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List of Tags Cited:

St - A - 0011 - 58a-5.0181(5) Fac - Admissions - Discharge S-S= D
St - A - 0026 - 58a-5.0182(2) Fac - Resident Care - Social & Leisure Activities S-S= D
St - A - 0028 - 58a-5.0182(4) Fac - Resident Care - Activities Of Daily Living S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= G
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0082 - 58a-5.0191(3) Fac - Training - S-S= D
St - A - 0083 - 58a-5.0191(4) Fac - Training - First Aid And S-S= D
St - A - 0084 - 58a-5.0191(5) Fac - Training - Assis Self-Admin Meds & Med Mgmt S-S= D
St - A - 0085 - 58a-5.0191(6) Fac - Training - Nutrition & Food Service S-S= D
St - A - 0090 - 58a-5.0191(11) Fac - Training - S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= B
St - A - 0167 - 58a-5.025(1) Fac - Resident Contracts S-S= B
St - A - Z815 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses S-S= C
St - A - Z827 - 408.812, Fs - Unlicensed Activity S-S= C

Specific Tag Findings:

0000-Initial Comments
An unannounced re-licensure Survey was conducted on .

Thornton Gardens Assisted Living Facility had deficiencies found at the time of the visit.

0011-Admissions - Discharge 58A-5.0181(5) FAC
Based on observations, record review and interview the facility retained 2 of 7 sampled residents (#1 and #2) who exceeded ALF residency criteria.

Findings:

1. During the tour of the facility on at approximately 9 AM, resident #1 was observed sitting in a chair with his legs on an ottoman. Further observations revealed that his left pants leg from the thigh area to his leg had on it, also his pants leg was raised and dried was observed and the ottoman also had on it.

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Staff C stated at the time that resident #1 had sores and would pick at them and that was where the came from.

An interview was attempted with resident #1 on at approximately 9:15 AM and due to his he was not able to answer any questions.
Through interviews with the staff present it was revealed that resident #1 required total care with his Activities of Daily Living (ADL's). The staff stated that the resident refused to assist with his care and would not walk at all.

During an Observation at approximately 12 PM revealed that the staff was providing lunch for the other residents in the dining , Resident #1 remained in the chair in the living around the corner at the staff placing the plates on the table for the other residents.
When the staff finished providing the food and drinks to the residents who were in the dining Staff F was observed bringing a plate to the resident. She was asked at the time why was resident #1 was not allowed to sit at the table with the other resident's to eat his meal. Staff F stated at the time that when they would try to get him up out of the chair he would become aggressive and refuse to get out of his seat. She was informed at the time that they were not observed at any time trying to get the resident up.
Staff F called for Staff C to come to assist the resident up, both staff attempted to persuade the resident to get up and tried to assist him up; but he refused, he bent his knees and he dropped down to the floor and he was resisting and yelling at them, he refused to walk and Staff F had to feed him in the living

During an Observation at approximately 4 PM revealed that resident #1 slid from out of the chair that he was sitting with the ottoman in front of him and almost to the floor, if the staff was not close by. The staff stated to resident #1 at the time to sit up in the chair and he refused. Both staff one on each side had to sit the resident up in the chair because he could not do it alone.

2. During the tour of the facility observations revealed at approximately 10 AM, that resident #2 was lying in her bed asleep. Further observations revealed that there was a Hoyer lift in the (A Hoyer lift is a type of hydraulic device used for moving people between short distances who cannot move by themselves and who are too heavy to be lifted by one or two aides.). Staff F stated that they facility staff had to use the Hoyer lift because the resident was not able to walk.

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During Observations at approximately 12 PM revealed that the resident was wheeled down to the dining lunch in her wheel chair, further observations revealed that the sling for the Hoyer lift was in the wheelchair underneath the resident.

On at approximately 2:30 PM the administrator was asked if resident #2 was able to transfer. She stated that she could. She was informed that the staff stated that they used the Hoyer life to transfer her. She stated that resident #2 did not need the Hoyer Lift and could transfer with assistance.

During an Observations of resident#2 at the time revealed that she was sitting in the living The administrator stated the resident could pivot and would take the resident to her transfer.

At approximately 2:40 PM the administrator wheeled the resident in her wheelchair to her transfer her. She informed the resident that she was going to transfer her to the bed. Resident #1 asked are we going to use the Hoyer lift. The Administrator replied to resident #1 no we were going to transfer using the walker. Resident #1 stated no; I am scared, I am terrified to try to walk. The administrator continued to try to tell her to let her assist her with her transfers and she did not have to worry about falling. The resident continued to say no I want you to use the Hoyer lift. Resident #1 stated she was terrified and she stated I do not want to I cannot walk.

