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	AL11966837	01/05/2015
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List of Tags Cited:

St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
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 - 0032 - 58a-5.0182(8) Fac - Resident Care - Elopement Standards S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0085 - 58a-5.0191(6) Fac - Training - Nutrition & Food Service S-S= D
St - A - 0090 - 58a-5.0191(11) Fac - Training - S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D
St - A - 0165 - 429.23(1-4 & 6-10) Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= B
St - A - 0167 - 58a-5.025 Fac - Resident Contracts S-S= B
St - A - L243 - 58a-5.0191(8) Fac - Lmh - Training S-S= D

Specific Tag Findings:

0000-Initial Comments
Re-licensure survey with Limited Nursing Services (LNS) and Limited Mental Health (LMH) was conducted in conjunction to complaint inspection # 2014010838 on Aasbury Manor had deficiencies found at the time of the visit.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on record review and interview the facility failed to ensure the health assessment contained all required information for 1 of 3 sampled resident's records (#7).

Findings:

Resident record review for resident #7 on at approximately 2 PM revealed she was admitted to the facility on Continued review revealed a health assessment report dated The assessment did not address the resident's needs regarding assistance with self -administration of medications.

In an interview with the supervisor on at approximately 2:30 PM, who stated the information had been overlooked.

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0010-Admissions - Continued Residency 58A-5.0181(4) FAC
Based on record review and interview the facility failed to ensure that 1 of 3 sampled residents (#2) had a face-to-face medical examination by a health care provider at least every 3 years after the initial assessment.

Findings:

Resident record review for resident #2 on [redacted] at approximately 2 PM revealed a health assessment report dated [redacted] that listed [redacted] high [redacted] and [redacted] B deficiency. He was a right arm amputee. According to the health assessment assistance with self-administration was needed. Continued review revealed no evidence to confirm that an updated health assessment had been obtained in [redacted] 2014.

In an interview with the supervisor on [redacted] at approximately 2:30 PM, who stated the assessment was overlooked.

Class III

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observations, record review and interview the facility failed to ensure it provided personal supervision as appropriate to 1 of 7 sampled residents (#1) that included daily observation by designated staff of the activities of the resident while on the premises and maintaining a general awareness of the resident's whereabouts and did not follow the healthcare provider's order regarding medication administration.

Findings:

Resident #1 stated in an interview on [redacted] at approximately 10 AM that she lived there for 2 years now. There is yelling and screaming all the time, especially in the morning with the baths. No they do not treat me well or respect me. They call me {explicit} and {explicit}. I ' m ready to go to jail, see I have my clothes on I ready for jail. I spoke with the owner about this; she said I am hallucinating, hearing voices. Everyone in here wants me out of here, they don't like me. I am ready to go to jail rather than be here. I left the other day, I did not have luggage. I did not have any money, so I was going to walk until I found a Catholic church. I did not tell them I was leaving. The police brought me back. Adult Services came, told me to stay here 30 days. The owner gave me a list of places to call, if I wanted to move. But nobody

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listens, I get no answers, No help.

The resident was dressed with sandals, socks, coat, sweat pants a sweater and a shirt. Her purse was on top of the bed. She did not have identification on her person. She was observed interacting with the residents, staff, and the owners. They spoke friendly to her, as did she to them. She asked resident #2 if he had received his medications. She smoked outside, she came in and out.

In an interview with Staff C on ..... at approximately 11:30 AM who stated resident #1 left twice, went out and was brought back by the police. "I was not here the last time she left".

In an interview with Staff A on ..... at approximately 11:50 AM who stated resident #1 said she was going to the store across the street and did not come back. When we realized she did not return we called the police. Staff A was here also.

Resident record review revealed an updated health assessment dated ..... that listed diagnoses of chronic ..... with acute hallucinations, ... and ..... She was alert and oriented to self, able to complete activities of daily living without prompt. Medication management and supervision was needed. She was an elopement risk when not stable. The assessment indicated she was a danger to self or others when not stable. She needed administration of medication.

Note dated ..... left the facility yesterday evening ..... about 7:30 PM. She did not sign out or told the staff where she was going, 911 was called. Orlando Police Department came and took a report and found her walking on the street. She said she was trying to find Jesus. She took her medications and went to bed.

Note dated ..... indicated the resident was ..... and ....., making accusations that he police is coming, others stealing from her, calling her names. "Since her admission here she runs away frequently". She gave 30 days' notice to move out.

On ..... she saw her doctor, he adjusted some medications. She thinks others talk about her; the police are coming to take her to jail and want to pluck her eyeballs out.

