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SUMMARY STATEMENT OF DEFICIENCIES
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0000 Initial Comments

An unannounced financial monitoring survey was conducted on / through at Gulf Winds, an assisted living facility in Venice, Florida.

The following deficient practice was identified during the visit.

0008 Admissions - Health Assessment

Based on resident record reviews and staff interviews, the facility failed to ensure 1 (Resident #2) of 4 resident health assessments reviewed was completed with all required information. The resident's special diet needs was not addressed.

The findings included:

A review of Resident #2's health assessment dated / showed there was no diet ordered on this assessment.

Observation during lunch on at 2:55 p.m. showed the staff gave Resident #2 a pureed diet. An interview was conducted with the cook at that time. The cook said he gives Resident #2 a pureed diet.

An interview was conducted with the Administrator on at 3:30 p.m. She reviewed Resident #2's Health Assessment and confirmed the diet order was not indicated on that assessment. She continued to review Resident #2's record. She said she found an order from hospice for a diet.

A review of the 4-cycle menus revealed only a regular menu with instructions to follow for a low-fat/low , no concentrated sweets, and no added salt diet.

Class III

0010 Admissions - Continued Residencv

Based on observations, resident record reviews, facility record review, and staff interviews, the facility admitted and retained 2 (Residents #4 and #5) of 29 residents to the facility who are inappropriate to reside in an assisted living facility. The facility readmitted Resident #5 when his needs (for care) could not be met by the facility. The facility provided care and services (administer and treatments) to Resident #4 by an unlicensed facility staff.

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The findings included:

1. A review of the facility admission and discharge log showed Resident #5 went to the hospital on and was readmitted to the facility on . A review of the health assessment by the physician at the hospital, dated / , showed Resident #5 requires 24-hour nursing supervision and, in his opinion, the resident's needs cannot be met in an ALF (assisted living facility). The health assessment showed " [patient] needs frequent assessments of LE [lower extremity] and care." The health assessment documented Resident #5 had "chronic LE wounds."

An interview was conducted with the Administrator on / at 2:00 p.m. She staid she was not aware this information was on his health assessment. She verified Resident #5 was currently in the hospital due to a change in the condition of these wounds.

2. Observation of Resident #4 on / / , revealed Resident #4 was returning to bed after supper. The resident was stood up, by Staff C grasping the resident under the arms and lifting her to her feet. The resident was able to bear her weight and was pivoted by Staff C and lowered onto the bed. Staff C then handed Resident #4 her tubing and clasped Resident #4's hands and fingers and attempted to manipulate the residents fingers to put the tubing in the residents nostrils. The resident was unable to do this and Staff C stopped after it became obvious the resident had asleep. Staff C continued to stand beside the bed and look at the resident. The Administrator, who was present, said the resident usually assisted with the , yet admitted when the resident could not assist, the staff applied the and turned on and set the concentrator.

Observation on included a beside Resident #4's bed. The Administrator verified the unlicensed staff administer the treatments to the resident. The Administrator stated, "Well we will be able to do these things soon." (The Administrator was referring to the anticipated changes in assisted living facility regulations resulting from changes in the Florida statutes.) The Administrator said Resident #4 was under hospice care and was ordered to have 2 liters of on when in bed. She verified hospice staff was not providing this service when it is needed. The Administrator verified the facility has no licensed staff.

Class III

0025 Resident Care - Supervision

Based on resident records reviewed and staff interview, the facility failed to notify the responsible parties

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when a significant weight loss occurred for 1 (Resident #4) of 5 resident records reviewed. The facility failed to document a significant incident for 2 (Resident #14 and #20) of 2 residents involved in an altercation. The facility failed to provide adequate assistance with transfers for 1 (Resident #25) of 29 residents resulting in an injury.

The findings included:

1. A review of Resident #4's record showed the following weights:
On / she weighed 103 lbs. (pounds);
On / / she weighed 101 lbs.;
On / the health assessment showed a weight of 96 lbs.;
On she weighed 95 lbs.;
On / she weighed 93 lbs.

This is a 10 pound weight loss in 10 months. Further review of Resident #4's record showed no documentation that the physician, hospice, and the resident's responsible party were notified of this significant weight loss.

An interview about the lack of notification was conducted with the Administrator on / at 1:10 p.m. She stated, "She is on hospice."

2. On / at 11:53 a.m., Resident #14 stated, Resident #20 punched her "in the mouth about 2 weeks ago and broke one of my [illegible]. I called the police on a violent resident, and I've been black balled by staff and some of the residents, about two weeks ago. I never went to the hospital or the dentist after that. [The Administrator] didn't want me to report it to the police."

On at 1:15 p.m., the Administrator said Staff F witnessed this incident and to speak with her.

On at 1:30 p.m., Staff F said approximately 3 weeks ago this incident happened. She said Resident #14 was taunting Resident #20. She was bringing a tray from a resident to the kitchen. She told Resident #14 to stop taunting Resident #20. She saw Resident #20 get up from the table where he was sitting and told him to sit back down and ignore Resident #14. She said she turned around and Resident #20 leaped over to Resident #14 and hit her in the jaw. She grabbed his arm too late. Resident #14 told Staff F she was going to call the police. Staff F said there were no injuries. When asked about Resident #14's missing lower [illegible], she confirmed Resident #14 had all her [illegible] before the incident.