After many times of asking her to transfer she had to request that one staff help her. The resident continued to state she was scared and she did not want to walk. The administrator and the staff placed socks and shoes on the resident to make her feel safe that she would not the administrator placed the walker in front of the resident and told her that she would help her up, the resident continued to refuse and stated that she could not and she was very afraid that she would The staff and the administrator had to lift the resident from the wheel chair to the bed. The resident did not move her feet at all to try to assist with the transfer.

During interviews with Staff on it was revealed that the staff was providing care to resident #2.

Staff C stated on at approximately 11 AM, that resident #2 had a bag and she emptied the bag. She further stated that when the wafer needed to be replaced

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she would replace it also.

Staff F stated on at approximately 1:30 PM that resident #2 had a bag and she emptied the bag and she also replaced the wafer, she stated that the administrator who was a nurse trained her to change the bag. She stated that she also burped the bag.

During an interview with the administrator on at approximately 4 PM she stated she was changing the wafer because she was a nurse. She was informed that the staff stated they did it and she stated that she would not let them do it.

The administrator was informed at the time that the facility did not have a Limited Nursing License required for her to perform the Care, she stated she did not realize she needed a Limited Nursing license because she was a nurse, she thought she could do the care.

Class III

0026-Resident Care - Social & Leisure Activities 58A-5.0182(2) FAC
Based on the activity calendars and interviews the facility failed to provide an ongoing activities program that provided diversified individual and group activities in keeping with each resident's needs, abilities and interests and the activity calendar did not reflect the amount of hours of the weekly activities.

Findings:

During Observations on at approximately 9 AM revealed that there were residents sitting in the living , a resident was on the porch visiting with family and other residents were in their . There were two staff working and the Administrator arrived at 10 AM.

Through interviews with the residents it was revealed that did have activities sometimes.

Review of the activities calendar that was posted in the living that there were activities noted daily, the times of the activities were not listed. There was no way to determine if the residents were provided activities 12 hours per week.
Further review of the activities calendar revealed it listed the following activities
Every Sunday was Church Service; on other days were This day in History, Current events, cards bingo, beach ball, Ice Cream Social, movies and popcorn and music fun.
Listed for the day of the survey was Words that start with "B", this day in history,

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without times. The facility consisted mostly of residents who were and could not participate in most of the activities. There were no activities noted on the calendar that were stimulating for those residents.

The residents were observed throughout the survey sitting in the living , walking around, sitting on the porch or in their there were no activities provided.

The administrator stated on at approximately 4:45 PM that it was a busy day with the survey and there were no activities provided. She stated that the facility did offer the activities that were listed. She was asked if all of the resident's participated in the Church Service and if someone came to the facility for all of them. She stated that the residents liked to watch Church service on the Television. She was informed at the time that watching television was not considered an activity for the purpose of meeting the 12 hour per week criteria.

Class III

0028-Resident Care - Activities of Daily Living 58A-5.0182(4) FAC
Based on observations and interview the facility failed to provide assistance with activities of daily living as needed by 1 of 7 residents (#1), who was and unable to help himself.

Findings:

Interview with Staff C on at approximately 9 AM revealed that there were 11 residents that resided in the facility. She stated that there was another staff upstairs giving a resident a shower.
Observations on at approximately 9 AM revealed that resident #1 was in a chair with his legs on an ottoman in a lying position. Further observations revealed that his left pants leg from the thigh area to his leg had on it, also his pants leg was raised and dried was observed and the ottoman also had on it.
Staff C stated at the time that resident #1 had sores and he would pick at them and that is where the came from.

An interview was attempted with resident #1 on at approximately 9:15 AM due to his he was not able to answer any questions.
Through interviews with the staff present it was revealed that resident #1 required total care with his Activities of Daily Living (ADL's). The staff stated that the resident refused to assist with his care and would not walk at all.