In an interview with the supervisor on ..... at approximately 4 PM, who stated he did not notice the assessment indicated she needed medications to be administered; that was an error as the resident was appropriate to receive assistance from the unlicensed staff. The

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resident was appropriate for assisted living; she was not a danger to herself or others.

Class III

0032-Resident Care - Elopement Standards 58A-5.0182(8) FAC
Based on observations, record review and interview the facility failed to ensure 1 of 6 sampled residents (#1) who was identified as elopement risk by the healthcare provider and had history of elopement had identification on her person at all times.

Findings:

Resident #1stated in an interview on at approximately 10 AM that she lived there for 2 years now. There is yelling and screaming all the time, especially in the morning with the baths. They did not treat her well or respect her. "They call me {explicit} and {explicit}. I'm ready to go to jail, see I have my clothes on I am ready for jail. I spoke with {name} about this, she said I am hallucinating, hearing voices. Everyone in here wants me out of here, they don't like me. I am ready to go to jail rather than be here. I left the other day, I did not have luggage. I did not have any money, so I was going to walk until I found a Catholic church. I did not tell them I was leaving. The police brought me back. Adult Services came, told me to stay here 30 days. The owner gave me a list of places to call, if I wanted to move. But nobody listens, I get no answers, No help.

The resident was dressed with sandals, socks, coat, sweat pants a sweater and a shirt. Her purse was on top of the bed. She did not have identification on her person. She was observed interacting with the resident, staff, and the owners.

Resident record review for resident #1 on at approximately 2 PM revealed an updated health assessment dated that listed diagnoses of chronic with acute hallucinations, and
She was alert and oriented to self, able to complete activities of daily living without prompt. Medication management and supervision was needed. She was an elopement risk when not stable. The assessment indicated she was a danger to self or others when not stable. She needed administration of medication.

Facility note dated "Left the facility yesterday evening about 7:30 PM. She did not sign out or told the staff where she was going, 911 was called. Orlando Police Department

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came and took a report and found her walking on the street. She said she was trying to find Jesus. She took her medications and went to bed".

Facility note dated indicated the resident was and making accusations that he police is coming, others stealing from her, calling her names. "Since her admission here she runs away frequently". She gave 30 days' notice to move out.

In an interview with the supervisor on at approximately 4 PM, who stated the resident had identification on her purse. The resident walked by; he asked about her identification; she did not have any on her person; it was in her purse and her purse was in her

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on observations, record review an interview the facility failed to ensure to make every reasonable effort to ensure that prescriptions for 1 of 3 sampled residents (#2) who receive assistance with self-administration of medication were refilled in a timely manner.

Findings:

In an interview with resident #1 on at approximately 9:15 AM who stated the staff help me with my medications "They set them out and I take them". "I have been without medications because of the VA, most of the time they do not deliver on time. No point in calling them, you get the run-around. They say call 10 days before, but they did not mail them out on time. I need these medications".

Resident record review for resident #2 on at approximately 2 PM revealed a health assessment report dated that listed , high B deficiency; he was a right arm amputee. Per report assistance was self-administration was needed.

The 2014 Medication Observation Record (MOR) listed 15 milligrams (mg) every day and had "N" from 10/3 to

The MOR 500 mg one twice daily as needed for pain and had "N" from 11/4 to 8 AM and 5 PM ; 400 mg one 3 times a day had '"N" from

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to at 8 AM, 12 Noon and 5 PM.

The 2014 MOR listed 500 mg one twice daily as needed for pain and had "N" from to .

Review of the resident's medications bottle revealed the label dated 15 milligrams (mg) one daily and label dated 80 mg take half tablet at bedtime; 1 pill was available.

The supervisor checked the medications supply and stated the resident did not have any more or available.

In an interview with the administrator and supervisor on at approximately 3:30 PM who stated the facility assisted with self-administration of medications and the resident ordered his medications. They had no evidence when medications were ordered to ensure timely refill time. If the medications did not come; he did not have them.

Class III

0078-Staffing Standards - Staff 58A-5.019(2) FAC
Based on personnel record review and interview the facility failed to ensure 1 of 3 sampled staff (C) provided the facility with a healthcare provider statement to indicate that she was free from communicable .

Findings:

Personnel record review on at approximately 3 PM for staff C hired revealed a healthcare provider statement dated that indicated freedom from . Continued review revealed no evidence to confirm the staff provided a healthcare provider statement within 30 days of hire, based on an examination conducted no earlier than 6 months prior to the hire date, that she was free from communicable .

In an interview with the supervisor on at approximately 3:30 PM, who stated he thought she had provided the correct statement from the doctor.

