STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966934	09/26/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
White Flowers	801 Ardenleigh Drive Orlando, FL 32828	
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 S-S= G
St - A - 0084 - 58a-5.0191(5) Fac - Training - Assis Self-Admin Meds & Med Mgmt S-S= D
St - A - 0091 - 58a-5.0191(12) Fac - Training - Documentation & Monitoring 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
Complaint Inspection #2014006511 was conducted from [redacted] White Flowers Assisted Living Facility had deficiencies found at the time of the visit.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on record review and interview, the facility failed to have evidence to confirm the administrator and staff protected the rights of the residents of the facility to live in a safe environment free from [redacted] and that a thorough [redacted] investigation was conducted by the facility for 1 of 4 sampled residents (#3).

Findings:

During an interview on [redacted] at approximately 11:15 AM with resident #3, she revealed that Staff A was mean to her, slammed the dishes, was rude and cursed, used vulgar language, and hit me with the cleaning cart. She [redacted] down. She told staff A she was hurt. Staff A told her she would call 911 but they never came. Thanks to her friend, resident #1, she helped her up. She told staff D and staff E about it. They said they reprimanded her and everything was OK.

During an interview with resident #1 on [redacted] at approximately 11:30 AM, she stated "A person was not supposed to talk bad about others but all was good now. Yes, (staff A) hit (resident #3) with the cleaning cart. She did things to me too, but it is all Ok now."

Neither resident#3 nor resident #1 was able to give the dates of the occurrence.

Record review for resident #1 and resident #3 did not have any documentation in their records about the incidents.

During an interview with staff E on [redacted] at approximately 10 AM, he stated he was informed

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966934	09/26/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
White Flowers	801 Ardenleigh Drive Orlando, FL 32828	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

of the alleged by Adult Protective Services (APS). The incident had occurred about a month before the report came. When resident #3's family came to visit the resident, he reported to them that staff A was mean to her and had hit her with a cart. He stated staff A resigned. He went on to explain that staff A told him it was time for her to move on, not because of what had happened. He stated when APS arrived, staff A was on vacation Saturday and was to return Friday. He explained during the time while staff A was on vacation, he conducted his investigation. He said he spoke with the resident and her family to try to determine what happened. The family wanted to speak with staff A after she returned. Before he allowed staff A to return to work, there was a meeting held with the resident, her family member, staff A and himself. He stated they all talked about everything and everyone left happy. He stated the resident felt comfortable having staff A around. Staff A even polished resident #3's nails and colored her hair. He said the resident did not feel threatened by staff A. He stated he would have never allowed staff A to return to work if he felt she was . After the meeting with the resident and her family, they were okay with staff A returning to work. If they were not okay with it, she would not have returned. He stated after the allegations, he would come to the facility more often and he would often review the camera in the facility. He asked both resident #1 and resident #3 why they did not come to him when this happened so he could have viewed the camera video.

Staff E was asked to provide documentation of the investigation into the grievance/alleged that he or the administrator had conducted once it was brought to his and the administrator's attention. He stated there was no documentation of the investigation.

He stated he had no documentation to confirm that he responded to the grievance/alleged once it came to his attention. He stated he did not know about the incident until after APS came in to do the investigation.

Personnel record review for staff A did not reveal any documentation in her record regarding the incident.

During an interview with resident #3's family member on at approximately 11:45 AM, the resident complained about staff A being rude and mean to her, like when she gave her food, setting the plate down with an attitude on the table, and hitting her with the cleaning cart. The resident said she spoke with staff E about the issue and he said he reprimanded staff A and all should be OK. She explained resident #3 continued to complain about staff A.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966934	09/26/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
White Flowers	801 Ardenleigh Drive Orlando, FL 32828	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

During an interview with staff E on ..... at approximately 10:00 AM said a man came out to investigate the because someone called after the facility did not do anything and staff A continued to work. Staff A went on vacation and after the vacation she returned to work. Sometime later, she quit the job. Now that she is not there, all seems well. He said he, staff A and staff E never had a conversation together. She thought that staff A should have been suspended while they investigated what happened but even after the man from Adult Protective services came, staff A continued to work.

During a telephone interview with the administrator (staff D) at 1:15 PM on , she stated she was informed of the incident the Monday following the report . She stated she spoke with staff A to ask her what happened. Staff A told her that she tried to provide good care to resident #3 and no matter what she did for her, she complained about it. She told staff A no matter what; you have to be nice and respectful to the residents. She stated she had never had a problem with staff A. She said staff A was an excellent employee; every time she was at the facility she took good care of the residents; she was very clean and nice to the residents. The administrator said something went wrong and she did not know what. When the administrator was asked if she had documentation to confirm that a thorough investigation was completed and that staff A was not allowed to work with the residents until after there was a conclusion, she stated she did an investigation along with staff E but they did not write anything down.

