STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943128	11/13/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
St Mary's Home	718 W. Winter Park Street Orlando, FL 32804	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0079 - 58a-5.019(4) Fac - Staffing Standards - Levels S-S= B
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= B

Specific Tag Findings:

0000-Initial Comments
An unannounced Complaint Inspection#2013-0011896 was conducted and

St. Mary's Home Assisted Living facility had deficiencies found at the time of the visit.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on record review and interview the facility failed to contact the health care provider when 1 of 3 sampled residents (#2) had a change in his behavior and later at the facility.

Finding:

During an interview with the administrator on at approximately 10 AM he stated resident #2 was active and would even walk and walk to the hospital. The administrator explained on at 6:30 AM resident #2 came into the living any clothes on at this time the resident was told to go and put some clothes on. The resident went to the shower and turned on the water. The administrator left the resdent. After about 15 minutes the resident was observed on the floor with no clothes on. The administrator asked the resident was he OK and the resident replied he needed an ambulance. The administrator stated that he called the non-emergency ambulance. According to the administrator he continued to check on the resident. The resident's and pulse were normal. The resident was told that the ambulance was on its way. After approximately ten minutes the administrator checked on the resident again and he was still on the floor under the bed, but breathing and

He stated he asked him if he was Ok and he stated I'm Ok; this was around 7:10 AM. The resident was still on the floor under the bed. The administrator checked on him and again took the resident's his vital signs. The resident's and pulse were ok. He stated the resident was breathing well and waiting for the ambulance. He stated that the

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resident was underneath his bed and he thought he was trying to get his luggage from under the bed to take with him to the hospital. He stated that the resident was grabbing for his luggage under the bed and his head and arms were under the bed and the rest of his body was outside of the bed.

He stated he went into the [redacted] pulled the luggage out for him and he still remained on the floor with it, he stated when he went back to check on the residents he was still under the bed messing around with the luggage. He stated when the paramedics arrived that was how they found him, halfway under the bed. He stated he did not call 911 because when they called too much, the paramedics would make faces about him calling too much. Because when they arrived and nothing was wrong with the resident they would always want to know why were they called. He stated he normally he call the non-emergency number. He stated that the resident was not in any distress. However, his behavior was not the same as it normally was. The administrator further stated that when the ambulance arrived he showed the staff the [redacted] they went in to check on the resident. They told him the resident was not breathing and they started [redacted]. He stated that when the paramedics arrived the resident was under the bed still. He was told by the non-emergency ambulance transport to dial 911.

A resident observation note documented the following:

[redacted] 6:30 AM, I saw resident #2 (name mentioned) walking naked in the living [redacted] I told him to put some clothes on. After 15 minutes I checked on him and he already on the floor holding his luggage. I asked him, how he was doing or feeling and he answered me to call the ambulance, so I called the non-emergency ambulance, meanwhile while I'm waiting for the ambulance to come, I checked his vital signs [redacted] pulse 72. I told him ambulance is on the way, after 10 minutes I checked on him again, still on floor but breathing and [redacted]. I asked him if he was ok and he said he was okay, around 7:10 AM he still on the floor. I checked on his vital sign again [redacted] is [redacted] pulse rate is 82. Resident breathing well and waiting for ambulance. I went out the resident [redacted] checked another resident. Around 7:30 ambulance came and pronounced the resident is [redacted].

Further record review revealed that there was no documentation that the health care provider was contacted when the resident began to display the behavior changes in order to obtain medical directions or orders from the health care provider.

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The Administrator stated on , at approximately 2 PM, he did not contact the health care provider when the resident's behavior changed as required.

Class III

0079-Staffing Standards - Levels 58A-5.019(4) FAC
Based on review of staff schedule review and interview the facility failed to maintain a written work schedule which accurately reflected the facility's 24 hour staffing pattern for a given time period.

Findings:

Review of the staff schedule for revealed on , the administrator (Staff A) was off for the day and was not scheduled to work on at 8 AM. The schedule noted that Staff B worked on from 8 AM until 8 AM on alone.
Record review for resident #2 revealed that on at approximately 6:30 AM the administrator noted that resident arrived in the living and was told to go into the get on some clothes. About 15 minutes later he went to check on him and asked him if he was alright and he was on the floor naked holding his luggage. He asked him how he was feeling and he told him to call the ambulance. He continued to check on the resident and his vital signs were alright. The administrator noted at 7:10 AM he checked his vital signs again; he left the check on the other residents. At 7:30 AM the ambulance arrived and pronounced the resident .

In a telephone interview with Staff B on at approximately 12:55 PM; he stated he started to work on at 8 AM and he left at around 6:15 AM on 11 . He explained he left because he had to go to another job. He stated that Staff A came early and he left. He then stated that the resident went to bed early on and woke up around 7 PM; that was all he remembered. He stated when Staff A arrived at the facility on at around 5 PM he stopped working and was watching TV. He was resting in the back. Staff A was there and gave out the medications.

In an interview with the administrator on at approximately 1 PM he stated he worked on because Staff B had another job and was resting. He confirmed that the schedule was not accurate and did not reflect the actual time that he and staff B worked.

Class

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0165-Risk Mgmt & QA; Adverse Incident Report 429.23 FS; 58A-5.0241 FAC
Based on record review and interview the facility failed to ensure an adverse incident report was submitted when 1 of 3 sampled residents (#2) at the facility and a police investigation was conducted.

Findings

In an interview with the administrator on at approximately 10 AM he stated resident #2 behaviors changed and he was walking around naked on at around 6:30 AM. He stated the non-emergency ambulance was called and when they arrived at the facility the resident was found not breathing. He further stated that the police arrived and was conducting an investigation.

The administrator stated that he had faxed the adverse report to the number that was on the form. He was informed at the time that the agency had not received a report from the facility. The administrator stated at the time that he would work on getting the Adverse Incident Report to the agency.

Class

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
St Mary's Home
718 W. Winter Park Street
Orlando, FL. 32804

Dear Administrator:

Re: CCR #2013011896

This letter reports the findings of a complaint investigation 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

Sincerely,

Theresa DeCanio, RN

Field Office Manager

LH/be
Enclosure

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