see him, I called the manager, she stated to call 911, I did and the police found him 6 miles away. The police were looking for him; he was gone a long time. They found him and brought him back. He was ok when he came back.

On [redacted] at 9 AM, after breakfast, resident #1 stated he did not want his medicine, he had a plastic bag and his cane, he told me he wanted to leave, I told him you can't go, please come back, he said no, I called 911, then called the manager. I saw him walk off down the street. Every time he tried to go, I said to him to come play dominos with me, he stated no, I'm going to my [redacted] watch TV. He does not want to be with the other residents. He says I want to go home; no one comes to see me. The police came to the facility with the resident about 6 minutes later.

Interview with the manager on [redacted] at 10:45 AM who stated Staff A was at the facility, when resident #1 went outside on [redacted] his family member gave him permission to sit outside. He came in and went back out again. The staff was watching him and called me and stated that she did not see him outside. Then the manager called 911. He walked 6 miles; it was at least 1 1/2 hours before they found him.

We called the police on [redacted] when the resident wanted to go home. The police stated they cannot come out unless the resident walked out the door.

Continued interview with the manager regarding

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the _ _ elopement who stated Staff A called me to tell me resident #1 wanted to go home at 7:30 and 7:45 AM. The manager talked to the resident and stated she needed to call his wife. We did a 3 way call with the family member and the resident and I, at about 8 AM. He stated to the family member he wanted to go home. The family member stated she was going to come to the facility and she wanted the manager to call the police. The staff stated to the family member, if he is not listening to us we will need to get the physician to get him evaluated. When the staff took another resident to the resident #1 walked out. Staff A called and told the manager he walked out, the manager told her to call the police. They came right out and found him near the facility.

The manager stated the resident got out in 2012, the resident stated he was going to get ice cream, he was almost at Winter Springs Boulevard (about a mile away from the facility), I called the police. I could not leave. She also confirmed the resident left the facility on _ and returned by the police.

The manager was then asked by the surveyor, what had the facility put in place to keep resident safe. The manager stated she took him to physician for an evaluation he ordered 25 milligrams twice a day for agitation. The manager was informed that the medication was a not an adequate plan to keep the resident safe and from further elopements, and he needed to be in a secure unit.

Interview on _ _ at 10 AM with resident #1 who stated, I feel like I'm in jail and I just got out of jail. He stated he did not have identification on his person. He stated he went to the physician

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yesterday and he wanted to give him shots for mental reduction. It's normal living here, I don't like it here. I can't walk away without the police after me. I got a mile away and 3 police surrounded me. They had me get into the car and brought me back. "I got 6 miles away the other day. I sat down, at a closed restaurant outside on a chair and took my shoes and socks off. The chair slipped and I [illegible] on the deck and I couldn't get up. No one came, traffic was going by. A woman came by who worked at the restaurant. I wasn't hurt, I pulled myself up. She took me in and gave me some lemonade and then the police came, put me in the car and brought me back here. I got clear down to Aloma". The resident was unable to state the address of the ALF and stated 2 other addresses. I didn't take my cane with me. A four prong cane was observed by his bed at the time.

He also stated, "It happened about 3 weeks ago, the same thing, I didn't get as far, I just wandered away, they said they looked for me in about 4-5 counties, I was gone about 1/2 day. I can't remember all of that."

Phone interview with the family member on [redacted] at approximately 12:55 PM who stated she was aware of resident's 3 elopements. She also stated someone from a secure, memory care unit would be there to assess the resident soon.

Phone call to Deputy A with the Seminole County Sheriff's office at approximately 1:15 PM, who stated he responded to the house of the owner of the facility, she dialed 911, she told staff to call her first. She was not there when 911 arrived at the facility. The owner stated the resident had [redacted] He went to the facility and the owner

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(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
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showed up. There was a communication problem between resident #1 and the staff. Our biggest concern was the resident wanders off and there needs to be some level of supervision. He talked to the family member yesterday, she wanted the resident to be [redacted] and I told her no. He was supposed to go to physician yesterday for a checkup. This was the 3rd time he had eloped from the facility, he was last found near Aloma and State Road 436. We suggested to the family he needed a facility where he would get more supervision. The family had concerns regarding the finances. They want him to come back home, but he was acting out and aggressive with the spouse.

Police Report #1
Review of police Event Detail for Missing Person dated [redacted] at 13:38:11 stated resident #1 was on foot, resident has [redacted] left sitting on porch, resident located on Winter Springs Boulevard on Tuskawilla Road, had visual on him on [redacted] at 13:46:59, subject returned to caregiver and event cleared on [redacted] at 13:58:08.