A review of the incident report showed this altercation occurred on between Resident #14 and

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#20. Staff F was the witness to the altercation. She wrote she had to "...pull them apart and everything was fine." The incident report failed to show the physician, law enforcement, the registry, and residents representatives were notified. The incident report failed to show any steps taken to prevent this from reoccurring.

A review of Resident #14's record showed no documentation of this incident or her missing.

3. On at 3:30 p.m. and again on at 2:15 p.m., a family member of Resident #25 said the resident used a walker when she moved in the facility, but now she is in a wheelchair and is . She said Resident #25 was dropped from her recliner to her wheelchair on / when transferring with the assistance of one staff. Resident #25's knee was " and painful. The resident had a mobile x-ray done after the injury. Due to continued pain, Resident #25 was sent to an acute care hospital for further evaluation.

On at 3:45 p.m., the Administrator verified Resident #25's with injury occurred while under the care of a facility caregiver. She admitted she had not completed any reports about the incident.

Class II

0026 Resident Care - Social & Leisure Activities

Based on observations, review of the facility calendar, and staff interview, the facility failed to provide resident activities. The facility also failed to ensure they are offering residents at least 12 hours of activities each week.

The findings included:

Observations on / / from 11:00 a.m. until 8:30 p.m. revealed there was only 1 activity, Bingo. The activity began when Resident #25's daughter came to the facility to run the Bingo game.

Observations on from 9:00 a.m. until 4:00 p.m. showed again there were no activities offered to the residents by staff. There was only 1 activity, Bingo, which occurred when Resident #25's daughter came to the facility to run the Bingo game.

Observations on from 9:00 a.m. through 2:30 p.m. showed residents were not offered activities.

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In an interview on at 11:53 a.m., Resident #14 stated, "Bingo is all they do here, and I'm not into it."

In an interview on / at 12:30 p.m., Resident # 18 stated, "What activities?"

In an interview on at 9:40 a.m. Resident #20 stated, "There are none. I wish they had more groups like singing groups, more things to do."

In an interview on at 11:00 a.m. Resident #22 stated, "Bingo? no!"

A review of the activity calendar posted in the dining : "AM: daily news, games and puzzles, music." Further review of the activity calendar showed a.m. activities listed and p.m. activities listed. The calendar did not show a total of 12 hours of activities per week.

On / at 2:45 p.m. Staff A and Staff D, both confirmed they did not offer residents activities today. They said they did not have any time to run activities because it takes most of their day to provide activities of daily living care to the residents along with two meals.

In an interview on at 2:35 p.m., Staff F said the music guy comes sometimes, they have Bingo and some cards. Activities are not done until after 3:00 p.m., if they are done.

Class III

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0030 Resident Care - Rights & Facility Procedures

Based on interviews and record reviews, the facility failed to ensure a safe environment for 3 (Resident #14, #22, and #25) of 29 residents. The facility failed to protect Resident #14 from Resident #20 resulting in Resident #14 being hit in the mouth and losing a . The facility failed to protect Resident #22 from . The facility failed to prevent injury for Resident #25. The facility failed to train staff as required.

The findings included:

1. On at 11:53 a.m., Resident #14 stated that Resident #20 punched her in the mouth about 2 weeks ago and broke one of my . She stated, "I called the police on a violent resident, and I've been black balled by staff and some of the residents, about two weeks ago. I never went to the hospital

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or the dentist after that. [The Administrator] didn't want me to report it to the police."

On at 1:15 p.m., the Administrator said Staff F witnessed this incident and to speak with her.

On at 1:30 p.m., Staff F said approximately 3 weeks ago this incident happened. She said Resident #14 was taunting Resident #20. She was bringing a tray from a resident to the kitchen. She told Resident #14 to stop taunting Resident #20. She saw Resident #20 get up from the table where he was sitting and she told him to sit back down and ignore Resident #14. She said she turned around and Resident #20 leaped over to Resident #14 and hit her in the jaw and she grabbed his arm too late. Resident #14 told Staff F she was going to call the police. Staff F also stated there were no injuries. When asked about Resident #14's missing lower , Staff F confirmed Resident #14 had all her before the incident.

A review of the incident report showed this altercation occurred on between Resident #14 and Resident #20. Staff F was the witness of this altercation. She wrote she had to "...pull them apart and everything was fine." A review of the incident report showed physician, law enforcement, registry, and residents representatives were not notified. Also no steps were taken to prevent this from reoccurring.

A review of Resident #14's record showed no documentation of this incident or her missing.

Review of facility records showed Staff F was hired on as a direct care staff. Staff F had no documentation of training in resident behaviors, resident rights, , neglect and , elopement, emergencies, incident reports or safe food handling. Staff F did have a certificate for a 75 hour Home Health Aide training. The certificate lacked the course content, so could it could not be determined which of the required training it may have met.

