STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910102	10/09/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Magnolia Retirement Home, Inc.	149 Magnolia Avenue Sebring, FL 33870	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0032 - 58a-5.0182(8) Fac - Resident Care - Elopement Standards S-S= D
St - A - L243 - 58a-5.0191(8) Fac - Lmh - Training S-S= D
St - A - Z827 - 408.812, Fs - Unlicensed Activity S-S= C

Specific Tag Findings:

A complaint survey, CCR# 2013010242, was conducted on .

The Magnolia Retirement Home, Inc., assisted living facility, had deficiencies at the time of the visit.

0032-Resident Care - Elopement Standards 58A-5.0182(8) FAC

Based on record review, and interview, the facility failed to make a daily effort to ensure two of two current residents identified by the facility as being at risk for elopement and with a history of elopement, had identifying information for the residents, as well as the facility ' s information on the residents (Resident#1 and #2). The facility also failed to conduct the at least two elopement prevention and response drills per year.

The findings include:

1. On the administrator identified resident #1 and #2 as resident at risk for elopement on the resident census.

2. A review of resident #1 ' s record revealed on resident #1 was documented as not being in the facility. Further documentation revealed the facility initiated an elopement response and notified the police. Resident #1 ' s record revealed he returned to the facility on . A review of a related police report (SPD13CAD014937) confirmed the police were called and a " Be on the Lookout " (BOLO) response was initiated for resident #1.

3. A review of resident #2 ' s resident record revealed on . Resident #2 eloped from the facility. Continued review revealed resident #2 was located returned to the facility on . A review of a related police report (SPD12OFFUU1965) confirmed on resident #2 eloped from the facility.

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4. On at approximately 9:36 a.m. an interview was conducted with the administrator. The administrator confirmed resident #1 and #2 were both missing from the facility and identified as elopement risk. At approximately 4:35 p.m. the administrator was re-interviewed. He denied the facility provided resident #1 and #2 with personal identification information which would include the facility ' s contact information.

5. On at approximately 4:38 p.m. resident #1 and resident #2 were interviewed. Both residents denied having any information on them. Resident #1 stated the facility did not provide him with any identifying information or locating information for the facility.

6. A review of facility records revealed the last elopement response drill was conducted on .

7. On at approximately 11:50 a.m. an interview was conducted with the administrator. The administrator confirmed the last documented elopement drill was conducted in 2009. He added the facility conducted an elopement drill in , but did not complete the documentation for the drill. The administrator confirmed the facility has not conducted an elopement drill since .

8. On at 2:37 p.m. an interview was conducted with Staff A. Staff A stated he has only participated in one elopement drill at the facility, he added this drill was conducted two years ago.

9. On at 3:08 p.m. an interview was conducted with staff B. Staff B stated she has worked at this facility since . Staff B stated she has not participated in an elopement drill since being employed at this facility.

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Class III

L243-LMH - Training 58A-5.0191(8) FAC

Based on interview and record review, the facility failed to ensure one of three staff members reviewed received Limited Mental Health (LMH) training within six (6) months of hire as required (Staff B). The facility also failed to ensure two of two staff members with received three (3) hours of continued education on subjects related to working with mental health residents biennially as required (Staff A and Staff C).

The Findings Include:

1. A review of the facility ' s licensure information revealed this facility has a standard license with a Limited Mental Health specialty license.

2. A review of staff B ' s personnel record revealed staff B was hired on as a caregiver. Continued review of staff B ' s personnel record revealed staff B did not complete the required LMH training.

3. A review of staff A ' s personnel record revealed staff A was hired on and completed his initial LMH training on . Staff A did not have documentation of three (3) hour biennial updates on mental health related subjects on file.

4. A review of staff C ' s personnel record revealed staff C was hired on as a caregiver and completed her initial LMH training on . Staff C did not have documentation of three (3) hour biennial updates on mental health related subjects on file.

5. On 3:37 p.m. the administrator was interviewed. The administrator confirmed staff B did not receive LMH training and added the provider the facility uses to conduct the LMH trainings only offers the LMH training once a year. The administrator stated he was not aware the direct care staff was required to have three (3) hours of continued education in relation to working with mental health residents.

Class III

Z827-Unlicensed Activity 408.812, FS

Based on observation, interview and record review, the facility provided a Limited Nursing Service (assistance with the application of anti- stockings) to one of four sampled residents for which the facility does not

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have a license to provide (Resident #2).

The findings include:

1. On at approximately 10:51 a. m. resident #2 was observed wearing hose.

2. On at approximately 10:51 a.m. resident #2 stated the facility staff assists him with putting on his hose (anti- stockings).

3. On at approximately 5:00 p.m. the administrator confirmed the facility ' s unlicensed staff members assist resident #2 with the application of his hose. The administrator reported he was not aware the facility needed a specialty license to assist resident #2 with this service.

4. A review of resident #2 ' s facility record revealed on resident #2 has a physician ' s order for the facility to assist the resident with the application of hose in the morning and to remove the hose in the evening to decrease .

Unclassifed

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Magnolia Retirement Home, Inc.
149 Magnolia Avenue
Sebring, FL 33870

Dear Administrator:

Re: **CCR# 2013010242**

This letter reports the findings of a complaint survey that was conducted on , 2013, by a representative of 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 days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review 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. Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

for Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

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