Police Report #2
Review of Seminole County Sheriff's Office report 2013043112 dated [redacted] at 10:25 AM stated an officer was dispatched to the ALF regarding a missing adult that was possibly endangered due to suffering from [redacted] Staff A was at the ALF and stated resident #1 went to sit outside in the rear of the house at approximately 10:15 AM and he was missing at approximately 10:20 AM. She called the manager and then called 911.

Upon arrival the area was searched with negative results. Staff A stated to the police the resident

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	AL11968271	A. BUILDING: _____ B. WING _____	

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had ... and did not take his medications today which he normally took and did not have any problems.

A short while later deputies located the resident walking on Aloma Avenue in Winter Park. The resident was escorted back to the ALF. The deputy advised the resident had ... and hurt his knees, but he denied medical attention. The deputy advised the resident had soiled himself and was covered in feces. The Seminole County Fire Department was contacted and responded to the ALF to check on the resident. They cleared the resident of injuries and assisted the staff in cleaning him up. The family was notified. Review of police Event Report revealed the resident was located on ... at 12:15:06 and the event was cleared on ... at 12:47:37.

Police Report #3
Review of police report dated ... at 9:19:27 call received, dispatched to the ALF regarding resident #1, who had walked away from the facility. Resident #1 was identified by deputies a short distance from the facility and returned. Review of police Event Detail revealed the last entry was on ... at 9:43:44.

The deputy met with the manager/owner at the facility who stated to him the resident had ... had been in the facility about 8 months and had previously walked away from the facility on ... and was found in Orange County. There had been no other issues with the resident at the facility other than the prior incident when he had walked away. The family was contacted and had made an appointment with the resident's physician for 2 PM on that date.

On ... at approximately 1:20 PM, staff from

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A 025	Continued From page 15 an ALF with a secure memory care unit came to assess the resident and stated they would admit him to their facility. The family relocated resident to secure unit at approximately 4:15 PM. Review of facility notes revealed there was no documentation to indicate the resident had eloped from the facility on [redacted]. There was no documentation to review to indicate the family or physician had been notified when the resident eloped on [redacted] and [redacted]. The facility did not provide adequate supervision and have knowledge of the resident's whereabouts at all times to keep him safe, let the resident sit outside unattended and unsupervised when he had a history of multiple elopements. The facility had no proactive plan in place to prevent further elopements with potential injuries and did not document significant changes. Class II	A 025		
A 030	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (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 Council shall 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 shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend	A 030		

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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 address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456.
(d) The statewide toll-free telephone number of the Florida Hotline " 1(800)9€ or 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents.
(e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility ' s policies with respect to such issues, for example, as resident responsibilities, the facility ' s and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements.
(f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law.
(g) The facility shall provide residents with

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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 shall not prohibit 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 shall be, at a minimum, an accessible telephone on each floor of each building where residents reside.
(h) Pursuant to Section 429.41, F.S., the use of physical shall be limited to half-bed rails, and only upon the written order of the resident ' s physician, who shall review the order biannually, and the consent of the resident or the resident ' s representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be 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

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A 030	Continued From page 18 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 community services and activities and to achieve 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 . . . 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) Access to adequate and appropriate health care 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	A 030		

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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.

This Statute or Rule is not met as evidenced by:
Based on observation and interview the facility failed to ensure they did not use on the front and back facility doors that would prevent the residents from safely exiting the facility.

Findings:

Observation on at approximately 12 PM revealed there were childproof plastic covers on the inside door handles on the front door of the facility and the back door, near the kitchen. The surveyor was unable to open either door to exit the facility without the staff opening the door. The residents were at risk of not being able to exit the facility in an emergency due to the apparatus the facility placed on the doors.