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0081-Training - Staff In-Service 58A-5.0191(2) FAC
Based on personnel record review and interview the facility failed to have evidence that 1 of 3 sampled staff (C) received the required in-service training within the required time frames.

Findings:

Personnel record review for staff C revealed she was hired on [redacted] and was a caregiver. Continued review revealed no evidence to confirm she received 3 hours in-service training regarding activities of daily living and resident behavior and needs, within 30 days of hire. There was no evidence she was a nurse, a certified nursing assistant (CNA) or a home health aide (HHA), therefore exempt from the training.

There was no evidence she received an in-service regarding the facility's resident elopement response policies.

In an interview with the supervisor on [redacted] at approximately 3:30 PM, who stated he could not locate documentation to confirm that the staff had obtained the training as required.

A phone call was received on [redacted] from the supervisor. He stated he located the [redacted] training for staff C and would submit it by e mail to the Agency representative. An e- mail was not received by close of business on

Class III

0085-Training - Nutrition & Food Service 58A-5.0191(6) FAC
Based on record review and interview the facility failed to ensure the person in charge of food services (staff C) completed 2 hours of continuing education annually in topics pertinent to nutrition and food service.

Findings:

In an interview on [redacted] at approximately 1 PM with staff C, who stated she was the person responsible for the facility's food service.

Personnel record review on [redacted] at approximately 2:30 PM for staff C revealed there was no documentation to confirm that she had completed 2 hours of continuing education annually regarding nutrition and food service in an assisted living facility.

In an interview on [redacted] at approximately 2:45 PM with staff C, who stated she needed to

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obtain the continuing education requirements.

Class III

0090-Training - 58A-5.0191(11) FAC
Based on personnel record review and interview the facility failed to ensure 1 of 3 sampled staff (C) who provided care to residents, received at last one hour of training in the facility's policies' and procedures regarding)within 30 days after employment.

Findings:

In an interview on at approximately 11:30AM with staff C who stated when asked if she knew what a was, "I can't remember". After the surveyor told her what it meant, "She stated I know that word; we have nobody like that here".

Personnel record review on at approximately 3 PM for staff C hired revealed no evidence to confirm that she received 1 hour of training in the facility's policies and procedures regarding within 30 days of employment.

In an interview with the supervisor on at approximately 3:30 PM, who stated he could not locate documentation to confirm the staff had obtained the training as required.

A phone call was received on from the supervisor. He stated he located the training for staff C and would submit it by e-mail to the Agency representative. An e- mail was not received by closing of business on

Class III

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on observations, interviews and records review the facility failed to ensure that regular and therapeutic menus were reviewed annually and a 3-day supply of nonperishable food, that included long life milk, was on hand at all times.

Findings:

During the facility tour on at approximately 9 AM staff C stated the facility census was 11 residents.

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Observations on at approximately 11:30 AM noted the menu posted and to be prepared and served was signed by the Registered Nutritionist on The menu was dated for the week in use.

Observations of the facility's emergency food supply at approximately 1:30 PM noted an open box of milk with an expiration date of

Based on a census of 1 residents and the 3 meals contracted to provide, the facility needed 16.5 quarts of milk (11 residents x 1/2 quarts x 3 days=16.5 quarts).

Review of the resident contract at approximately 2 PM for residents #1 and #2 revealed the facility would provide 3 meals a day.

In an interview with the administrator on at approximately 1 PM who stated the menu was not updated because the nutritionist was out of town and she did not notice the milk had been opened and expired.

Class III

0162-Records - Resident 58A-5.024(3) FAC
Based on record review and interview the facility failed to ensure that 1 of 3 sampled residents (#1) who received assistance with the supervision of self-administered medications from unlicensed staff, had a signed informed consent form that indicated whether the unlicensed staff would or would not be supervised by a nurse.

Findings:

Observations on at approximately 9:15 noted resident #1 took his medications with assistance from the facility staff.

Resident record review for resident #1, on at approximately 2 PM revealed an updated health assessment dated that listed diagnoses of chronic with acute hallucinations, She was alert and oriented to self, able to complete activities of daily living without prompt. Medication management and supervision was needed. She was an elopement risk when not stable. The assessment indicated she was a danger to self or others when not stable. She needed administration of medications. Continued review revealed the unlicensed staff assisted the resident with self- administration of medications as evident by

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their initials on the Medication Observation Records dated 1024 and 2015. An informed consent regarding receiving assistance with self-administration of medications from unlicensed staff was not available.

In an interview with the supervisor on at approximately 2:30 PM, who stated he did not notice the assessment indicated she needed medications to be administered; that was an error as the resident was appropriate to receive assistance from the unlicensed staff. The form was overlooked.

