AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2014

Administrator
Good Samaritan Retirement Home
507 S.E. 1st Avenue
Williston, FL 32696

Dear Administrator:

Re: CCR #2013013064

This letter reports the findings of a state licensure survey that was conducted on . 2013 by a representative of this office.

Enclosed 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 . 2014 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 this office at (386) 462-6201.

Sincerely,

Kristie J. Mennella
Field Office Manager

KJM/amw

Enclosure

Headquarters
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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910275	12/18/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Good Samaritan Retirement Hm	507 S.E. 1st Avenue Williston, FL 32696	
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 - 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

Specific Tag Findings:

0000-Initial Comments

On unannounced complaint survey (CCR #2013013064) was conducted at Good Samaritan Assisted Living Facility in Williston Florida. Discernible deficiencies were identified as a result of this survey. The facility was not in compliance at this time.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on record reviews and interviews the facility failed to provide appropriate supervision for 1 of 4 residents (#1).

The findings include:

1. On during a record review of Resident #1's health assessment it was observed that the resident has a diagnoses of Mood and requires daily supervision.

2. On a record review was conducted on the one day adverse incident report filed on by the facility in reference to the elopement of Resident #1 on The report states that the resident did not show up for the noon or evening meal. At 9:00 PM evening staff contacted the owner of the facility and advised her that Resident #1 had not come back to the facility and did not sign out. The noon meal is served at 11:30 AM. From 11:30 AM to 9:00 PM is 9.5 hours before law enforcement was notified that Resident #1 was missing.

3. On a record review was conducted on the facility's elopement policy. The Policy states: "A resident has eloped when he/she left the facility grounds without signing Resident Sign-Out Log regardless of the length of time away from the facility." Further review of the facility's elopement policy revealed the facility's elopement procedure is (regardless of who is on duty) is to immediately notify the local police department. According to the adverse incident report staff knew that the Resident #1 did not show up for two meals and had left the facility and did not sign out, which according to the policy was an elopement.

Class III

0028-Resident Care - Activities of Daily Living 58A-5.0182(4) FAC
Based on observation record review and interview, the facility failed to assist 1 of 4 sampled residents with Activity of Daily Living (ADL) care as required (Resident #3).

The findings include:

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On at approximately 12:21 PM an observation was made of Resident #3 who was in a wheelchair. Resident #3 had on blue shorts which were soiled (wet) in the crotch area. Resident #3 went to his got into a chair and watched TV wearing the same soiled shorts.

On at approximately 1:50 PM Resident #3 was observed wearing purple shorts.

On Resident #3 was interviewed, he was asked what happened to his blue shorts, and he stated he changed them because he wet them. He was asked if staff assisted him with changing and Resident #3 denied he was assisted by staff and stated the reason he was not assisted was that there were no staff around to assist him.

On a record review was conducted on Resident #3 health assessment. It was revealed Resident #3 needs assistance with the following ADL care: ambulation, bathing, dressing and toileting. Further review revealed of the health assessment revealed Resident #3 needs supervision with self care and transferring.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on interviews and record reviews the facility failed to provide a 45 day notice of relocation or termination for 1 of 4 residents (#1).

The facility failed to honor the rights of 1 of 4 sampled residents by not providing a 45 day notice of discharge or termination.

The findings include:

On at approximately 10:45 AM an interview was conducted with the Administrator in reference to the elopement of Resident #1. The Administrator stated that on local law enforcement contacted her and advised her that Resident #1 was located at the hospital. The Administrator stated she told law enforcement that the facility could not accept Resident #1 back into the facility because Resident #1 caused too many problems. The Administrator stated Resident #1 constantly argued with staff and residents and she did not sign out of the facility like she was supposed to. The Administrator was asked if the facility had documentation showing that Resident #1's alleged behavior was disruptive or a danger to other residents and the Administrator said, "no". The Administrator was asked if the facility gave resident #1 a 45 day notice of discharge and she said, "no". The Administrator said that Resident #1 gave them a 30 day notice that she was going to move out on and it was recorded on the resident observation log.

On during a record review of Resident #1 records it was observed that the resident observation log contained the following entry's:
On Resident #1 was admitted into the facility as a routine admission.
On resident wrote a letter complaining about her The facility contacted the Veterans Administration Psychologist Office in Lake City. The facility then contacted Department of Children and Family Services. The case worker at DCF told Resident #1 to leave or stay and pay.
On Resident #1 gave a 30 day notice.
On the Administrator was unable to find 30 day notice Resident #1 gave the Administrator. The owner called and informed Administrator on Saturday that Resident #1 was missing and the incident was reported to the

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local police department.
Late entry for states Resident #1 was noticed with a black eye. Resident was questioned but refused to tell what happened. Gave the law enforcement information and a picture of Resident #1. At 9:30 PM law enforcement notified administrator that Resident #1 was located at a hospital. Resident #1 wanted to come back to the facility, but the Administrator refused to accept Resident #1 back, due to all the problems she had caused and because the owner also instructed the Administrator not to accept Resident #1 back to the facility.

Class III