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A 030	Continued From page 20 Phone interview with the Seminole County Fire Department inspector on ____ : at approximately 4 PM who stated regarding the childproof covers over the inside door handles on the front and rear doors of the facility, that the doors could not require special knowledge or effort for operation from the egress side of the door. The facility removed the childproof plastic door handles from both doors on ____ at approximately 4:15 PM. Interview with the manager on ____ at approximately 4:15 PM who was not aware the door handles were a form of physical ____ preventing the residents from exiting the facility. Class III	A 030		
A 032	58A-5.0182(8) FAC Resident Care - Elopement Standards (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement shall be identified so staff can be alerted to their needs for support and supervision. 1. As part of its resident elopement response policies and procedures, the facility shall make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility ' s name, address, and telephone number. Staff attention shall be directed towards residents assessed at high risk for elopement, with special attention given to those with ____ and related ____ assessed at high risk.	A 032		

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2. At a minimum, the facility shall have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The photo identification shall be made available for the file within 10 calendar days of admission. In the event a resident is assessed at risk for elopement subsequent to admission, photo identification shall be made available for the file within 10 calendar days after a determination is made that the resident is at risk for elopement. The photo identification may be taken by the facility or provided by the resident or resident ' s family/caregiver.
(b) Facility Resident Elopement Response Policies and Procedures. The facility shall develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures shall include:
1. An immediate staff search of the facility and premises;
2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities;
3. The identification of staff responsible for contacting law enforcement, the resident ' s family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and
4. The continued care of all residents within the facility in the event of an elopement.
(c) Facility Resident Elopement Drills. The facility shall conduct resident elopement drills pursuant to Sections 429.41(1)(a)3. and 429.41(1)(l), F.S.

This Statute or Rule is not met as evidenced by:
Based on observation, record review and interview the facility failed to ensure a resident

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with any history of elopement had identification on their person that included their name, the facility's name, address and telephone number for 1 of 5 sampled residents (#1).

Findings:

Resident record review for #1 revealed an Assisted Living Facility health assessment form 1823 dated [redacted] with diagnoses of [redacted] and [redacted]; and indicated the resident used a walker, was a [redacted] risk and had difficulty with recall. The resident needed assistance with all activities of daily living.

Police Report #1
Review of Police Event Detail for Missing Person dated [redacted] at 13:38:11 stated resident #1 was on foot, resident has [redacted], left sitting on porch at facility, resident located on Winter Springs Boulevard on Tuskawilla Road, had visual on him on [redacted] at 13:46:59, subject returned to caregiver and event cleared on [redacted] at 13:58:08.

Police Report #2
Review of Seminole County Sheriff's Office report 2013043112 dated [redacted] at 10:25 AM stated an officer was dispatched to the ALF regarding a missing adult that was possibly endangered due to suffering from [redacted] Staff A was at the ALF and stated resident #1 went to sit outside in the rear of the house at approximately 10:15 AM and he was missing at approximately 10:20 AM. She called the manager and then called 911.

Upon arrival the area was searched with negative results. Staff A stated to the police the resident had [redacted] and did not take his medications today which he normally took and did not have

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A 032	Continued From page 23 any problems. A short while later deputies located the resident walking on Aloma Avenue in Winter Park. The resident was escorted back to the ALF. The deputy advised the resident had and hurt his knees, but he denied medical attention. The deputy advised the resident had soiled himself and was covered in feces. The Seminole County Fire Department was contacted and responded to the ALF to check on the resident. They cleared the resident of injuries and assisted the staff in cleaning him up. The family was notified. Review of police Event Report revealed the resident was located on at 12:15:06 and the event was cleared on at 12:47:37. Police Report #3 Review of police report dated at 9:19:27 call received, dispatched to the ALF regarding resident #1, who had walked away from the facility. Resident #1 was identified by deputies a short distance from the facility and was returned to the facility. Review of police Event Detail revealed the last entry was on at 9:43:44. Observation on at approximately 10 AM revealed resident #1, with a history of multiple elopements, did not have identification on his person that stated the resident's and the facility's name, address and phone number. Interview with manager on at approximately 2 PM who stated the resident did not have the required identification on his person. Class III	A 032		
A 054	58A-5.0185(5) FAC Medication - Records	A 054		

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A 054	Continued From page 24 (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed under subsection (2), the facility shall keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider ' s name, the resident ' s name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility shall maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications or medication administration. A MOR must include the name of the resident and any known , the resident may have; the name of the resident ' s health care provider, the health care provider ' s telephone number; the name, strength, and directions for use of each medication; and a chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The MOR must be immediately updated each time the medication is offered or administered. (c) For medications which serve as chemical , the facility shall, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician ' s annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure staff maintained a daily Medication Observation Records (MORs) for 1 of 5 sampled residents (#1), who received assistance with self-administration of medications. Findings:	A 054		