2. On at 11:00 a.m. Resident #22 stated, "They told me I had to go to bed when I did not want to. I hate it here. A night staff female yells at me. I've had things stolen, a brand new pair of shoes. I told the Administrator about the shoes being stolen and nothing happened."

On at 2:35 p.m. Staff F said Resident #22 is concerned about "the girls" who provide care (Staff B and Staff C). Staff F said Resident #22 thinks they are not doing anything for him. Staff F said Resident #22 said they talk nasty to him.

3. On at 3:30 p.m. and again on at 2:15 p.m., a family member of Resident #25 said the resident used a walker when she moved in here, but now she is in a wheelchair, and is . She said Resident #25 was dropped on / / when transferring from her recliner to her wheelchair with the

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assistance of one staff. Resident #25's knee was [illegible] and painful. The resident had a mobile x-ray done after the injury. Due to continued pain, Resident #25 was sent to an acute care hospital for further evaluation.

On [illegible] at 3:45 p.m. the Administrator, verified Resident #25's [illegible] with injury occurred while under the care of a caregiver. She verified she had not completed any reports about the incident.

4. Personnel record reviews revealed 12 (Staff A, B, C, D, E, F, G, H, J, K, L, and N) of 13 persons hired as direct care staff or employed over 30 days lacked documentation of required trainings. Staff lacked training in [illegible] control, activities of daily living and resident behaviors, resident rights, [illegible], neglect and [illegible], elopement, emergencies, incident reports, or safe food handling. A culture where staff are not trained as required to perform their job duties from [illegible] 2014 through [illegible], 2015 is a direct threat to the health and well-being of the residents.

Class II

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0031 Resident Care - Third Partv Services

Based on resident records reviews, observation and staff interviews, the facility failed to ensure they have a policy relating to the communication between the facility and home health agencies. The facility failed to ensure information was communicated between the facility and the home health agencies providing care and services for 2 (Residents #5 and #9) of 5 residents reviewed with third party services.

The findings included:

1. On [illegible] at 11:00 a.m., the administrator stated that Resident #5 was receiving home health care for the [illegible] on his toe.

On [illegible] at 10:05 a.m., home health agency folder was observed in Resident #5's [illegible]. A review of the home health agency notes show the last visit from the agency was [illegible]. Documentation on [illegible] visit showed "[illegible] care" written and there are vital signs. There was no description of the type of [illegible], treatment done, size, location, etc.

On [illegible] at 11:10 a.m., the Administrator reviewed the home health agency sheet in Resident #5's [illegible] confirmed this information was not on the form. The Administrator was not able to say what type of care and treatment the home health agency was providing for this [illegible]. She stated the

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is on Resident #5's left big toe and his legs are wrapped up to his calf/knee area.

On [illegible] at 12:15 p.m., the Administrator said she does not have a written policy for communication with home health agencies who deliver care and services to residents. She stated the verbal policy is the agencies will sign in the book and fill out the form and place it back in the book. The book is located in the front lobby of the facility. She will take these filled out forms and then put them in the residents' records.

A review of Resident #5's record showed there were no forms filled out by the home health agency providing him [illegible] care. There was no communication found between the home health agency and the facility concerning Resident #5's [illegible].

2. On [illegible] at 11:53 a.m., observation of Resident #14 revealed an indwelling [illegible] in place. A review of health assessment dated [illegible] / [illegible] showed the resident had a [illegible].

The Administrator provided a list of residents who received home health care. Resident #14 was on this list.

A review of Resident #14's record and the home health agency book showed no documentation related to the third party services provided to Resident #14.

Class III

0052 Medication - Assistance with Self-Admin

Based on observation and interview, the facility failed to ensure unlicensed staff assisted 4 (Resident #4, #5, #7, and #9) of 7 residents with self-administration of medication within the scope of their duties and training required under Florida Statutes (FS). The facility failed to provide prescribed medications to 2 (Resident #18 and #5) of 4 residents reviewed for medications.
Unlicensed and untrained staff drawing [illegible] into a syringe has the potential to directly affect the safety and well-being of the resident. Unlicensed staff are required to have 4 hours of medication training which does not include [illegible] dosing. Unlicensed and untrained staff do not have training in [illegible] titration which can affect the safety and well-being of the resident by over or under [illegible].

FS 429.52 (6) "Staff involved with the management of medications and assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of

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training provided by a registered nurse, licensed pharmacist, or department staff. The department shall establish by rule the minimum requirements of this additional training."
At the time of the survey, training for assisting with self-administration of medications by unlicensed staff did not address sugar testing, and administration. The minimum requirements for this additional training had not been established.

The findings included:

1. On at 12:00 noon, observations included Staff D gave Resident #18 his medications. The (an medication) card showed there was one pill left. A review of the Medication Observation Record (MOR) revealed he was going to receive this medication at 4:00 p.m. that day.

On at 12:00 noon, the was still in the medication card for Resident #18. An interview was conducted with Staff F at this time. She stated she did not give this medication to Resident #18 in the morning.