Class III

0165-Risk Mgmt & QA; Adverse Incident Report 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC
Based on records review and interview the facility failed to submit to the Agency the 1 and 15 day reports for 3 of 3 incidents where the police was called regarding a missing resident (#1).

Findings:

In an interview with the supervisor on at approximately 10 AM there were no adverse reports available as none had taken place.

Resident #1 stated in an interview on at approximately 10 AM that she lived there for 2 years now. There is yelling and screaming all the time, especially in the morning with the baths. They do not treat me well or respect me. "They call me {explicit head and {explicit}. I'm ready to go to jail, see I have my clothes on I ready for jail. I spoke with the owner about this; she said I am hallucinating, hearing voices. Everyone in here wants me out of here, they don't like me. I am ready to go to jail rather than be here". I left the other day, I did not have luggage. I did not have any money, so I was going to walk until I found a Catholic church. I did not tell them I was leaving. The police brought me back. Adult Services came, told me to stay here 30 days. Diane gave me a list of places to call, if I wanted to move. But nobody listens, I get no answers; No help.

The resident was dressed with sandals, socks, coat, sweat pants a sweater and a shirt. Her purse was on top of the bed. She did not have identification on her person.

Residents were observed to go shower, there was no screaming or behavior problems. She took a shower as well. She sat and ate lunch with the other residents. She joked with residents and staff. She was comfortable in her surroundings. She smoked outside, she came in and

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out.

Resident record review revealed an updated health assessment dated that listed diagnoses of chronic with acute hallucinations, She was alert and oriented to self, able to complete activities of daily living without prompt. Medication management and supervision was needed. She was an elopement risk when not stable. The assessment indicated she was a danger to self or others when not stable. She needed administration of medication.

The facility notes documented that on the resident woke up in the morning about 6AM and she found herself lying on the floor in the Her pants were own the floor, wet. She said she did not know how long she was there. The staff stated her pants were soaked with smelly strong odor of At approximately 3 PM she stated she did not know if she was raped. She was informed the police would be called and she needed to go to the hospital. She stated maybe I had an accident and refused to go to the emergency talk with the police. "She is and Police was called. The resident told the police she did not know why she said she was raped because she was a light sleeper and if someone touched her; she would wake up. The resident refused medical treatment. She stated she was OK, needed some rest. She was seen by doctor the day before. She was prescribed 50 mg at bedtime and continue Thorazine in the morning for 1 week. The was to be increased to 100 mg after 1 week.

Note dated Returned from hospital, in good spirits. At about 7 PM she called the police and ambulance stated she needed and cigarettes. She hit her head against the window; like she wanted to break it. She was given what she wanted, she calmed down after the police and emergency personnel came.

Note dated Left the facility yesterday evening about 7:30 PM. She did not sign out or told the staff where she was going, 911 was called. Orlando Police Department came and took a report and found her walking on the street. She said she was trying to find Jesus. She took her medications and went to bed.

Note dated indicated the resident was and making accusations that the police is coming, others stealing from her, calling her names. "Since her admission here she runs away frequently". She gave 30 days' notice to move out.

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In an interview with the supervisor on [redacted] at approximately 10 AM there were no adverse reports submitted as he did not know that when the police was called, a report needed to be filed.

Class [redacted]

0167-Resident Contracts 58A-5.025 FAC
Based on resident record review and interview the facility failed to ensure the resident contracts for 1 of 3 sampled resident records (#1) contained all the necessary requirements.

Findings:

Resident record review for resident #1 on [redacted] at approximately 2 PM revealed the contract did not include a provision that indicated that all residents must be assessed upon admission pursuant to subsection 58A-5.0181(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4) of that rule.

In an interview with the supervisor on [redacted] at approximately 2:30 PM, who stated the contract must have come apart because she was sure the information was included in the contract.

Class [redacted]

L243-LMH - Training 58A-5.0191(8) FAC
Based on personnel record review and interview, the facility failed to ensure that 1 of 3 sampled staff (B) received a minimum of 3 hours of Limited Mental Health (LMH) continuing education biennially.

Findings:

Personnel record review on [redacted] at approximately 3 PM for staff B, the registered nurse and administrator, who had direct contact with the facility residents; revealed the staff received the initial LMH training in 1999. She attended continuing education courses until 2012. Further review revealed no evidence to confirm the staff received 3 hours of continuing education in topics related to mental health every 2 years thereafter.

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In an interview with the administrator on at approximately 3:30 PM, she confirmed the findings.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2015

Administrator
Aasbury Manor Alf
5302 Satel Dr
Orlando, FL 32810

RE: Biennial w/LNS & LMH

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2015 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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