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A 054	Continued From page 25 Review of the Assisted Living Facility health assessment form for resident #1 dated revealed the resident needed assistance with self-administration of medications. Review of the MORs on at approximately 4 PM revealed: (for 500 milligrams (mg) take 1/2 tablet twice a day at 9 AM and 6 PM was not charted as given, no initials in the box at 9 AM on and and at 6 PM on and (for 10 mg daily at 9 PM was not charted as given on and (for 5 mg XL daily at 9 AM was not charted as given on and (for lipids) 20 mg daily at 9 AM was not charted as given on and Amlopidine (for 10 mg daily at 9 AM was not charted as given on and Interview with the manager on at approximately 3 PM who stated she was not aware the MORS was not up to date. Class III	A 054		
A 077	58A-5.019(1) FAC Staffing Standards - Administrators Staffing Standards. (1) ADMINISTRATORS. Every facility shall be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of adequate care to all	A 077		

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residents as required by Part I of Chapter 429, F.S., and this rule chapter.
(a) The administrators shall:
1. Be at least ;
2. If employed on or after , 1990, have a high school diploma or general equivalency diploma (G.E.D.), or have been an operator or administrator of a licensed assisted living facility in the State of Florida for at least one of the past 3 years in which the facility has met minimum standards. Administrators employed on or after , 1995, must have a high school diploma or G.E.D.;
3. Be in compliance with Level 2 background screening standards pursuant to Section 429.174, F.S.; and
4. Complete the core training requirement pursuant to Rule 58A-5.0191, F.A.C.
(b) Administrators may supervise a maximum of either three assisted living facilities or a combination of housing and health care facilities or agencies on a single campus. However, administrators who supervise more than one facility shall appoint in writing a separate " manager " for each facility who must:
1. Be at least ; and
2. Complete the core training requirement pursuant to Rule 58A-5.0191, F.A.C.
(c) Pursuant to Section 429.176, F.S., facility owners shall notify both the Agency Field Office and Agency Central Office within ten (10) days of a change in a facility administrator on the Notification of Change of Administrator, AHCA Form 3180-1006, 2006, which is incorporated by reference and may be obtained from the Agency Central Office. The Agency Central Office shall conduct a background screening on the new administrator in accordance with Section 429.174, F.S., and Rule 58A-5.014, F.A.C.

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	AL11968271	A. BUILDING: _____ B. WING _____	

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ANNE'S HOME ALF INC	955 TUSKAWILLA RD WINTER SPRINGS, FL 32708

(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
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This Statute or Rule is not met as evidenced by:
Based on record review and interview the administrator who was responsible for the operation and maintenance of the facility including the management of all staff and the provision of adequate care to all residents failed to ensure:
1. The facility provided adequate supervision to meet the needs of 1 of 5 sampled residents (#1) to prevent elopement
2. Residents who had a history of elopement had identification on their person for 1 of 5 sampled residents (#1)
3. Residents were appropriate for admission to the facility for 1 of 5 sampled residents (#2)
4. Medication Observation Records (MORs) were not altered for 1 of 5 sampled residents (#1)
5. The facility had a maintained written work schedules
6. Adverse incident reports were submitted for 2 of 5 sampled residents (#1 & 2)
7. Exit doors to the facility did not have apparatus on them that prevented exit from the facility.
8. All unlicensed staff was trained providing assistance with self-administration of medications before assisting with medications for 1 of 1 sampled staff (Staff A).

Findings:

1. The facility failed to provide adequate supervision to meet resident #1's needs to prevent elopement.

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Resident record review for #1 revealed an Assisted Living Facility health assessment form 1823 dated [redacted] with diagnoses of [redacted] and [redacted] and indicated the resident used a walker, was a [redacted] risk and had difficulty with recall. The resident needed assistance with all activities of daily living.

Police Report #1
Review of Police Event Detail for Missing Person dated [redacted] at 13:38:11 stated resident #1 was on foot, resident has [redacted] left sitting on porch at facility, resident located on Winter Springs Boulevard on Tuskawilla Road, had visual on him on [redacted] at 13:46:59, subject returned to caregiver and event cleared on [redacted] at 13:58:08.

Police Report #2
Review of Seminole County Sheriff's Office report 2013043112 dated [redacted] at 10:25 AM stated an officer was dispatched to the ALF regarding a missing adult that was possibly endangered due to suffering from [redacted] Staff A was at the ALF and stated resident #1 went to sit outside in the rear of the house at approximately 10:15 AM and he was missing at approximately 10:20 AM. She called the manager and then called 911.

