STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965487	12/11/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Bloomfield Manor	**2774 Wesleyan Dr Palm Harbor, FL 34684**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records
St - A - 0079 - 58a-5.019(4) Fac - Staffing Standards - Levels
St - A - 0083 - 58a-5.0191(4) Fac - Training - First Aid And

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

An unannounced extended congregate care (ECC) monitoring visit was conducted on

The Bloomfield Manor, assisted living facility, had deficiencies found at the time of this visit.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS

Based on observation, interview, and record review, the facility failed to ensure that residents of the facility are living in a safe environment, free from and neglect, treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.

Findings include:

Two AHCA Surveyors arrived at the facility on at 10:20am. Surveyor pushed front doorbell-heard ring, but nobody responded within ~2 minutes. Surveyor again pushed doorbell-heard ring-again there was no response within another ~2 minutes. Surveyors started to go around house to the right when we heard the front door open. Surveyors returned to front door being held open by woman-Surveyor asked woman if she lives here; she replied: " Yes. " When asked her name, Resident #1 provided her name. When asked if there was a staff person in the house, resident stated: " No. " When asked if there was an employee in the house, resident stated that her sister is here. Surveyors asked if we could come in to see her sister; resident opened door wide and let Surveyors enter. Surveyors introduced selves to resident upon entry--when closing door behind us, observed sign on inside of door, stating: " <Resident #1 ' s Name> Don ' t Open the Door " --and walked through house entryway to area adjacent to kitchen. A woman entered the kitchen from an entryway to right of kitchen. Surveyors introduced selves to woman and asked if she works at the facility. When told we rang the doorbell and asked why she didn ' t respond, the woman stated that she did not hear the doorbell because she was on the phone. Surveyor asked her name; she replied she is <Staff B>. Surveyor asked if she is working today- Staff B stated she usually works Fridays 9am through Monday 9am, but is filling in for somebody who is out. Staff B stated she is a Resident Aide. Surveyors followed Staff B through the kitchen entryway from which she had emerged to a back office where facility records are kept. While Surveyors were looking at records, Staff B went in & out (several times) of a door in the office that opened to a a bed and a television (on) in the

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It was apparent that Staff B did not hear the doorbell because she was in that back , the television on-and perhaps also on the phone, as she earlier stated. Surveyors became concerned that there was no staff supervision of residents; specifically concerned re. Resident #1 having answered the door, seeing note on door instructing her not to open the door, and considering that approximately 10 minutes had passed from the time Surveyors rang the doorbell and reached a staff person.

Surveyors conducted a record review specific to Resident #1 beginning at approximately 12:10pm) -Admit date . There were 2 Incident Reports in the record: one dated , indicating resident was hospitalized, but not admitted; and a second report dated to read, but indicated resident not admitted-signed on by the Administrator, per facility Manager. Surveyors reviewed the facility ' s communication log specific to Resident #1 - Notes are entered from through beginning document resident ' s increasing state of ; an incident on when Resident #1 became very agitated / angry at Staff C and her , including threatening to choke her ; and when Staff C was awoken at 6:00am by Resident #1 opening the front door to go outside: Per the communication log, Staff C " explained to <Resident #1> that she is not allowed to open the door-Resident became angry, went to her , and returned to open the front door again " 5 to 10 minutes later. " Resident #1 opened the front door again and told Staff C that she is allowed and < Staff C> is not her boss. Staff C wrote that she tried to explain to resident that " it was not safe, but she did not want to listen. " Staff C recorded that at 7:00am, Resident #1 ' s told Staff C that Resident #1 hit her; Staff C asked Resident #1 why, and was told by Resident #1 that her " kept saying things. " The next entry is at " 9:00or so-- <Resident #1> was sent to Hospital due to physician request. <Resident #1> was admitted.>> The next, and final, entry in the communication log specific to Resident #1 is dated : " <Resident #1> returned from hospital, is doing fine but very , does not remember some of the residents. " -- no case notes beyond readmission.

There was no Incident Report found in facility records regarding Resident #1 hitting her on .

There was no mention of possible harm caused Resident #2 from being hit by Resident #1 on , and there was no corrective plan found in facility records to prevent such an incident from occurring again. There are 4 residents in the facility.

There were no notes regarding hospital treatment, no hospital discharge plan, and no updated Resident Health Assessment for Assisted Living Facilities (AHCA Form 1823) signed by doctor or healthcare professional; there was no indication that Resident #1 is deemed eligible and appropriate for continued Assisted Living Facility residence or that her changing needs can be met by the current facility.

Class III

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	AL11965487	12/11/2013
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Bloomfield Manor	2774 Wesleyan Dr Palm Harbor, FL 34684	
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0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC

Based on record review and interview, the facility failed to ensure that either a nurse or an unlicensed staff member trained to assist with self-administered medication is available to assist residents with self-administered medications as prescribed. The facility also failed to ensure that assistance with self-administration was not provided for medications ordered by the physician or health care professional with prescriptive authority to be given "as needed" unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, at the request of a competent resident, for which the reason for administration did not require judgment or discretion on the part of the unlicensed person.