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At 10 AM, the administrator arrived she was asked at the time why was resident #1 she stated that he had sores and he picked at them causing them to

Observations throughout the survey at 10:45 AM, 11 AM, 11:30 AM, 12:05 PM, 1 PM, 2:20 PM and 3 PM revealed that the resident sat in the same seat with the bloody clothes on, staff were observed giving other residents shower's during this time and did not attempt to change the resident clothes nor did they take him to the change his adult brief.
The administrator was asked on at approximately 2:20 PM how often the residents who could not go to the are toileted. She stated after each meal or 4 or more times if needed. She was informed that resident #1 was observed from 9 AM to the present and was not taken to the change his bloody clothes and his adult briefs.
The administrator stated at the time the resident resisted Activities of Daily Living (ADL) Care and would fight with the staff. At approximately 3 PM while in the dining , resident #1 was heard yelling out loudly from his The administrator stated the staff was changing the resident and that is why he was yelling.
At approximately 3:15 PM, resident #1 was observed sitting in a wheelchair in his further observation revealed that the staff had finally changed his clothes.

Review of the resident #1's record revealed a Resident Health Assessment form 1823 that was dated with diagnosis that included and Osteo . He required supervision with ambulation, bathing, dressing and and required assistance with toileting and transfers.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observations, record review and interview the facility failed to ensure it complied with the Resident's Bill of Rights to be treated with consideration and respect and with due recognition of personal dignity and allowed 1 of 7 sampled residents (#1) to remain in bloody pants throughout the day.

Findings:

Interview with Staff C on at approximately 9 AM revealed that there were 11 residents that resided at the facility. She stated that there was another staff upstairs giving a resident a shower.

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Observations on [redacted] at approximately 9 AM revealed resident #1 was in a chair in the living [redacted] his legs stretched out on an ottoman in a lying position. Further observations revealed that his left pants leg from the thigh area to his leg had [redacted] on it, also his pants leg was raised and dried [redacted] was observed and the ottoman also had [redacted] on it. Further observations revealed that there were 5 other residents who were also sitting in the living [redacted] resident #1. Observations at the time revealed there were family members also present who were visiting another resident, they were observed passing by resident #1 when they entered and exited the living [redacted]. Staff C stated at the time that Resident #1 had sores and would pick at them and that was where the [redacted] came from.

An interview was attempted with resident #1 on [redacted] at approximately 9:15 AM and due to his [redacted] he was not able to answer any questions.

Through interviews with the staff present it was revealed that resident #1 required total care with his Activities of Daily Living (ADL's). The staff stated that the resident refused to assist with his care and would not walk at all.

At 10 AM, the administrator arrived she was asked at the time why was resident #1 [redacted] she stated that he had sores and he picked at them causing them to [redacted]
At 10:45 AM the administrator was observed doing laundry, the other staff was providing showers for other residents and no one attempted to provide care to resident #1.

During Observations at approximately 11:30 AM, There were 2 other family members that arrived at the facility to visit another resident who was also sitting in the living [redacted] Resident #1 remained in the lying position with his leg on the ottoman with the [redacted] on his pants and leg and ottoman. During observations throughout the survey at 10:45 AM, 11 AM, 11:30 AM, 12:05 PM, 1 PM, 2:20 PM and 3 PM revealed that the resident sat in the same seat with the bloody clothes on, staff were observed giving other residents shower's during this time and did not attempt to change the resident clothes. At approximately 3 PM while in the dining [redacted] resident #1 was heard yelling out loudly from his [redacted] The administrator stated that the staff was changing the resident and that's why he was yelling.

During Observation at approximately 3:15 PM, resident #1 was sitting in a wheelchair in his [redacted] Further observation revealed the staff had finally changed his clothes. The facility staff allowed resident #1 who was not capable of changing his, to remain in his bloody clothes

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while other residents and family member were in his presence. The staff present stated that the resident was resistant to care and would not allow them to change him without being combative.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on facility record review, resident record review and interview the facility failed to ensure that when staff provided assistance with the self-administration of medications, the staff followed the appropriate procedure at all times which resulted in wrong medication being given at the wrong time for 1 of 7 sampled resident (#3).

Findings:

During the medication pass on [redacted] at approximately 12:10 PM, Staff C was observed taking a cup of pills to resident #5 and telling her these are your medications. Staff C who was an unlicensed staff did not take the Medication, in its dispensed, properly labeled container, from where it was stored to give to the resident. She did not in the presence of the resident, read the label, open the container, remove a prescribed amount of medication from the container, and close the container. Further observations on [redacted] at 12:20 PM, revealed that Staff C handed a cup with a pill inside to resident #3. She stated here are your medicines and turned her back.