Upon arrival the area was searched with negative results. Staff A stated to the police the resident had [redacted] and did not take his medications today which he normally took and did not have any problems.

A short while later deputies located the resident walking on Aloma Avenue in Winter Park. The resident was escorted back to the ALF. The deputy advised the resident had [redacted] and hurt his knees, but he denied medical attention. The

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deputy advised the resident had soiled himself and was covered in feces. The Seminole County Fire Department was contacted and responded to the ALF to check on the resident. They cleared the resident of injuries and assisted the staff in cleaning him up. The family was notified. Review of police Event Report revealed the resident was located on _____ at 12:15:06 and the event was cleared on _____ at 12:47:37.

Police Report #3
Review of police report dated _____ at 9:19:27 call received, dispatched to the ALF regarding resident #1, who had walked away from the facility. Resident #1 was identified by deputies a short distance from the facility and was returned to the facility. Review of police Event Detail revealed the last entry was on _____ at 9:43:44.

The manager was asked by the surveyor, what has the facility put in place to keep resident safe. The manager stated she took him to physician for an evaluation , he ordered 25 milligrams twice a day for agitation. The manager was informed that the medication was a not an adequate plan to keep the resident safe and from further elopements and he needed to be in a secure unit.

The facility did not provide adequate supervision and knowledge of the resident's whereabouts at all times to keep him safe, let the resident sit outside unattended and unsupervised when he had a history of multiple elopements, and had they no plan in place to prevent further elopements.

The resident was relocated to a secure memory care unit on _____ at approximately 4:15 PM.

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2. The facility failed to ensure resident #1 who had a history of multiple elopements and did not have required identification on their person.

Observation on _____ at approximately 10 AM revealed resident #1, who had a history or multiple elopements, did not have required identification on his person that stated the resident's and the facility's name, address and phone number.

Interview with manager on _____ at approximately 2 PM who stated the resident did not have the required identification on his person.

3. The facility failed to ensure resident #2 was appropriate for admission to the facility.

Resident record review revealed an Assisted Living Facility health assessment form 1823 dated _____ with diagnoses of _____ agitation. The 1823 stated the resident posed a danger to self or others due to agitation and punched the family. The resident was admitted on _____

The resident was observed on _____ at approximately 2:45 PM walking in facility, attempted interview revealed resident did not speak English anymore and reverted to her primary language.
Review of Altamonte Springs Police report #20122021923 dated _____ at 16:17 stated officer responded in regard to a disturbance near a restaurant in Altamonte Springs. Resident #2 was with the ALF caregivers on an errand for the first time and became upset when she could not get out of the car. The resident got agitated easily, due to _____ and hit the caregiver in the head. The caregiver placed her

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hand on the resident's arm to stop her. The resident and caregiver were sitting in the back seat of the car when the officer arrived. The resident was still attempting to hit the caregiver in the face. The resident had no visible signs of injury. The resident's family member was contacted and she confirmed the resident had was with her caregiver from the ALF, became upset very easily and she trusted her caregiver.
The resident was harmful to herself or others due to her agitation upon admission to the facility, was inappropriate for admission and was at risk of punching others.
Interview on at 2:30 PM with the manager who stated she and her family member and I took the resident to the mall. When we got to our destination the resident stated I am almost home and was trying to get out of the car. There was a police not too far away. The police came and talked to her and told her she could not leave. The police called her the family member, who stated I was the caregiver and she knew I was the caregiver. The resident was not being restrained or held back when the police came. She also stated she was not aware the 1823 stated the resident was a danger to self or others.
4. The facility failed to ensure Medication Observation Records (MORs) were not altered for 1 of 5 sampled residents (#1).
Review of the Assisted Living Facility health assessment form for resident #1 dated revealed the resident needed assistance with self-administration of medications. Review of the MORs on at approximately 4 PM revealed:
(for 500 milligrams (mg) take 1/2 tablet twice a day at 9 AM and 6 PM was not charted as given, no initials in the box at 9 AM on and and at 6 PM on