Findings include:

Surveyors conducted review the facility ' s Medication Observation Records on . . . . beginning at approximately 12:50pm. There were no staff signatures or initials on the reverse sides of any of the Medication Observation Records. There was a listing at the front of the Medication Observation Records of " Employees who assist residents with self-administration of medications. " Five employees are listed; only 3 provided their initials in the column allotted for initials. The Administrator (no initials provided), the Manager (initials provided), and 3 additional staff are listed (2 of 3 providing initials). Two of the 3 staff listed as " Employees who assist residents with self-administration of medications " are not listed anywhere on the staffing schedule for the months of , , or , 2013. Of the 5 listed as Employees who assist residents with self-administration of medications, only 2 are scheduled to work per review of , , and , 2013, staff schedules. Only one of the 2 provided initials in space allotted next to employee name. The initials for Staff A & Staff C having assisted residents with self-administration of medications can be identified on the Medication Observation Records; there are other initials that are indistinguishable and do not match staff names; most notably, Surveyors could not determine who provided meds assist on . . . . at 12pm, 5pm, 8pm or , . & . at 8am, 12pm, 5pm, or 8pm-or what the squiggly lines in the initials boxes that look like single " S " s signify. The Manager assisted Surveyors with determining some of the initials, identifying the Administrator ' s initials. The Manager was unable to decipher all initials, or identify who gave meds as listed on Resident #1 ' s Medication Observation Records-specifically, the markings for , 6, & 7 (2013) do not match any of the names or initials provided on the listing of " Employees who assist residents with self-administration of medications. " The Staff schedule for , 6, & 7 (2013) indicates Staff C & D working on . . . . 3-Staff C ' s initials are clearly indicated elsewhere on the MOR and are not the initials entered on ; per earlier discussion with the Administrator, Staff D did not work beyond . . . . . The Manager was unable to identify who worked on . . . . . The Administrator & Staff D are listed on the schedule as working on . . . . 3--The Administrator ' s initials are indicated elsewhere on the MOR (per assistance from the Manager) and are not the initials entered on , per earlier discussion with the Administrator, Staff D did not work beyond . . . . . The Manager was unable to identify who worked on Staff D is the only person listed on the schedule as working on ; per earlier discussion with the Administrator, Staff D did not work beyond . . . . The Manager was unable to identify who worked on . . . . . Surveyors were unable to track who gave medications on 12/5, 12/6, & 12/7, 2013-there was no evidence of a person properly trained in providing assistance with self-administration of medications having provided such assistance on . 6, & 7

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(2013).

Per Surveyor review of Resident #1 ' s Medication Observation Records, Resident #1 is prescribed a PRN medication with the following instructions: " Take one tablet by mouth two times daily as needed for pain/agitation. " Markings on Resident #1s Medication Observation Record indicate the PRN medication was given on . It is unclear who gave the medication and at what time the medication was given, and there is no entry on the reverse side of the record indicating the purpose or result of providing the PRN medication. The Manager was unable to identify who worked on who marked having provided the resident with the PRN medication, why the medication was given, or what effect the medication may have had on the resident. Since the person who marked having given the medication cannot be identified, there is no evidence that the medication was provided by a licensed person or by an unlicensed person who has undertaken the required training.

Class III

0054-Medication - Records 58A-5.0185(5) FAC

Based on observation, record review, and staff interview, the facility failed to ensure the Medication Observation Record (MOR) is immediately updated each time the medication is offered.

Findings include:

Surveyors conducted review of Resident #1 ' s Medication Observation Records on 12/11/13 beginning at approximately 12:50pm. The Manager stated (at 12:55pm) that he already gave the 12:00pm medications. The Manager also stated that he came into the facility and gave the 8:00am medications, adding that the staff on duty " can give meds, though, because she has been med trained. " Resident #1 ' s Medication Observation Records indicate that she is to receive 2 medications at 12:00pm -There were no initials for these 2 medications having been given at 12:00pm on the day of visit . When this was pointed out to the Manager at approximately 1:10pm, he stated: " I got a phone call from the big facility, so I did the meds on time, but I was unable to sign. "

Class III

0079-Staffing Standards - Levels 58A-5.019(4) FAC

Based on observation, record review, and interview, the facility failed to ensure that the facility is maintaining the minimum required staff hours per week or has enough qualified staff to provide adequate resident supervision.

Findings include:

There was no evidence of, or guarantee that, the facility is maintaining a minimum of 168 staff hours per week or

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Bloomfield Manor	2774 Wesleyan Dr Palm Harbor, FL 34684	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

has enough qualified staff to provide resident supervision. Vacant positions or absent staff may not be counted.