Staff C was asked at the time what was the name of the medications that she gave to resident #3. Staff C handed the surveyor the Medication Observation Record (MOR) and pointed to the [redacted] 25 milligram (mg) - 1/2 daily at noon and at the time she initialed the MOR for the medication.
Staff C was asked at the time for the medication container. Staff C provided a medication package of [redacted] 3.125 milligram (mg) 1- 2 times daily. Further review of the MOR revealed that the [redacted] was to be given at 8 AM and 8 PM. The MOR was marked as given already at 8 AM. The staff was asked again where the [redacted] 25 mg because that was what the MOR noted he was to have at noon. She stated this is the [redacted] (referring to the [redacted] package). It was explained to Staff C that [redacted] was not the same as [redacted] She stated at the time that she was having a problem reading the label. She pointed to the spelling of the [redacted] and stated it had an "A" in it, that matched the A in the [redacted] and she thought that was the same medication.

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Immediately the administrator was informed of what had just occurred, Staff C was asked again in the presence of the administrator, which of the medications she gave the resident, the medications were all placed on the table. Staff C again pointed to the _____. Also on the table with the medications was a package of medication that prescription label noted 25 mg take 1/2 12.5 mg by mouth every morning for high . The medication was to be given in the morning not at noon. Staff C stated she was not aware that was the same medication as the (although it was on the label). She stated that the medication use to come in a package that was easier to read than the current packaging. She stated that the medication package was new and just delivered to the facility recently. Further review of the medication labels for all of the resident's medications revealed that they were labeled in a form that was easy to interpret.

The administrator stated at the time that she was surprised at the finding, she was not aware that Staff C was having difficulties reading the prescription label. The administrator was informed at the time that the health care provider should be contacted to make him/her aware that the resident was given another dosage of the medications and did not receive the medications as ordered.

In a telephone interview was conducted with the Health Care Provider on at approximately 12:50 PM, she stated she had informed the administrator to check the resident's in 1 hour and notify her if there were any abnormalities and to hold the and the second dose of for the day.

Class II

0054-Medication - Records 58A-5.0185(5) FAC
Based on record review and interview the facility did not maintain an up-to-date daily medication observation records (MORs) for 5 of 8 sampled residents (#1, #2, #3, #4 and #5) who received assistance with self-administration of medications.

Findings:

Review of the MOR's for residents #1,#2, #3, #4 and #5 revealed that there were blank spaces and there was no way to determine whether or not the residents were given their medications as Follows:

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1. Resident #1 MOR for had blank spaces for
1 daily on at 8 AM on and
Mila and Benefiber 1 scoop/1 teaspoon at 8 AM on and at 8 PM on and

2. Resident #2-MOR for 10 mg 1 daily was left blank at 8 AM on and
20 mg 1 daily at 8 AM was left blank on and
100 mg 1 at bedtime was left blank at 9 PM on and
10 mg 1-2 times daily was left blank at 8 AM on and and at 5 PM on 10/3, and
Olanziine 5 mg 1 daily at 8 AM on and

3. Resident #3 MOR for 25 mcg 1 daily was left blank on at 6 AM.

The MOR noted 25 milligram (mg) - 1/2 daily at noon, review of the medication prescription label revealed that it noted 25 mg take 1/2 12.5 mg by mouth every morning for high MOR did not match the prescription label.

4. Resident #4- MOR for Divaloproex 125 mcg 1 2 times daily was left blank at 5 PM on 11/6
0.5 mg 1-2 times daily was left blank on 11/6 at 5 PM.

5. Resident #5-MOR for 1 daily was left blank at 8 AM on 11/6 and 11/7.
25 mg 1 at noon was left blank on 11/5 and 11/6.

The administrator reviewed the MORs on at approximately 4 PM and named the staff that she thought was responsible for the omissions and stated that she did not mark the MORs as required.

Class III

0078-Staffing Standards - Staff 58A-5.019(2) FAC
Based on record review and interview the facility staff performed duties that were not consistent with their level of education, training, preparation, and experience in that unlicensed personnel were provide a nursing service care) to 1 of 7 sampled

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residents (#2) and did not ensure a nurse administered medications to 1 of 7 sampled residents (#1) who was not capable of assisting with the self-administration of his medications and did not obtain a freedom from communicable statement including for 2 of 4 sampled staff (C and D).

