STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964655	12/15/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Fremont Manor	909 Fremont Avenue Winter Park, FL 32789	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0079 - 58a-5.019(3) Fac - Staffing Standards - Levels S-S= D
St - A - 0084 - 58a-5.0191(5) Fac - Training - Assis Self-Admin Meds & Med Mgmt S-S= D
St - A - L243 - 58a-5.0191(8) Fac - Lmh - Training S-S= D

Specific Tag Findings:
0000-Initial Comments
A complaint investigation CCR# 2014012013 was conducted on . Fremont Manor Assisted Living Facility had deficiencies found at the time of the visit.

0010-Admissions - Continued Residency 58A-5.0181(4) FAC
Based on record review and interview the facility failed to monitor the continued appropriateness of placement for 1 of 8 sampled residents by obtaining an updated health assessment when the resident underwent a significant change (#5).

Findings:

1. On , at 2:55 pm, during an interview with Resident #2, he stated that Resident #5 has a problem with using the rest Resident #2 stated that Resident #5 likes to wet his pants and pee in the living ..... Resident #2 stated that it makes the entire house smell like pee.

2. On at 12:20 PM, during an interview with Resident #4, he stated that Resident #5 likes to use the bath ..... It was also stated by Resident #4 that Resident #5 uses the the floor and in other parts of the house.

3. On , at 10:00 AM, during a tour of the facility it was observed in . that the bed used by Resident #5 was covered in ... and feces. Resident #5 was observed sitting on the side of the bed with his pants around his ankles trying to toilet himself.

4. On , at 10:20 AM, in an interview with Staff A and Staff B, they stated the way

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and the adjoining found today is normal.

5. On at 3:24 PM, in an interview with the facility administrator, he acknowledged that the facility had not contacted the primary health care provider for Resident #5 regarding the significant behavioral change in not being able to toilet himself. The facility administrator acknowledged that the facility failed to have the current health assessment, which was completed on updated to document the change in the behavior. The facility did not request or obtain an updated Health Assessment Form. The facility administrator stated that Resident #5's incontinence problem has gotten worse over the past 90 days and Resident #5's refusal to wear disposable undergarments has been hard on the staff. The facility administrator stated that they had talked to Resident #5's sister about the possibly of moving Resident #5 to another facility but the facility had failed to document those efforts.

6. On at 10:55 AM in an interview with Staff A, it was stated that the facility was aware of the deteriorating behavior of Resident #5 regarding his inability to toilet independently, but they did not keep on-going notes or discuss an alternative placement facility. Staff A described Resident #5's behavior as having starting 90 days ago with the adjustment of Resident #5's medication. Staff A stated Resident #5 was wetting himself, wetting the bed and on the floor.

7. On at 3:18 PM, in an interview with Staff A, stated the facility did not talk with the primary health care provider for Resident #5 at any time about the changes in toileting.

8. A review of Resident #5's record conducted on revealed no documentation regarding change in his toileting or contact with the family or his health care provider.

Class III

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on record reviews and interviews it was found that the facility failed to contact the health care provider of Resident #5 based on significant change (the inability to toilet himself) and also failed to maintain a written record of those significant changes.

Findings:

On , at 10:00 AM, during a tour of the facility it was observed in bed that the bed used by Resident #5 was covered in and feces. Resident #5 was observed sitting

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on the side of the bed with his pants around his ankles trying to toilet himself.

2. On , at 10:00 AM, in an interview with Staff A and B, they stated the way and the adjoining found today is normal.

3. On , at 2:55 PM, during an interview with Resident #2, they stated that Resident #5 has a problem with using the rest Resident #2 stated that Resident #5 likes to wet his pants and pee in the living Resident #2 stated that it makes the entire house smell like pee.

4. On , at 12:20 PM, during an interview with Resident #4, they stated that Resident #5 likes to use the It was also stated by Resident #4 that Resident #5 uses the the floor and in other parts of the house.

5. On , during a record review of Resident #5, it found that the facility failed to provide a written record of the significant changes in the behavior of Resident #5 which includes his inability to toilet himself.

6. On , at 3:24 PM, in an interview with the facility administrator, it was stated that the facility acknowledges that they (the facility) had failed to properly document the changes to Resident #5, which included the inability to toilet himself and his failure to be in wearing disposable undergarments.

7. On , at 3:24 PM, in an interview with the facility administrator, it was stated that Resident #5 incontinence problems has gotten worse over the past 90 days and that Resident #5's refusal to wear disposable undergarments has been hard on the staff. The facility administrator stated that they had talked to Resident #5's sister about the possibly of moving Resident #5 to another facility but the facility had failed to document those efforts.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observations and interviews the facility failed to provide a safe and decent living environment for 11 of 11 residents by not taking steps to properly insure the living environment was free of and feces due to a resident being unable to toilet independently.

