STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932406	09/08/2015
NAME OF PROVIDER OR SUPPLIER **ALL SEASONS ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **509 W. VERONA STREET** **KISSIMMEE, FL 34741**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

The re-licensure survey with Limited Nursing Services (LNS) and Limited Mental Health (LMH) was conducted on / . All Seasons Assisted Living had deficiencies found at the time of the visit.

0025 Resident Care - Supervision

Based on record review and interview the facility failed to ensure the healthcare provider and the responsible party were notified of a significant change for 1 of 3 sampled residents (#3).

Findings:

Resident record review revealed and Assisted Living Facility Health Assessment Form (1823) updated / / that indicated diagnosis of

Review of the facility notes dated / / revealed the resident was sent to the emergency . There was no documentation to review that indicated the healthcare provider and responsible party were notified.

In an interview with the manager on / at approximately 3 PM who stated the facility did not document that they were notified.

Class III

0081 Training - Staff In-Service

Based on review of personnel files and interview the facility failed to ensure direct care staff received the required training within 30 days of hire for 1 of 6 sampled staff (Staff C).

Findings:

Review of personnel files revealed staff C, caregiver, date of hire / , did not receive Resident Rights training within 30 days of hire.

In an interview with the manager on / at approximately 3 PM she stated the staff received the training with the , Neglect and training, however it was not documented on a training certificate.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932406	**09/08/2015**
NAME OF PROVIDER OR SUPPLIER **ALL SEASONS ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **509 W. VERONA STREET** **KISSIMMEE, FL 34741**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

Class III

0091 Training - Documentation & Monitoring

Based on review of personnel files and interview the facility failed to ensure certificates included the number of hours and date of the training program for 1 of 6 sampled staff (Staff C).

Findings:

Review of personnel files for Staff C revealed the hours and date were not documented on the training certificate for training and for the Safe Food Handling training on , the hours were not documented.

In an interview with the manager on at approximately 3 PM who stated the training programs were one hour and the dates were not documented, she also stated she was the trainer.

Class III

0093 Food Service - Dietary Standards

Based on interviews the facility failed to ensure that a 3-day supply of nonperishable food, that included water, based on the number of weekly meals the facility had contracted with residents to serve, was on hand at all times.
Findings:
During the facility entrance on / at approximately 9 AM the manager stated the facility census was 54 residents.
Observations on at approximately 12 PM of the facility's emergency food supply noted there was no water stored for use in the event an emergency. The facility needed at least 162 gallons of water (54 residents x1 gallon x 3 days).
In an interview with the cook on / at approximately 12 PM who stated the facility had collapsible water containers.
Continued observations noted 50 collapsible containers with a 5 gallon capacity each.
At approximately 12:30 PM the manager provided a letter from a water distribution company in which it indicated the water company would make reasonable effort to deliver water in the event of an emergency. She also provided a letter dated submitted to the County Emergency Management to update the facility's emergency plan.
Review of the facility's Emergency Management Plan revealed the collapsible containers were not included as the source of water, but rather had the contract with the water company.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932406	09/08/2015
NAME OF PROVIDER OR SUPPLIER **ALL SEASONS ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **509 W. VERONA STREET** **KISSIMMEE, FL 34741**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

Class III

L243 LMH - Training

Based on record review and interview the facility failed to ensure staff received a minimum of 6 hours of approved training in Limited Mental Health within 6 months of hire for 1 of 6 sampled staff (Staff C).

Findings:

Review of personnel files revealed staff C, date of hire / , did not have documentation that he had received 6 hours of training in Limited Mental Health within 6 months of hire.

In an interview with the manager on / at approximately 3 PM who stated she was unable to locate his training certificate and stated staff had recently taken the training.

Class III

Z816 Background Screening-Compliance Attestation

Based on personnel record review and interview the facility failed to ensure that 1 of 6 sampled (Staff C) completed the Affidavit of Compliance with Background Screening.

Findings:

Personnel record review for Staff C, caregiver, date of hire / /15, revealed there was no documentation to review that indicated Affidavit of Compliance with Background Screening was completed.

During an interview with the manager on / at approximately 3 PM, who stated the employee did not complete the Affidavit of Compliance with Background Screening.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[illegible], 2015

Administrator
All Seasons Assisted Living
509 W. Verona Street
Kissimmee, FL 34741

RE: Relicensure w/LNS/LMH

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on [illegible] 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than [illegible], 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 [illegible]-2502.

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