Findings:

1. During interviews with Staff on , it was revealed that the staff was providing care to resident #2.

Staff C stated on at approximately 11 AM, that resident #2 had a bag and she emptied the bag. She further stated that when the wafer needed to be replaced she would replace it also.
Staff F stated on at approximately 1:30 PM that resident #2 had a bag and she emptied the bag and she also replaced the wafer, she stated that the administrator who was a nurse trained her to change the bag. She stated that she also burped the bag.
Record review for resident #2 revealed that her Resident Health Assessment form dated noted that she had diagnosis of , and .

Interview with Resident #2 on at approximately 2 PM, revealed that she was alert with she stated that the facility staff changed her bag for her.

The administrator stated on at approximately 4:30 PM she was changing the wafer because she was a nurse. She was informed that the staff stated they did it and she stated that she would not let them do it.

2. Record review for resident #1 revealed a resident health assessment form 1823 that was dated with a diagnosis of . The 1823 noted that the resident needed his medications administered. Observations of the resident on at approximately 9 AM revealed that he was and was not able to provide an interview.
Review of the Medication Observations Record (MOR) for revealed that the unlicensed staff (non-nurses) was giving the resident his medications.

The administrator stated on at approximately 5 PM that she was not aware that the 1823 noted that resident was to have a nurse administer his medications.

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3. Personnel record review for Staff C hired ... had a ... test dated ... (due ... Further record review revealed that there was no documentation to confirm that she had obtain annually a freedom from ... statement

4. Personnel record review for Staff D hired ... revealed that there was no documentation to confirm that she was free from Communicable ...

The administrator reviewed the personnel record and stated on ... at approximately 4 PM that she did not find the annual ... test for staff C and communicable ... statement for Staff D in their files.

Class III

0082-Training - ... 58A-5.0191(3) FAC
Based on review of personnel files and interview the facility failed to ensure that 1 of 4 sampled staff (C) had completed a one-time education course on ... and ...

Findings:

Personnel record review for Staff C hired ... revealed that there was no documentation to confirm that she had completed a one-time education course on ... and ...

The administrator reviewed Staff C's personnel file and stated on ... at approximately 4 PM, that the staff had the training and she could not locate the certificate.

Class III

0083-Training - First Aid and ... 58A-5.0191(4) FAC
Based on personnel record review and interview the facility failed to have evidence that a staff member (B) who worked alone in the facility had completed courses in ... and held a currently valid card documenting completion of the course.

Findings:

Review of the staff schedule for ... ber/2013 revealed that staff B worked alone. Personnel record review for Staff B revealed that there was no documentation in her file to confirm that she had completed a ... course.

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Interview with the administrator on at approximately 4:30 PM revealed Staff B did work alone and she had completed a course. The administrator explained that she could not locate the documentation.

Class III

0084-Training - Assis Self-Admin Meds & Med Mgmt 58A-5.0191(5) FAC
Based on personnel record review and interview the facility failed to ensure that 2 of 4 sampled unlicensed staff (C and D) who provided assistance with the resident's medications received 2 hours in-service training each year in providing assistance with self-administered medications and safe medication practices in an Assisted Living Facility (ALF).

Findings:

The administrator stated on at approximately 2 PM that Staff C and D provided assistance with the resident's medications.

Personnel Record review conducted revealed that Staff C had a 4 hour medication training on (due Staff D had a 4 hour medication course on (due and There was no documentation in their record to confirm that they had received the 2-hour training each year as required.

The administrator reviewed the above staff record and stated on at approximately 4 PM they did not have the training as required.

Class III

0085-Training - Nutrition & Food Service 58A-5.0191(6) FAC
Based on review of personnel files and interview the administrator who was responsible for the facility's food service and the day-to-day supervision of food service staff failed to obtain a minimum of 2 hours continuing education each year in topics pertinent to nutrition and food service in an ALF.

Findings:

The Administrator stated on at approximately 1 PM that Staff E was responsible for the facility's food service.

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Thornton Gardens	618 E Central Blvd. Orlando, FL 32821	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Personnel record review for Staff E revealed that there was no documentation to confirm she had received the training from a qualified food service trainer the 2 hour continuing education in topics pertinent to nutrition and food service in an ALF.

The administrator confirmed on [redacted] at approximately 4 PM that staff E had not taken the training annually as required.

Class III

0090-Training - [redacted] 58A-5.0191(11) FAC
Based on personnel record review and interview the facility failed to have evidence that 3 of 4 sampled staff (B, C and D) had at least one hour of training in the facility's policies and procedures regarding [redacted] that included information in Rule 58A-5.0186, F.A.C.