On / at 2:15 p.m., Staff C said she gave the to Resident #18 last night. However, observation at 12:00 noon showed this pill was still available.

A review of the MOR showed Resident #18 is to receive this medication three time a day. Resident #18 did not receive his third pill on / .

2. A review of Resident #5's physician order on the health assessment dated showed, " care - [right] great toe and leg - clean w/[with] ns [normal] apply prisma [a dressing], cover w/mepilex border [a foam dressing with adhesive]. change mwf [Monday, Wednesday, Friday]. Apply [a lactic formulated] lotion to legs and feet (not between toes) q [every] shift."

A review of Resident #5's MORs for through 2015 showed he was not receiving the lotion.

A review of Resident #5's home health agency notes showed there was no documentation they were providing the lotion.

On at 11:50 a.m., the Administrator reviewed the physician order on the health assessment and stated she was not aware of the order.

On /5 at 12:00 p.m., the home health agency Director of Nursing, said the nurse comes to the

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facility every day to do care with Viscopaste [a paste bandage] and stretch guard and paper tape for Resident #5. She was not aware of the order for the lotion and they are not putting this lotion on his legs.

3. On / at 2:30 p.m. Staff F said she assisted Resident #5 and #9 with their sugar testing and . She said she gives Resident #5 the stick (lancet) and he pokes himself. She places the tape into the device and hands it to him. She then takes it back and notes the sugar test result and writes it down. She then dials the dose amount on the pen. Resident #5 then gives himself .

For Resident #9, Staff F said she does the same for the sugar, but the is in a bottle. She draws the amount needed up and hands the syringe to Resident #9. She said she knew how to draw up the bottled into the syringe.

4. On / at 10:00 a.m., Resident #7 said staff assist her with her medications. She said she will wake up and find her pills on the floor or water spilled on the floor. She will be sleeping, the staff will place pills on her night table and not wake her up.

5. Observation of Resident #4 on / , revealed Resident #4 was returning to bed after supper. The resident was stood up, by Staff C grasping the resident under the arms and lifting her to her feet. The resident was able to bear her weight and was pivoted by Staff C and lowered onto the bed. Staff C then handed Resident #4 her tubing and clasped Resident #4's hands and fingers and attempted to manipulate the residents fingers to put the tubing in the residents nostrils. The resident was unable to do this and Staff C stopped after it became obvious the resident had asleep. Staff C continued to stand beside the bed and look at the resident. The Administrator, who was present, said the resident usually assisted with the , yet admitted when the resident could not assist, the staff applied the and turned on and set the concentrator.

Observations on / included a beside the Resident #4's bed. The Administrator verified the unlicensed staff administer the treatments to the resident. The Administrator stated, "Well we will be able to do these things soon." (The Administrator was referring to the anticipated changes in assisted living facility regulations resulting from changes in the Florida statutes.) The Administrator said Resident #4 was under hospice care and was ordered to have 2 liters of on when in bed. She verified hospice staff were not providing this service when it is needed. The Administrator verified the facility has no licensed staff.

Class II

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0077 Staffing Standards - Administrators

Based on observation, resident and staff interviews, the court appointed receiver (as a financial manager), subcontracted management company, and Administrator failed to ensure enough staff to provide care and services to meet resident needs for 6 (Residents #2, #6, #13, #23 #25, and #29) of 29 current residents. The managers and Administrator failed to prevent and ensure a safe environment for 3 (Resident #14, #22, and #25) of 29 residents. The managers and Administrator failed to provide all residents scheduled activities. The managers and Administrator failed to schedule the facility for 24 hour First Aid and ( ) coverage. The managers and Administrator failed to ensure all staff had training necessary to do their jobs and failed to audit the daily financial operations of the facility, ensure the properly executed contracts for each resident were honored and failed to ensure resident personal income was provided to them for 6 (Residents #2, #14, #18, #19, #22 and #30) of 35 residents reviewed for financial information.
These failures directly threaten the residents and resulted in Residents #14 and #25 being injured, Resident #2 waiting hours for meals, and Resident #22 being .

The findings included:

1. a) On / at 11:53 a.m., Resident #14 stated that Resident #20 punched her in the mouth about 2 weeks ago and broke one of my . She stated, "I called the police on a violent resident, and I've been black balled by staff and some of the residents, ... I never went to the hospital or the dentist after that. [The Administrator] didn't want me to report it to the police."

On at 1:15 p.m., the Administrator said Staff F witnessed this incident and to speak with her.

On at 1:30 p.m., Staff F said approximately 3 weeks ago this incident happened. She said Resident #14 was taunting Resident #20. She was bringing a tray from a resident to the kitchen. She told Resident #14 to stop taunting Resident #20. She saw Resident #20 get up from the table where he was sitting. She told him to sit back down and ignore Resident #14. She said she turned around and Resident #20 leaped over to Resident #14 and hit her in the jaw. She grabbed his arm too late. Resident #14 told Staff F she was going to call the police. She said there were no injuries. When asked about Resident #14's missing lower , she confirmed Resident #14 had all her before the incident.