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A 077	Continued From page 32 and (for 10 mg daily at 9 PM was not charted as given on and (for 5 mg XL daily at 9 AM was not charted as given on and (for lipids) 20 mg daily at 9 AM was not charted as given on and Amlopidine (for 10 mg daily at 9 AM was not charted as given on and Review of MORs on at approximately 10 AM revealed the MORs was altered to state the following medications listed above were given: (for 500 milligrams (mg) take 1/2 tablet twice a day at 9 AM and 6 PM were charted as given; initials were in the box at 9 AM on and and at 6 PM on and (for 10 mg daily at 9 PM were charted as given, initials were in the box on and (for 5 mg XL daily at 9 AM was charted as given; initials were in the box on 2/18 and (for lipids) 20 mg daily at 9 AM was charted as given; initials were in the box on and Amlopidine (for 10 mg daily at 9 AM was charted as given, initials were in the box on and The MORs on stated the medications were not given. The MORs were altered/falsified and indicated the medications was given when reviewed on Interview with the manager on at approximately 3 PM who stated she was not aware the MOR was not up to date and were then	A 077		

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altered.
5. The facility failed to maintain written work schedules.
Review of the facility's work schedule revealed there were no schedules to review before [redacted] 2013.
Interview with the administrator on [redacted] at approximately 3 PM who stated she did not have the prior work schedules.
6. The facility failed to submit adverse incident reports for 2 of 5 sampled residents (#1 & 2).
Resident #1
Police Report #1
Review of Police Event Detail for Missing Person date [redacted] at 13:38:11 stated resident #1 was on foot, resident had [redacted], was left sitting on porch, resident located on Winter Springs Boulevard on Tuskawilla Road had visual on [redacted] at 13:46:59, the resident was returned to the facility to caregiver and event cleared on [redacted] at 13:58:08.

Review of Adverse Incident reports revealed there was no documentation to review to indicate the facility had submitted a report within one business day when resident #1 eloped from the facility.

Interview with the manager on [redacted] at approximately 3 PM who was unable to present the adverse incident report submitted.

Resident #2
Review of Altamonte Springs Police report #20122021923 dated [redacted] at 16:17 stated officer responded in regard to a disturbance near a restaurant in Altamonte Springs. Resident #2 was with the ALF caregivers on an errand for the first time and became upset when she could not get out of the car. The resident got agitated

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easily, due to ... and hit the caregiver in the head. The caregiver placed her hand on the resident's arm to stop her. The resident and caregiver were sitting in the back seat of the car when the officer arrived. The resident was still attempting to hit the caregiver in the face. The resident had no visible signs of injury. The resident's family member was contacted and she confirmed the resident had ... was with her caregiver from the ALF, became upset very easily and she trusted her caregiver.

Review of Adverse Incident reports revealed there was no documentation to review to indicate the facility had submitted a report within one business day when a disturbance was reported to police involving an elderly, disoriented ALF resident on an outing with the ALF manager.

Interview with the manager on ... at approximately 3 PM who was unable to present the adverse incident report submitted.

7. The facility failed to have exit doors to the facility that did not have ... apparatus on them that prevented exit from the facility.

Observation on ... at approximately 12 PM revealed there were childproof plastic covers on the inside door handles to front door of the facility and the back door, near the kitchen. The surveyor was unable to open either door to exit the facility without the staff opening the door. The residents were at risk of not being able to exit the facility in an emergency due to the ... apparatus the facility placed on the doors.

Phone interview with the Seminole County Fire Department inspector on ... at

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A 077	Continued From page 35 approximately 4 PM who stated regarding the childproof covers over the inside door handles on the front and rear doors of the facility, that doors cannot require special knowledge or effort for operation from the egress side of the door. The facility removed the childproof plastic door handles from both doors on _____ at approximately 4:15 PM. Interview with the manager on _____ at approximately 4:15 PM who was not aware the door handles were a form of physical _____ preventing the residents from exiting the facility. 8. Interview with Staff A on _____ at approximately 4 PM who stated she provided assistance with self-administration of medications to the residents. Review of personnel files for Staff A hired on _____ revealed there was no documentation to indicate Staff A completed the initial 4 hours of training in providing assistance with medications and safe medication practices in an assisted living facility. During interview with the manager on _____ at approximately 12:15 PM it was not revealed if the staff had had the required training. Class II	A 077		
A 079	58A-5.019(4) FAC Staffing Standards - Levels (4) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities shall maintain the following minimum staff hours per week: Number of Residents Staff Hours/Week	A 079		

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0-5	168
6-15	212
16-25	253
26-35	294
36-45	335
46-55	375
56-65	416
66-75	457
76-85	498
86-95	539

For every 20 residents over 95 add 42 staff hours per week.

2. At least one staff member who has access to facility and resident records in case of an emergency shall be within the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.

3. In facilities with 17 or more residents, there shall be at least one staff member awake at all hours of the day and night.