Findings:

Personnel record review revealed for Staff B hired [redacted], Staff B hired [redacted] and Staff D hired [redacted] revealed that there were certificates for Staff B dated [redacted], Staff C dated [redacted] and staff D dated [redacted] for a 1 hour training that included [redacted] and Elopement training. There was no documentation found in their records to confirm that that had at least a 1 hour training for [redacted] only.

The administrator stated on [redacted] at approximately 4 PM that she did not have any other documentation to confirm that the above staff has completed at least a 1 hour [redacted] training.

Class III

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on observations and interview the facility failed to maintain a 3-day emergency supply of water to meet the nutritional needs of the 11 residents that resided in the facility in the event of an emergency.

Findings:

Observations of the emergency food supply on [redacted] at approximately 11:45 PM revealed that there was no water on hand at the facility for the 11 residents in the event of an emergency.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965768	11/07/2013
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SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

The administrator stated on , at approximately 12:15 PM that the facility had 3 five gallon collapsible bags she had plan to use the bags. She further stated she thought that it was approved in the emergency management plan.

The administrator provided the emergency management plan that she had sent to the local disaster preparedness authority with the use of collapsible bag handwritten in the plan, further review of the plan revealed that there was no documentation to confirm that the plan had been approved.

The administrator stated at the time she did not receive the plan approval letter from the local disaster preparedness authority to use the collapsible bag in the event of an emergency.

Class III

0162-Records - Resident 58A-5.024(3) FAC
Based on record review and interview the facility failed to obtain a copy of the Power Of Attorney (POA) documentation for 1 in a sample of 3 residents whose record was reviewed (#1).

Findings:

Record review for resident #1 revealed a demographic sheet that listed a Power Of Attorney. Review of the contract revealed that the POA had signed the resident's contract on . Further record review revealed that there was no Power of Attorney documentation found in the record.

The administrator reviewed the record and stated on , at approximately 4 PM that there was no POA documentation in the record.

Class

0167-Resident Contracts 58A-5.025(1) FAC
Based on resident record review and interview the facility failed to ensure that each resident contract contained the rights, duties and , of residents, other than those specified in the Resident Bill of Rights for 3 of 3 sampled residents. (#1, #2 and #3)

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965768	11/07/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Thornton Gardens	618 E Central Blvd. Orlando, FL 32821	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Findings:

Resident record review including contracts for residents #1, #2 and #3 revealed that their contracts did not include a statement to inform the residents or responsible party that all residents must be assessed upon admission, every 3 years thereafter, or after a significant change, whichever comes first.

The administrator stated on [redacted] at approximately 2:30 PM the above information was not included in contracts.

Class [redacted]

Z815-Background Screening; Prohibited Offenses 408.809, 435.02(2), 435.06
Based on personnel record review and interview, the facility failed to ensure that 2 of 4 sampled staff (B and D) was in compliance with the background screening requirements.

Findings:

Personnel record review for Staff B hired on [redacted] and Staff D was hired on [redacted] and both were required to undergo the Level 2 background screening and there was no documentation in their records to confirm that they had completed any type of affidavit or documentation attesting, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if [redacted] for any of the disqualifying offenses while employed by the employer per 435.05(2), Florida Statutes.

The administrator stated on [redacted] at approximately 4 PM that the affidavits were not in their records as required.

Unclassified

Z827-Unlicensed Activity 408.812, FS
Based on Observations and interviews, the facility failed to ensure it did not provide services other than a service for which it was licensed to provide.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Findings:

Observations on at approximately 9 AM of the facility's license revealed that it was a standard license.

During staff interviews on it was revealed that the staff was providing care to resident #2. .

Staff C stated on at approximately 11 AM, that resident #2 had a bag and she emptied the bag. She further stated that when the wafer needed to be replaced she would replace it also.

Staff F stated on at approximately 1:30 PM that resident #2 had a bag and she emptied the bag and she also replaced the wafer. She further stated that the administrator who was a nurse trained her to change the bag. She stated that she also burped the bag.

The administrator stated on at approximately 4 PM that she was the one changing the wafer because she was a nurse. She was informed that the staff stated they did it and she stated that she would not let them do it.

The administrator was informed at the time that the facility did not have a Limited Nursing License required for her to perform the Care, she stated she did not realize she needed a Limited Nursing license because she was a nurse, she thought she could do the care.

Unclassified

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Thornton Gardens
618 E Central Blvd.
Orlando, FL 32821

Dear Administrator:

Re: Biennial relicensure

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 (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 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

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