A review of the incident report showed this altercation occurred on between Resident #14 and #20. Staff F was the witness of this altercation. She wrote she had to "...pull them apart and everything

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was fine." A review of this incident report failed to show the physician, law enforcement, registry, and residents representatives were notified. Also, there were no steps taken to prevent this from reoccurring.

A review of Resident #14's record showed no documentation of this incident or loss of her .

Review of personnel record showed Staff F was hired on / as a direct care staff. Staff F had no documentation of training in resident behaviors, resident rights, , neglect, and , elopement, emergencies, incident reports or safe food handling. Staff F did have a certificate for a 75-hour Home Health Aide training. The certificate lacked the course content, so could it could not be determined to meet the training requirements.

b) In an interview on at 11:00 a.m. Resident #22 stated, "They told me I had to go to bed when I did not want to. I hate it here. A night staff female yells at me. I've had things stolen. A brand new pair of shoes. I told the Administrator about the shoes being stolen and nothing happened."

On at 2:35 p.m. Staff F said Resident #22 is concerned about "the girls" who provide care (Staff B and Staff C). Staff F said Resident #22 thinks they are not doing anything for him. Staff F said Resident #22 said they talk nasty to him.

c) On / at 3:30 p.m. and again on at 2:15 p.m., a family member of Resident #25 said the resident used a walker when she moved in here, but now she is in a wheelchair and is . She said Resident #25 was dropped on / when transferring from her recliner to her wheelchair with the assistance of one staff. Resident #25's knee was " and painful. The resident had a mobile x-ray done after the injury. Due to continued pain, Resident #25 was sent to an acute care hospital for further evaluation.
On at 3:45 p.m. the Administrator verified Resident #25's with injury occurred while under the care of a caregiver. She verified she had not completed any reports about the incident.

2. Observation of the noon meal on revealed the Cook called off and the Administrator said she could not get anyone else to come in. The meal was being served by the a housekeeper. The facility served all the residents in the dining meals, special requests and re-orders. After all residents in the dining served at 2:00 p.m., the staff began to serve the residents in their . Observation of the food preparation found staff did not know how to puree a meal. The ground hot dog was put into a blender and blended into small chucks. The housekeeper put the baked beans in the blender and made a soupy paste. The second time she was prompted by another staff to added water to the hot dogs and got a more puree consistency. She added water to both the beans and corn. The beans were very runny. The corn became a watery corn-flavored liquid. This was served to

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Residents #2 and #13.
Observation on revealed the supper meal began at 5:15 p.m. Since the housekeeper was gone, only two staff were scheduled on the second shift. One staff became the cook and the second staff waited tables. Food service and resident care continued until 6:45 p.m. At 7:00 p.m. Resident #2, who is bedbound, had still not been assisted to eat.
Observation during lunch on / at 12:20 p.m. showed there are two staff serving lunch to the residents and one cook preparing meals. There is a table of six residents sitting together. Five residents were served their lunch by 12:23 p.m. Resident #6 was not served until 12:50 p.m. Four of these residents finished eating by 12:40 p.m. Resident #23 (who is sitting at this table) requested a sandwich at 12:35 p.m. She said did not like the pork. She received her sandwich at 1:15 p.m.

Residents #2 and #13 are on hospice care and remain in their beds at all times.
On at 12:55 p.m., Staff D stated that these two residents eat in their .
Observation on at 1:43 p.m. showed Residents #2 and #13's pureed foods were prepared by the cook. The cook placed them in bowls on the kitchen counter waiting for the staff to serve the two residents.

The surveyor notified Staff A at 1:45 p.m. that the food was ready for the two residents to be served. She put the food bowls onto plates and walked away.

Observation at 2:30 p.m. showed the food was sitting on the kitchen counter. After surveyor intervention at 2:30 p.m., Residents #2 and #13 were both served their lunch by 2:55 p.m.

On / at 2:30 p.m., Staff D and Staff A both said they were taking care of Resident #22 who requires two people to assist with his needs. They were also taking care of other residents' toileting needs. Staff D also had to take care of the medication pass. They both stated they need one staff for medication pass and two staff for resident care needs. There are only two staff on this shift. As a result, they can't take care of all the resident needs timely.

3. Observations on / throughout the course of the day showed no activities being offered. A review of the activity calendar located in the dining ': "AM: daily news, games and puzzles, music" are scheduled in the morning.
On at 2:45 p.m., Staff D and Staff G both stated they do not have any time to run these activities. It takes most of their time to provide activities of daily living for the residents and provide assistance for two meals. When they had three staff working on this shift "everything ran much easier" and they were able to provide the scheduled activities.
Observation on from 9:00 a.m. through 2:30 p.m. showed the scheduled activities on the calendar were not offered. On / the facility had added a pool staff person on the day and evening

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shifts. This additional help still did not allow staff to have time to provide activities.
4. In an interview on at 10:22 a.m., Resident #8 said she needs assistance with her showers. Staff told her not to shower without assistance. She wants a shower every other day but only gets two a week. "There are only 2 people working each night and has to wait and wait and wait."

