STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910298	01/28/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Agnes St Hm For The Elderly	1346 Agnes Street Jacksonville, FL 32208	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= G
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D
St - A - Z815 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses S-S= C

Specific Tag Findings:

0000-Initial Comments

On 14-28, 2014 at Agnes Street Home For The Elderly assisted living facility, an unannounced complaint investigation (CCR# 2013013321) was conducted. There were deficiencies found at the time of the visit.

0078-Staffing Standards - Staff 58A-5.019(2) FAC

Based on interviews and observations the assisted living facility failed to ensure the appropriate trained staff member provided supervision and care and services to 7 of 7 residents (#2, #3, #4, #5, #6, #7, and #8). The unqualified staff member cooked, cleaned, and passed medications to residents in the facility. (Staff Member B)

The findings include:

1) On at 11:00 AM an interview was conducted the State Fire Marshall Detective. The Detective stated on he visited the facility and met with Staff member B. The Detective stated Staff member B advised him the Administrator asked him to watch the residents while he ran an errand. The Detective stated he observed three residents at the facility along with Staff member B.

2) On at 1:16 PM an interview was conducted with the Administrator. The Administrator stated that if he goes to the gas station up the street then residents are left at the alone at the facility. The Administrator stated staff member B was standing outside watching the facility on the day the Fire Marshall Detective visited the facility. The Administrator stated Staff member B only watched the residents on that one day until he went to get a drink from the store. The Administrator stated that Staff member B does not have a background screening and only worked out side of the facility. However, residents have confirmed staff member B cooked, cleaned, and passed out medications.

3) On at 2:11 PM an interview was conducted with Resident #8. Resident #8 stated there is someone at the facility at all times. He stated staff member B is at the facility 7 days a week both day and night. Resident #8 stated staff member B cooked, cleaned, and helps out with other needs of the residents. He stated staff member B passed out medication to residents.

4) On at 2:15 PM an interview was conducted with Resident #7. Resident #7 stated Staff member B does everything. He stated staff member B helps out with the cooking, cleaning and gives out medications. Resident #7 stated staff member B is 24 hour watchmen and lives at the facility. He reported staff member B is up 24 hours in the living TV.

5) On at 2:29 PM an interview was conducted with Resident #5. Resident #5 reported staff member B is

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at the facility all the time. Resident #5 stated staff member B cooks, clean and watches TV. He stated staff member B passed out all the medications every once in a while. Resident #5 reported staff member B was at the facility the same morning of the survey and assisted the residents in getting going off to the Community Rehabilitation Center (CRC).

On at 2:35 PM an interview was conducted with the Administrator. The Administrator confirmed staff member B did not have a background screening, Limited mental health training, or medication training.

On at 9:01 AM a phone interview was conducted with Department of Children and Families, Adult Protective Investigator (API). The API stated she visited the facility for an investigation on resident #1 being at the facility. The API stated during her investigation visit, the Administrator told her the guy who cooked was not there at the time. The API stated she has seen staff member B at the facility in the past about two or three years ago for during other investigations at the facility. The API stated she remember during one of those visits, staff member B was in the kitchen preparing dinner for the residents.

On at 1:17 PM a phone interview was conducted with staff member B. Staff member B stated a couple weeks ago a DCF worker came to the facility while he was standing outside doing yard work. He stated the Administrator had gone to the store for about five minutes and five residents left at the facility. Staff member B stated he contacted the Administrator for the DCF worker.

Class II

0165-Risk Mgmt & QA; Adverse Incident Report 429.23 FS; 58A-5.0241 FAC

Based on interviews, observations, and record reviews the assisted living facility failed to file an adverse incident report for an incident that required 1 of 8 residents (Resident #1) being transferred to the hospital for more acute care and required law enforcement investigation in which the facility personnel could exercise control and was not a result of the residents condition.

On Resident #1 was transported from the facility to the hospital for and activity. However, unexplainable were observed on Resident #1's body when he arrived at the hospital, and he later from Injuries.

Findings include:

1) On at 9:07 AM an interview with the Administrator was conducted. The Administrator stated on around 4:30 PM-5:00 PM Resident #1 had a while he was outside sitting in a chair. The Administrator stated he and resident #5 saw resident having the . He stated Resident #5 was keeping Resident#1 comfort until the Emergency Medical Services arrived. The Administrator stated he contacted the and they took Resident #1 to the hospital. The Administrator reported that the hospital staff advised him that Resident #1 had a high level of monoxide. The Administrator stated the hospital sent the fire department to the facility to check the monoxide levels. He stated the Fire Marshall came to the facility as and checked all . The Administrator reported the fire department did not find monoxide in the facility.

The Administrator stated the hospital contacted him about 9:30 PM on asking him about

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Resident #1's on his body. He stated that he advised the hospital he did not notice any on Resident #1. The Administrator reported he asked all the residents at the facility including Resident #1's (Resident #3, Resident#4, and Resident #6) about Resident #1's The Administrator stated the resident's advised him, they did not see Resident #1 smoking or any on the Resident #1. The Administrator stated he was surprised when the hospital contacted him about the He stated he advised the hospital to smell Resident#1's clothes. The Administrator stated Resident #1 smoked folded newspaper and cigarettes. The Administrator stated that Resident #1 at the hospital, and he was discharge from the facility.