Staff B was the only staff person in the facility when Surveyors entered the facility at approximately 10:30am. Staff B stated that she usually works from Fridays starting at 9:00am through Mondays at 9:00am. Staff A arrived at the facility on at approximately 11:00am-He identified himself as the Facility Manager and stated that he had called Staff B in to work on , that Staff B is the only staff on duty, but that he pops in throughout the day. The staff schedule posted in the back office, not within view of residents or visitors, listed Staff C as staff on duty on both & . When Surveyors requested a copy of the schedule, the Manager crossed out Staff C and wrote Staff B in for the day . The Manager stated that he worked all day all by himself so called Staff B in to work . The Manager acknowledged that he was the only staff on duty and that although he pops in to the facility throughout the day, Staff B is the only staff person on duty .

On beginning at approximately 11:30am, Surveyors requested employee files for Staff A, B, C, and D - There was no file for Staff D-Per interview with the Manager, Staff D no longer works at the facility; Manager was unable to provide a termination date, so called Administrator, who stated to Surveyor on telephone at approximately 11:30am) that Staff D only worked one day with the Administrator, so he didn ' t put together a file for her--started on Sunday, scheduled her for month of , but let her go at 3pm on " because it did not work out. " Administrator stated he worked with Staff D the entire day. Staff C is listed on the schedule as the only staff person working on there is no indication that the Administrator or Staff D worked on that day, though they are scheduled elsewhere on the schedule. Surveyor review of Medication Observation Records (begun at approximately 12:50pm) indicated that Staff C provided resident medications from 8:00am through 8:00pm on Administrator stated he had already put Staff D on schedule for month of and did not change the schedule because " It says right on the schedule that the schedule is subject to change. " As of Surveyor visit, Staff D is still listed on schedule as working through 2013.

Per interview with the Manager, Staff B is not working weekends; she is only part-time on call. Staff B told Surveyors she works weekends and was just filling in on day of visit. The Manager stated that Staff B is on call and will not be working weekends, that she is part-time as needed.

Surveyors reviewed schedules for through , 2013 , beginning at approximately 11:20am): Except for the schedule change made by the Manager while Surveyors were at the facility on (change from Staff C to Staff B on , Staff B is not listed as working any time during the month of ber-she is not on the schedule. Staff B is listed as working during & , 2013, as follows: Tuesdays, & Wednesdays, 10/2, , possibly , & Thursdays 10/3, , , , 11/7, , & Fridays , 11/8, , & Saturday , & possibly (The 2 possibly scheduled dates had different names for end of month week on the following month ' s schedule.) None of the scheduled dates match Staff B ' s statement that she works Fridays starting at 9:00am through Monday morning at 9:00am.

The schedule lists Staff C & the Administrator working neither worked that day. The schedule does not

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contain work hours for the Manager. The work schedule for 2013 states Staff C is full-time live in 24 hours/5 days; Staff D is part-time live in 24 hours/2 days; and the Administrator ' s schedule is 9am-12:30 & 5-9pm; The Administrator, Staff C, and Staff D are the staff scheduled for the month of

Staff D, who Administrator stated only worked with him one day and was let go at the end of that day, is listed on the schedule (as of as working 12/5-12/8, &

Surveyor observation and review determined that the facility is not using or posting an accurate staff work schedule--there was no evidence that the facility is providing the minimum of 168 staff hours required per week for a facility with 4 residents. Per regulation, vacant positions or absent staff may not be counted. There was no evidence that the facility has enough qualified staff to provide adequate resident supervision.

Class III

0083-Training - First Aid and 58A-5.0191(4) FAC

Based on observation, record review, and interview, the facility failed to ensure that a staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses is in the facility at all times.

Findings include:

Per observation, Staff B was the only staff member on duty in the facility on when Surveyors arrived at 10:20am.

Per interview with the facility Manager on at approximately 11:00 am, Staff A was the only staff member on duty in the facility on The Manager emphasized that there are currently only 4 residents living at the facility, so only one staff person is usually on duty. He stated that since he had worked the previous day all by himself, he called in Staff B to work He further stated that he usually pops in during the day.

AHCA Surveyor review on beginning at approximately 11:40am of the personnel record for staff A revealed there was no evidence of staff A completing courses in First Aid. AHCA Surveyor review of the personnel record for staff B revealed staff B was certified in from there was no evidence of renewal beyond the expiration. There was therefore no staff member with a currently valid card documenting completion of First Aid and in the facility at all times.

The facility manager acknowledged at approximately 12pm) the above findings and the need for training/updates.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Bloomfield Manor
2774 Wesleyan Dr
Palm Harbor, FL 34684

Dear Administrator:

This letter reports the findings of an extended congregate care (ECC) monitoring visit 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 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 **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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