On at 11:10 a.m., Resident #24 said staff help her with showers, dressing, and sometimes the . Sometimes they are "slow." She has to wait a little longer "maybe about 1/2 hour."

On at 12:25 p.m., Resident #6 said he always has to wait a long time to get his food (he is ordered a puree diet). He is the last to eat. There are not enough staff in the dining . For every meal everyone has to wait a long time to be served.

On at 10:20 a.m. Resident #29 said she has been here about 15 months. The night staff asleep on the couch. They (the administration) know about it.

On / at 3:30 p.m. and again on at 2:15 p.m., a family member of Resident #25 said the resident used a walker when she moved in here, but now she is in a wheelchair, and is . She said Resident #25 was dropped on when transferring from her recliner to her wheelchair. Resident #25's knee was " and painful. The resident had a mobile x-ray done after the injury. Due to continued pain, Resident #25 was sent to an acute care hospital for further evaluation.

On at 3:45 p.m., the Administrator verified Resident #25's with injury occurred while under the care of a caregiver. She verified she had not completed any reports about the incident.

On / at 2:30 p.m., Staff I said there are not enough staff to take care of laundry. Sometimes there is no cook and one of the direct people has to cook leaving one person on the floor through dinner.

On at 2:35 p.m. Staff F said there are not enough staff. "We need 3 not 2. Two staff is a rush and we have to focus on medications, dining , laundry and people."

A review of the staff schedule on / / revealed two direct care staff are scheduled for each shift. A cook is scheduled from 7:00 a.m. to 7:00 p.m., and a housekeeper is scheduled from 7:00 a.m. to 3:00 p.m. Monday through Friday. No additional staff are scheduled to replace the housekeeper on the weekends; thereby adding to the work load of the direct care staff. The Administrator does not appear on the schedule.

The staffing schedule was reviewed with the Administrator on and again on / . On the Cook was present for the noon meal, but not the supper meal. The lack of care and food service

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was discussed with the administrator at 7:30 p.m. on and again at 2:30 p.m. on . The administrator said 4 current residents required two-person assistance with activities of daily living and transferring. She then said it would take another 2 staff to evacuate the remaining 25 residents in 13 minutes. She was told she must staff to meet the needs of the residents including unplanned emergency needs.

On one agency staff person was placed on the day and evening shift. The services went quicker, but still no activities were provided to residents and Resident #2 was not assisted to eat until after all the other residents had eaten.

5. Record review revealed:
a) 12 (Staff A, B, C, D, E, F, G, H, J, K, L, and N) of 13 persons employed as direct care staff or employed over 30 days lacked documentation of required trainings. Staff lacked training in control, activities of daily living and resident behaviors, resident rights, , neglect, and , elopement, emergencies, incident reports or safe food handling.

b) 9 (Staff B, C, D, E, F, G, H, K, and M) of 10 direct care staff employed over 30 days failed to receive the training in the facility's policy and procedures for ( ) within 30 days of employment.

c) 2 (Staff D and G) of 6 unlicensed staff assisting with medications failed to obtain the required 4 hours of initial training. Unlicensed untrained staff assisting with medications have the potential to effect the health and well-being of the residents.

d) The Administrator failed to ensure at least one staff member per shift, who had completed courses in First Aid and and holds a currently valid card documenting completion of such courses, was in the facility at all times for 13 (Staff A, B, C, D, E, F, G, I, J, K, L, N, and O) of 15 staff employed and 3 of 3 shifts, except 5 days a week when Staff H worked the 6:00 a.m. to 2:00 p.m. shift, or when the Administrator was in the building.

On at 7:30 p.m. the Administrator said the information in the staff files was all she had. She verified everything was filed in the folders. She stated she knew Staff H had First Aid and recently and she was current also.

A review of the staff schedule showed 5 of 7 days when Staff H worked the 6:00 a.m. to 2:00 p.m. shift, so the facility had coverage for that shift. The remaining scheduled shifts did not provide First Aid/ coverage. The Administrator did not appear on the schedule and the facility maintained no time sheets.

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She verified the schedule only has 5 of 21 shifts weekly where there is First Aid and coverage. She said she did not know if anyone else had the training and admitted she had not planned the schedule for coverage.

6. On at 11:30 a.m. the Administrator said she had become the administrator about two weeks ago. She had taken and passed the Assisted Living Facility (ALF) Core training and had recently had a ALF Core up-date. Record review revealed a receiver was appointed by the Court on / . The Administrator said the Receiver subcontracted with a Management Company, closer to the facility, to assist with the operations of the facility. The administrator said the manager acted as the administrator until they asked her if she wanted to be the administrator and she was promoted. The Administrator said she was not given any instructions on the financial or business aspect of running the facility. She said the Management Company does all of that. She said she only knew how much to collect from the residents because she was given a list of resident and amounts owed.
She said there was no accounting in the facility. She accepted checks and deposited them in the facility business account. She did not keep a separate account for resident funds, but co-mingled all funds in the business account.