2) A review was conducted of resident#1's hospital medical record. The Emergency Medicine Intervention form dated revealed Resident#1 admitting diagnosis were Status , and Monoxide (CO) (Medical Records Obtained)

3) On at 8:42 AM the Emergency Medical Technician (EMT) was interviewed via telephone. The EMT stated the Emergency Medical Service responded to the facility for resident #1 having a . The EMT stated once they arrived at the facility Resident #1 and other residents were located outside of the facility. He stated he thought since the facility had limited mental health residents, they were just standing outside. The EMT stated there were no signs of a fire and he did not smell any smoke. The EMT stated they spent about an hour with the resident and did not know he was He noticed later like bumps on the Resident#1's hand then the started turning into marks and became

4) A review of the EMT report revealed the EMT's arrived at the facility on at 5:00 PM for activity. Resident#1 was found slouched back in a chair, with snoring and no apparent pain. The EMT's notice Resident #1 had strange on his anterior chest and upper thighs. The then developed into superficial and partial There was no fire noted on scene. report obtained)

5) On at 10:25 AM an interview with Resident #1's Representative Payee was conducted via telephone. Representative Payee stated the hospital told her Resident #1's were hours old after he was admitted. She stated the looked like something had scolded Resident #1. The Payee stated the doctor told her Resident #1's were not cigarette because there was no trace of on his hands. She stated the facility was checked and there were no signs of a fire or cigarettes. The Representative Payee stated Resident#1 lost 75% of his and his kidney was shut down when he She stated the medical examiner advised her that the Fire Marshall report was not in the facility's favor. The Payee stated she did not know what happen to Resident#1 but the Medical Examiner found something acidic in the Resident #1's body. She stated she did not believe Resident #1 had his self.

6) On at 3:45 PM an interview was conducted State Fire Marshall, Detective C. Detective C stated his investigation with the facility was open and active. He stated his issues were that Resident #1's clothing he was wearing was not the same clothing he had on when arrived at the hospital. Detective C stated Resident #1's injuries were consistent with resident sitting down and dropping something in his lap. Detective C stated his investigation could turn criminal if the Administrator changed resident #1's clothes and it resulted in any medical negligence.

7) On at 11:00AM-12:15 PM a meeting was conducted with Detective C and Jacksonville Sheriff

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Office (Homicide unit) Detective K and Detective L. Detective C reported the Medical Examiner has not completed Resident #1's cause of , however, the Medical Examiner is calling the cause of Injury along with resident's other medical issues. Detective K stated they did not suspect homicide. Detective K suggested gaining entrance into the facility to ask further questions and if nothing is found it may be an accidental

8) On at 12:50PM the Administrator stated during an interview with Detective C that he could assure him the Resident #1 did not get in the facility. The Administrator remember Resident #1's clothing as jeans and a couple of shirts. The Administrator reported Resident#1's clothes were the same clothes he had on when he left the facility and when he last saw Resident #1 during lunch before resident #1 had his

9) On at 12:59PM resident#1's former observed to have some of his clothing ' s in the drawers. Pictures were taken by Detective C. There was no observable evidence found.

Class III

Z815-Background Screening; Prohibited Offenses 408.809, 435.02(2), 435.06

Based on interviews and observations, the assisted living facility failed to ensure 1 of 1 staff member (Staff member B) had a Level 2 background screening before providing direct care and services to residents 7 of 7 residents (#2, #3, #4, #5, #6, #7, and #8). Staff member B cooked, cleaned, and passed medications to residents.

Findings include:

1) On at 11:00 AM an interview was conducted the State Fire Marshall Detective. The Detective stated on he visited the facility and met with Staff member B. The Detective stated Staff member B advised him the Administrator asked him to watch the residents while he ran an errand. The Detective stated he observed three residents at the facility along with Staff member B.

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6) On at 2:35 PM an interview was conducted with the Administrator. The Administrator confirmed staff member B did not have a background screening.

7) On at 9:01 AM a phone interview was conducted with Department of Children and Families, Adult Protective Investigator (API). The API stated she visited the facility for an investigation on Resident #1 being at the facility. The API stated during her investigation visit, the Administrator told her the guy who cooked was not there at the time. The API stated she has seen staff member B at the facility in the past about two or three years ago for during other investigations at the facility. The API stated she remember during one of those visits staff member B was in the kitchen preparing dinner for the residents.

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Unclassified

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Agnes Street Home for the Elderly
1346 Agnes Street
Jacksonville, FL 32208

Dear Administrator:

This letter reports the findings of a complaint #2013013321 inspection survey conducted on 2014-J , 2014, by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **five business days** of receipt of this hand delivered report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= G
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D
St - A - Z815 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses S-S= C

Directed Corrective Actions:

1. The Administrator is required to immediately remove Staff Member B from providing supervision and direct care and services including cooking, cleaning, passing medication to all residents.

2. The Administrator is required to ensure Staff Member B and all newly hired staff members that provide direct care and services are in compliance with a Level 2 Background screen. Staff members who do not receive a Level 2 background screen cannot have contact with residents, resident's property, or resident's funds.

3. The Administrator is required to ensure Staff Member B and all newly hired staff members complete all initial trainings, medication trainings, Limited Mental Health trainings, and all required training for newly hired staff.

Agnes St Hm For The Elderly
2014

Please note: The facility had other deficiencies cited during the survey on 2014. The facility is obligated to correct these deficiencies as well.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call Catherine Anne Avery, Survey and Certification Support Branch, at (850) 412-4505.

Sincerely,

Robert E. Dickson
Field Office Manager

CB/RED/sm

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