4. At least one staff member who is trained in First Aid and . as provided under Rule 58A-5.0191, F.A.C., shall be within the facility at all times when residents are in the facility.

5. During periods of temporary absence of the administrator or manager when residents are on the premises, a staff member who is at least . , must be designated in writing to be in charge of the facility.

6. Staff whose duties are exclusively building maintenance, clerical, or food preparation shall not be counted toward meeting the minimum staffing hours requirement.

7. The administrator or manager ' s time may be counted for the purpose of meeting the required staffing hours provided the administrator is actively involved in the day-to-day operation of

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the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility ' s staffing schedule.
8. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted.
(b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, shall have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents scheduled and unscheduled service needs, resident contracts, and resident care standards as described in Rule 58A-5.0182, F.A.C.
(c) The facility must maintain a written work schedule which reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules for direct care staff available to residents or representatives, specific to the resident ' s care.
(d) The facility shall be required to provide staff immediately when the Agency determines that the requirements of paragraph (a) are not met. The facility shall also be required to immediately increase staff above the minimum levels established in paragraph (a) if the Agency determines that adequate supervision and care are not being provided to residents, resident care standards described in Rule 58A-5.0182, F.A.C., are not being met, or that the facility is failing to meet the terms of residents ' contracts. The Agency shall consult with the facility administrator and residents regarding any determination that additional staff is required.
1. When additional staff is required above the minimum, the agency shall require the submission, within the time specified in the

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notification, of a corrective action plan indicating how the increased staffing is to be achieved and resident service needs will be met. The plan shall be reviewed by the agency to determine if the plan will increase the staff to needed levels and meet resident needs.
2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, modifications may be made in staffing requirements for the facility and the facility shall no longer be required to maintain a plan with the agency.
3. Based on the recommendations of the local fire safety authority, the Agency may require additional staff when the facility fails to meet the fire safety standards described in Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the Agency that fire safety requirements are being met.
(e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios.
(f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of Rule 58A-5.029, 58A-5.030, or 58A-5.031, F.A.C., respectively.

This Statute or Rule is not met as evidenced by:
Based on record review and interview the facility failed to ensure it maintained an up to date, written work schedules.

Findings:

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A 079	Continued From page 39 Review of the facility's work schedule revealed there were no schedules to review before [redacted] 2013. Interview with the administrator on [redacted] at approximately 3 PM who stated she did not have the prior work schedules. Class III	A 079		
A 084	58A-5.0191(5) FAC Training - Assis Self-Admin Meds & Med Mgmt (5) ASSISTANCE WITH SELF-ADMINISTERED MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with self-administered medications as described in Rule 58A-5.0185, F.A.C., must meet the training requirements pursuant to Section 429.52(5), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques and	A 084		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNE'S HOME ALF INC	955 TUSKAWILLA RD WINTER SPRINGS, FL 32708

(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 084	Continued From page 40	A 084		

provide opportunities for hands-on learning through practice exercises.
(b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates an ability to:
1. Read and understand a prescription label;
2. Provide assistance with self-administration in accordance with Section 429.256, F.S., and Rule 58A-5.0185, F.A.C., including:
a. Assist with oral dosage forms, dosage forms, and and nasal dosage forms;
b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions;
c. Recognize the need to obtain clarification of an " as needed " prescription order;
d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident ' s health care provider or facility employer of inability to assist in the administration of such orders;
e. Complete a medication observation record;
f. Retrieve and store medication; and
g. Recognize the general signs of adverse reactions to medications and report such reactions.
(c) Unlicensed persons, as defined in Section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 4 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training shall only be provided by a licensed registered nurse, or a licensed pharmacist.

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A 084	Continued From page 41 This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 1 of 1 sampled staff (Staff A), who assisted with self-administration of medication, before providing assistance received the initial 4 hours of training in providing assistance with medications and safe medication practices in an assisted living facility. Findings: Interview with Staff A on _____ at approximately 4 PM who stated she provided assistance with self-administration of medications to the residents. Review of personnel files for Staff A hired on _____ revealed there was no documentation to indicate Staff A completed the initial 4 hours of training in providing assistance with medications and safe medication practices in an assisted living facility. During interview with the manager on _____ at approximately 12:15 PM who did reveal if the staff had had the required training. Class III	A 084		
A 165	429.23 FS; 58A-5.0241 FAC Risk Mgmt & QA; Adverse Incident Report Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality	A 165		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 165	Continued From page 42	A 165		

assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences.
(2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, " adverse incident " means:
(a) An event over which facility personnel could exercise control rather than as a result of the resident ' s condition and results in:
1.
2. or spinal damage;
3. Permanent
4. or of bones or joints;
5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives;
6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or
7. An event that is reported to law enforcement or its personnel for investigation; or
(b) Resident elopement, if the elopement places the resident at risk of harm or injury.
(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility ' s investigation of the incident.
(4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United