She showed the surveyor a binder she was recording the resident funds kept by the facility. For 2 of 3 (Residents #22 and #14) resident fund accounts reviewed, neither account had been credited for personal funds not contractually owed to the facility.

The administrator said she logs the monthly payment checks into a receipt book by check number only and occasionally makes a copy of the checks.

The administrator verified the facility was a representative payee for 2 residents (Residents #20 and #22). The administrator said the facility had been the payee for these two residents since their respective admissions. The administrator verified the social security check for Resident #14 is stamped before deposit, like the other two Social Security checks and deposited in the facility account. She verified, the check is not made out to the facility as representative payee, but it is treated like it is. She said these checks are deposited in the one facility account from which all transactions are paid out.

The administrator verified there is no surety bond as required.

Attempts were made to get payment records and bills for each resident. Spread sheets were finally obtained on , but only showed partial money collections by month from 2015 to 2015.

The administrator and Consultant verified the facility has no ongoing accounting for each resident since

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their admission, or through , 2015.

a) A review of the safekeeping documentation revealed Resident #22 had no money deposited in the safekeeping accounting since his admission on / except for $24.00. The resident was charged for haircuts and nail trimming and owed the facility a balance of $26.

Resident #22 receives $1057.00 a month from Social Security.
A review of the contract revealed Resident #22 was to pay the facility $700.00 a month with an additional $1100.00 from the Health Maintenance Organization. This amount would leave a balance of $357 each month for the resident. Which leaves $1785.00 unaccounted for.

On the administrator stated she just deposits the whole check. She had not realized the entire amount was not owed to the facility and should be credited to the resident for spending money.
She was observed to immediately write "$1785" at the top of the safekeeping form for Resident #22.

She further said the facility pays for Resident #22's medications monthly. A review of the pharmacy statement for / revealed the resident's year to date medication expense totaled $266.83, leaving $1518.17 unaccounted for.

b) A review of safekeeping documentation showed Resident #14 debits for hair care. As of / the account shows a negative balance of $20.00 and no money.

A review of the contract signed / revealed Resident #14 was to pay $600.00 to the facility and the Health Maintenance Organization would pay $1200.00 a month. A rate change notification revealed the contracted amount was lowered from $1800.00 a month to $1200.00 a month for a semi-private

On , Financial Spread sheets from 2015 through 2015 show the facility was collecting $1724.00 a month and documenting a debit of $76.00 a month for lack of payment.

As of , the facility should have refunded $185.90 for the decrease in rent due to living in a semi-private . Also the facility should not have collected the $524.00 for or .
The safekeeping documentation showed a debit of $20.00 and no deposit of the funds from to , leaving $1233.90 unaccounted for and due to Resident #14.

Staff M, Administrator, said she did not realize the money was not due the facility. She stated she deposits the checks and the facility pays for the resident's medications monthly ($24.66 a month).
A review of the pharmacy invoice obtained on , revealed the resident's year to date medication

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expense was $206.42. That amount plus the $20.00 for beauty salon services, would leave a credit of $1007.48 unaccounted for.

c) A review of Resident #18's contract dated revealed the amount contracted for was $1600.00. A review of the financial spread sheets from 2015 to 2015 revealed the resident is being charged $2200.00 a month. This would constitute an overpayment of $600.00 a month.

d) A review of Resident #2's contract dated and revealed the amount contracted for was 2500.00. A review of the financial spread sheets from 2015 to 2015 revealed the facility is charging Resident #2 $3400.00 a month. This is an overcharge of $900.00 a month without contractual right or $5400.00 overpayment.

On / the facility submitted a statement from Resident #2's Bank trust showing the $3400.00 has been paid monthly since . These 35 overpayments would amount to $31,500.00.

e) A review of Resident #19's contract revealed the contract was executed on . The contract amount was $1950.00 a month. Review of the facility accounting spread sheets from 2015 to 2015 revealed the resident is being charged $2000.00 a month. No rate increase notice was present in the resident's record. This amounts to a $50.00 a month rate increase without contractual right.

f) A review of Resident #30's contract revealed the signatures were not dated. The contract showed Resident #30 was to pay $800.00 a month and the Health Maintenance Organization (HMO) was to pay $1100.00 a month. A review of the financial spread sheets revealed the facility had been collecting $1900.00 from the resident and $1100.00 from the HMO since 2015 at least. This would be an overpayment of $1100.00 a month.

Class II

0078 Staffing Standards - Staff

Based on record reviews and staff interview, within 30 days after beginning employment:
1) The facility failed to ensure newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable for 10 (Staff B, C, D, E, G, H, J, K, L, and N) of 11 staff hired since 2014 and employed over 30 days. The examination performed by the health care provider must have been conducted no earlier

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than 6 months before submission of the statement. Evidence of a negative examination must be documented on an annual basis.
2) The facility (with licensed capacity greater than 17) failed to provide a written job descriptions to each staff member for 9 (Staff A, B, E, F, J, L, N, O, and the Administrator) of 15 staff employed.
3) The facility failed to maintain time sheets for all 15 staff.
A culture where the facility fails to ensure staff are medically screened within 30 days of hire and annually thereafter from 2014 to 2015 has the potential to threaten the health and well-being of residents.

