STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910731	**08/30/2013**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
St Joseph Residence	**3485 Nw 30th Street Lauderdale Lks, FL 33311**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D

Specific Tag Findings:

0000-Initial Comments
An Assisted Living Facility biennial relicensure survey was conducted on and St. Joseph residence, had licensure deficiencies found at the time of the visit.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observation, record reviews and interviews, it was determined that the facility failed to ensure the resident's health care provider was notified that the Resident #3 exhibited significant change and failure to provide appropriate supervision for Resident #3.

The findings include:
1) A record review of Resident #3's current health assessment (Form 1823) dated listed diagnoses of , and . The resident's or behavioral status was listed as Resident #3's activities of daily living on his 1823 is checked off as Independent with toileting and supervision needed for bathing, dressing, self-care
The 1823 indicated that Resident #3's needs could be met in an assisted living facility.

2) During the initial tour of the facility on beginning at 9:40 AM, Resident #3 was observed in his The resident appeared unshaven, hair unkempt and greasy. The resident was noted to have a pungent body odor. The resident's noted to have the same strong pungent odor emanating throughout the unit. An observation on at 11:58 AM, Resident #3 was observed lying in a chair across from the dining the same hygienic concerns and appeared unclean.

3) A review of interdisciplinary progress notes revealed the following behaviors:

a) On Resident #3 was resistant to care. His son was informed.

b)) Resident #3 was calling Resident #2 names on Resident was made aware that his behavior was unacceptable. Resident #3's son was informed and stated he would speak with his father regarding behavior exhibited.

c) On Resident #3 continued to need verbal prompts to attend meals and shower at times.

d) On a waitress in the dining who no longer works at the facility, approached another staff member and said she needed some "help" regarding Resident #3's behavior. The waitress further elaborated that for the last two months, Resident #3 has been making inappropriate, odd noises toward her, progressed to making gestures, and now is touching her, despite her repeatedly telling him not to do so. Resident #3's son was called, apologized, and said he would, "put a stop to it."

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e) On , Resident #3 was with at times and often refuses to shower, change his clothes, or shave. He sometimes goes days without changing his clothes. When he is asked, he becomes verbally and barks like a dog. Staff continues to encourage him to take showers and change his clothes. Both residents ' sons were made aware of the issues.

f) Resident #3 is listed on as being of at times.

g) On , Resident #2 complained that Resident #3 continued when entering elevator for breakfast and lunch. Resident #3's son was informed.

h) On , Resident #3 was observed taking a female resident to his A staff member was walking behind him when he took the female resident into his locked the door. The staff member knocked on the door before going in and observed the female resident standing next to the bed while Resident #3 was lying in bed with his pants off. The female resident was taken out of the No investigation was completed. On , Resident #3's son met with a staff member in the Nursing office regarding his father. The son stated he would speak to his father regarding his behavior.

In the incidents listed above regarding Resident #3 ' s inappropriate behavior and verbal altercations, his physician was not notified according to the progress notes. There was no documentation found in the facility's incident/unusual occurrence log and no investigations were completed. In an interview with the Administrator and the Corporate Vice President of Risk Management and Regulatory Compliance, they stated they had no knowledge of the above incidents. In an interview conducted on at 3:24 PM, the DON stated she mentioned the incident to the Administrator. An interview conducted on at 3:49 PM, the Vice President of Risk Management and Regulatory Compliance said that she spoke with the Administrator and reading the incident triggered her memory and she did remember the DON speaking to her about the incident. At the time, the facility' s risk manager stated he had no knowledge of any of the incidents above until he read the nursing notes.

The resident ' s current Health Assessment (AHCA form 1823) dated documented that Resident #3 is independent for toileting. However, he is noted to be with at various times, within his file. His physician was not notified according to the progress notes.

Resident #3's non-compliance with dressing, showering, general hygiene and behavioral changes were not communicated to his physician.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation and interviews, it was determined that the facility failed to ensure that the facility failed to follow proper hand washing control practices during medication administration for 3 out of 16 sampled residents (Resident #8, #9 and #10).

The findings include:

On at approximately 9:40 AM the facility's Nurse was observed dispensing prescribed medications for Resident #8, 9and #10 in the library She was not observed using hand sanitizer before medication

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administration to Resident #8. The Nurse was then observed to continue with the medication assistance and observed to prepare the medications for Resident # 9. The staff was observed to assist Resident # 9 with self-administration of medications and was not observed to wash and or sanitize her hands prior to commencing or at the concluding of assisting Resident #9 with self-administration of medication. The Nurse was then observed to assist Resident #10 with self-administration of medication and was observed to not wash or sanitize her hands prior to commencing and or completing assistance with self-administration of medications.

On [redacted] at approximately 10:00 AM during an interview with the Director of Nursing, she confirmed surveyor's findings.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on observations, interviews and record review, the facility failed to obtain a physician order for [redacted] (O2 [redacted] for 1 out of 18 sampled residents (Resident #3).

The findings include:

On an initial tour of the facility on [redacted] beginning at 9:40 AM, an [redacted] unit and multiple [redacted] tanks were observed in Resident #3's [redacted]. An interview was conducted with Resident #3 on [redacted] at approximately 9:44 AM, he stated that he sometimes uses the [redacted] as needed. The [redacted] tank was observed to be excessively filthy and covered with a thick layer of dirt, hair, and debris.

On [redacted] at 3:05 PM. an interview was conducted with the Director of Nursing (DON) who confirmed that there was no physician order on file for Resident #3 to have [redacted] and that she was unaware the resident had tanks in his [redacted]. A tour of the resident's [redacted] conducted with the DON who observed the [redacted] tank and units in place in the resident's [redacted]. She asked Resident #3 how he gets the [redacted] Resident #3 stated, "I give it to myself."

The DON stated that he should not be on [redacted] Record review of the resident's file revealed there was no current physician's order available prescribing use of [redacted] for Resident #3.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2013

Administrator
St Joseph Residence
3485 NW 30th Street
Lauderdale Lks, FL 33311

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on . 2013 by representatives from this office. Attached is the provider's copy of the State (5000-3547) 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 (30) 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 representatives. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene -Davis
Field Office Manager

AMD/dso
Enclosure: State forom 5000-3547
XG90

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