According to resident #3, she had previously complained to staff D and staff E about the treatment she received from staff A and nothing was done. The facility did not have any documentation to confirm that they had conducted an investigation to ensure all the residents of the facility were protected. Documentation to confirm that the facility had responded to the complaint of resident #3 regarding the ..... was not found.

According to staff E, staff A was not allowed to work until after he concluded his investigation and was sure that the residents were safe. He also stated he had a meeting with the family to discuss the allegations and they were alright with the results and staff A could return to work.

The family member, who staff E stated he had a meeting with, denied that the facility staff had a meeting with the family and was surprised that staff A continued to work with the residents after the allegation was made and the investigation was ongoing. The family member did not remember a meeting taking place. There was no way to determine whether the facility had conducted the investigation and protected the residents from .....

Class II

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966934	09/26/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
White Flowers	801 Ardenleigh Drive Orlando, FL 32828	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

0084-Training - Assis Self-Admin Meds & Med Mgmt 58A-5.0191(5) FAC
Based on record review and interview, the facility failed to ensure unlicensed staff that assisted with self-administration of medications received the required 4 hour training in providing assistance with the self-administration of medications and safe medication practices in an Assisted Living Facility provided by a Registered Nurse (RN) or Registered Pharmacist (RPh) for 1 of 5 sampled staff (C).

Findings:

During an interview with staff E (direct care staff) on at approximately 12:30 PM he stated staff C provided assistance with the self-administration of the resident's medications.

Personnel record review for staff C revealed a certificate that was dated The training was for 4 hours and was titled "medication administration". The certificate was signed by someone who did not include their credentials. Further Personnel record review for staff C revealed there was no documentation to confirm that she had received the initial 4 training in providing assistance with the self-administration of medications and safe medication practices in an Assisted Living Facility provided by an RN or RPh.

During an interview with staff E on at 1:15 PM, he confirmed that the required training was not provided.

Class III

0091-Training - Documentation & Monitoring 58A-5.0191(12) FAC

Based on personnel record review and interview, the facility failed to have evidence that 1 of 5 sampled staff (C) received the required in-service training within 30 days of hire.

Findings:

During an interview with staff E on at approximately 12:30 PM, he stated staff C was hired on

Personnel record review for staff C did not reveal any documentation to confirm that she had received the following training within 30 days of hire:

1. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11966934	(X3) DATE SURVEY COMPLETED 09/26/2014
NAME OF PROVIDER OR SUPPLIER White Flowers	STREET ADDRESS, CITY, STATE, ZIP CODE 801 Ardenleigh Drive Orlando, FL 32828	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

2. Resident rights in an assisted living facility and Recognizing and reporting resident neglect, and
3. Facility's resident elopement response policies and procedures
4. Safe food handling practices
5. Reporting major incidents and Reporting adverse incidents
6. Policy and Procedure

During an interview with staff E on at approximately 1 PM, he stated the administrator had provided the training to the staff and was working on giving her the certificates.

Class III

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 5 sampled staff (A & B) met the background screening requirements and were allowed to provide personnel care to the residents of the facility.

Findings:

1. Personnel Record review for staff A revealed she was hired on Further record review revealed that there was a Level II background screening result that was printed on The results noted staff A was "not eligible". Review of the agency's background screening website on at 12:25 PM noted staff A was "not eligible". Not eligible meant the staff was not eligible to work in the facility because of a disqualifying background screening offense.

2. Personnel record review for staff B hired revealed a level 1 background screening result that was dated over Review of the agency's background screening website on at 1 PM noted "New Screening Required".

During an interview with staff E on at approximately 1:15 PM, he stated he was not aware that staff A had "not eligible" results and he was not aware staff B was required to have a new screening.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

White Flowers
801 Ardenleigh Drive
Orlando, FL 32828
Attention: Blanca Flores, Administrator

Dear ..... Flores:

This letter reports the findings of a a complaint inspection (CCR#2014006511) conducted on . 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:

1) A0030 - Resident Care - Rights & Facility Procedures Class II
The Assisted Living Facility administrator and staff failed to protect the rights of the residents of the facility to live in a safe environment free from ..... and did not conduct a thorough investigation of alleged ..... This had the potential of leaving the resident at harm.

Your facility must comply with the following:

1) Your facility must conducted a thorough investigation of the alleged ..... that was reported. A copy of the investigation along with all supportive documentation must be available for AHCA staff to review. This must be completed within **5 calendar days** from the date of this letter.

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

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com

White Flowers
, 2014

Should you have any questions, please call ..... Lorraine Henry, Assisted Living Supervisor Orlando, at (407) 420-2534.

Sincerely,

Lorraine Henry
Health Facility Evaluator Supervisor

LH/be

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone (407) 420-2502; Fax (407) 245-0998

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
White Flowers
801 Ardenleigh Drive
Orlando, FL 32828

RE: CCR#2014006511

Dear Administrator:

This letter reports the findings of a state licensure complaint investigation survey that was conducted on , 2014 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 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

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com