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Findings:

1. On , at 10:00 AM during a tour of the facility it was observed in bed that the bed used by Resident #5 was covered in and feces. Resident #5 was observed sitting on the side of the bed with his pants around his ankles trying to toilet himself. Exiting the was observed in the adjoining the floor was covered in and feces. The smell from both bed and the adjoining overwhelming and you had to leave the be able to breath. It was observed that the direct care staff (staff B) was talking with residents and did not attempt to clean the Staff B had to be directed to address cleaning and the adjoining

2. On , at 10:20 AM, Staff B was questioned about the condition of and the adjoining he stated that Resident #5 does this all of the time. He stated that Resident #5 urinates in his bed at night.

3. On , at 10:20 AM, in an interview with Staff A and Staff B, it was stated that Resident #5's behavior has gotten worse. They stated that he uses the rest wets his pants because he has no control. It was stated that Resident #5 will not wear disposable undergarments. They stated that he will fight them to put them on. They stated the way and the adjoining found today is normal.

4. On , at 10:55 AM, staff A stated that the facility does not maintain an on-going housekeeping schedule. Staff A stated that the staff cleans up after Resident #5 when they discover a problem.

5. On , at 12:20 PM, in an interview with Resident #4, it was stated that Resident #4 has witnessed Resident #5 dropping his pants and using the rest bed and not going to the rest go to the bath Resident #4 stated that Resident #5 goes to the bath the middle of the night and staff does not clean it up until the morning.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observations and interviews the facility failed to keep centrally stored medications in a locked area at all times.

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Findings:

1. On at 10:00 AM a tour of the facility was conducted. It was observed that bottled medication was stored on the dresser in which is assigned to staff. The door to was unsecured and within access to 11 of 11 residents.

2. On at 10:20 AM, during interviews with direct care staff A and B, that the bottle medication is stored on the dresser while the "bubble" pack medication is stored in a locked cabinet in the dining

3. On at 10:20 AM, during interviews with direct care staff A and B, they stated that is assigned to staff and that the door is kept unlocked.

Class III

0079-Staffing Standards - Levels 58A-5.019(3) FAC
Based on record reviews and interviews the facility failed to maintain the minimum 212 staff hours of coverage a week for a facility with 6 to 15 residents.

Findings:

1. On a record review was conducted on the monthly work schedule for the facility. It showed that the facility provided 168 hours of weekly staffing hours for residents #1 to #11, weekly for the month of 2014. The census at the time of the complaint investigation was 11 residents.

2. On at 3:24 PM, during an interview with the facility administrator he stated that the monthly work schedule is accurate. He stated that he was unaware that he needed to provide a minimum of 212 hours of coverage on weekly basis for a facility of 6 to 15 residents.

Class III

0084-Training - Assis Self-Admin Meds & Med Mgmt 58A-5.0191(5) FAC
Based on record reviews and interviews the facility failed to maintain the necessary annual training requirements for Assistance with Self-Administration of Medication for 2 of 4 staff (B and C).

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Findings:

1. On training record reviews were conducted on 4 of 4 staff that provided assistance with self-administration of medication. It was determined that 2 of 4 staff members (staff member B and C) did not maintain the required 2 hours of annual training for assistance with self-administration of medication. Staff B had completed the initial 4 hours of training for assistance with self-administration of medication on with no annual follow up hours completed. Staff C completed the initial 4 hours training on with no annual follow-up.

2. On at 3:24 PM the facility administrator stated during an interview that the training records provided during the record review were accurate and complete. It was stated that he was not aware that on-going training was needed.

Class III

L243-LMH - Training 58A-5.0191(8) FAC

Based on record reviews, the facility failed to maintain the necessary 3 hours of biennial training requirements for a Limited Mental Health Specialty license for 4 of 4 staff (Staff A, B, C and D).

Findings:

1. On a training record reviews were conducted on 4 of 4 staff working at the facility. Staff A completed the initial training Staff B completed the initial training on , Staff C completed the initial training on , and Staff D completed the initial training There was no additional training documentation in the files.

2. On at 3:24 PM- facility administrator stated during an interview that the files provided regarding employee training were accurate and complete. He stated that he was not aware of the training requirements needed to hold the Limited Mental Health Specialty License.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Fremont Manor
909 Fremont Avenue
Winter Park, FL 32789

RE: CCR #2014012013

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
XG90

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