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A 165	Continued From page 43 States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility ' s investigation into the adverse incident. (6) neglect, or must be reported to the Department of Children and Family Services as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The Department of Elderly Affairs may adopt rules necessary to administer this section.	A 165		

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A 165	Continued From page 44 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within one (1) business day after the incident on AHCA Form 3180-1024, Assisted Living Facility Initial Adverse Incident Report-1 Day, 2006, and incorporated by reference. The form shall be submitted via electronic mail to riskmgmtps@ahca.myflorida.com; on-line at http://ahca.myflorida.com/reporting/index.shtml; by facsimile to (850)922-2217; or by U.S. Mail to AHCA, Florida Center for Health Information and Policy Analysis, 2727 Mahan Drive, Mail Stop 16, Tallahassee, Florida 32308-5403, telephone (850)412-3731. AHCA Form 3180-1024 is available from the Florida Center for Health Information and Policy Analysis at the address stated above. The Initial Adverse Incident Report is in addition to, and does not replace, other reporting requirements specified in Florida Statutes. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported under subsection (1) above, the facility shall submit a full report within fifteen (15) days of the incident. The full report shall be submitted on AHCA Form 3180-1025, Assisted Living Facility Full Adverse Incident Report-15 Day, dated 2006, and incorporated by reference. The methods for obtaining and submitting the form are set forth in subsection (1) of this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure an adverse incident report was	A 165		

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submitted within one business day when 1 of 5 sampled residents (#1) eloped from the facility and when the police were called for 1 of 5 sampled residents (#2) in reference to a disturbance.

Findings:

1. Resident record review for #1 revealed an Assisted Living Facility health assessment form 1823 dated [redacted] with diagnoses of [redacted] and [redacted] and indicated the resident used a walker, was a [redacted] risk and had difficulty with recall. The resident was observed on [redacted] at approximately 10 AM and was ambulatory and noted to be [redacted] at times.

Police Report #1
Review of Police Event Detail for Missing Person date [redacted] at 13:38:11 stated resident #1 was on foot, resident had [redacted], was left sitting on porch, resident located on Winter Springs Boulevard on Tuskawilla Road had visual on [redacted] at 13:46:59, the resident was returned to the facility to caregiver and event cleared on [redacted] at 13:58:08.

Review of Adverse Incident reports revealed there was no documentation to review to indicate the facility had submitted a report within one business day when resident #1 eloped from the facility.

Interview with the manager on [redacted] at approximately 3 PM who was unable to present the adverse incident report submitted.

2. Resident record review revealed an Assisted Living Facility health assessment form 1823 dated [redacted] with diagnoses of [redacted]

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agitation. The 1823 stated the resident posed a danger to self or others due to agitation and punches the family. The resident was admitted on . The resident was observed on at approximately 2:45 PM walking in facility, attempted interview revealed resident speaks did not speak English and was .

Review of Altamonte Springs Police report #20122021923 dated at 16:17 stated officer responded in regard to a disturbance near a restaurant in Altamonte Springs. Resident #2 was with the ALF caregivers on an errand for the first time and became upset when she could not get out of the car. The resident got agitated easily, due to and hit the caregiver in the head. The caregiver placed her hand on the resident's arm to stop her. The resident and caregiver were sitting in the back seat of the car when the officer arrived. The resident was still attempting to hit the caregiver in the face. The resident had no visible signs of injury. The resident's family member was contacted and she confirmed the resident had was with her caregiver from the ALF, became upset very easily and she trusted her caregiver.

Review of Adverse Incident reports revealed there was no documentation to review to indicate the facility had submitted a report within one business day when a disturbance was reported to police involving an elderly, disoriented ALF resident on an outing with the ALF manager.

Interview with the manager on at approximately 3 PM who was unable to present the adverse incident report submitted.

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AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Anne's Home Alf Inc
955 Tuskawilla Rd
Winter Springs, FL 32708

Dear Administrator:

Re: CCR #2013001960

This letter reports the findings of a state licensure survey that was conducted on 2013 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after **2013,** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Lorraine Henry at .

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

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