The findings included:

1. Staff personnel record review on and revealed the following:

a) Staff A was hired on as a direct care staff. Staff A had no job description in the file.

b) Staff B was hired on as a direct care staff. Staff B had no documentation of freedom from communicable including . Staff B had no written job description.

c) Staff C was hired on / as a direct care staff. Staff C had no documentation of freedom from communicable including .

d) Staff D was hired on as a direct care staff. Staff D had no documentation of freedom from communicable including .

e) Staff E was hired on as a direct care staff. Staff E had no documentation of freedom from communicable including . Staff E had no written job description.

f) Staff G was hired on / as a direct care staff. Staff G had no documentation of freedom from communicable including .

g) Staff H was hired on as a direct care staff. Staff H had no documentation of freedom from communicable .

h) Staff J was hired on as a housekeeper. Staff J had no documentation of freedom from communicable including . Staff J had no written job description.

i) Staff K was hired on / as a direct care staff. Staff K had no documentation of freedom from communicable including .

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j) Staff L was hired on / as a cook. Staff L had no documentation of freedom from communicable . Staff L had no written job description for cook.

k) Staff N was hired on / as a cook. Staff N had no documentation of freedom from communicable including . Staff N had no written job description for cook.

l) The Administrator was recently promoted to the administrator position. Record review found no documentation of the promotion and no job description for an administrator.

2. In an interview on at 7:30 p.m., the Administrator stated the information in the staff files was all she had. She verified everything was filed in the folders. The Administrator said staff had not completed time sheets for as long as she knew, and she had worked there since . She said the only record was the work schedule, there were no time sheets for any staff.

Class III

0079 Staffing Standards - Levels

Based on observations, resident, family, and staff interviews, and review of facility records, the facility failed to ensure there are enough staff to provide care and services to meet resident needs for 6 (Residents #2, #6, #13, #23 #25, and #29) of 29 residents and to provide all residents scheduled activities.
Failure to staff to meet the needs of the residents directly threatens the residents, resulted in injury to Resident #14, and resulted in Resident #2 waiting hours for meals.
Per Florida Administrative Code 58A-5.019 (3)(d) "The facility must provide staff immediately when the agency determines ... that adequate supervision and care are not being provided to residents, ..."

The findings included:

1. On at 11:53 a.m., Resident #14 said that Resident #20 punched her in the mouth about 2 weeks ago and broke one of her . She never went to the hospital or the dentist. She went and told the Administrator and the Administrator didn't want her to call the police.

On at 1:30 p.m., Staff F said approximately 3 weeks ago this incident happened. She said Resident #14 was taunting Resident #20. She was bringing a tray from a resident to the

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kitchen. She told Resident #14 to stop taunting Resident #20. She saw Resident #20 get up from the table where he was sitting. She told him to sit back down and ignore Resident #14. She said she turned around and Resident #20 leaped over to Resident #14 and hit her in the jaw. She grabbed his arm too late. Resident #14 told Staff F she was going to call the police. Staff F said there were no injuries. When asked about Resident #14's missing lower [illegible], she confirmed Resident #14 had all her [illegible] before the incident.

2. Observation of the noon meal on [illegible] revealed the cook called off today and the Administrator could not get anyone else to come in. The meal was being served by the housekeeper. The facility served all the residents in the dining [illegible] meals, special requests, and re-orders. After the dining [illegible] (except Resident #6's puree diet) was served at 2:00 p.m., the staff began to serve the residents in their [illegible]. Observation of the food preparation found staff did not know how to puree a meal. A hot dog was put into a blender and blended into small chucks. The housekeeper put the baked beans in the blender and made a soupy paste. The second time she was prompted by another staff to added water and got a more puree consistency for hot dogs. She added water to both the beans and corn. The beans were very runny and corn was a watery corn-flavored liquid. This was served to Residents #2 and #13.
Observation of the supper meal on [illegible] revealed the meal began at 5:15 p.m. Since the housekeeper was gone, only two staff were remained on the second shift. One staff became the cook and the second staff waited tables. Food service and resident care continued until 6:45 p.m. At 7:00 p.m. Resident #2, who is bedbound, still had not been assisted to eat.
Observation during lunch on [illegible] at 12:20 p.m. showed there were two staff serving lunch to the residents and one cook preparing meals. There was a table of six residents sitting together. Five residents were served their lunch by 12:23 p.m. Four of the residents finished eating by 12:40 p.m. Resident #6 was not served until 12:50 p.m. Resident #23 (who is sitting at this table) requested a sandwich at 12:35 p.m. She did not like the pork. She received her sandwich at 1:15 p.m.

Residents #2 and #13 were on hospice care and remained in their beds at all times.
On [illegible] at 12:55 p.m. Staff D said that these two residents eat in their [illegible].

Observation at 1:43 p.m. showed Residents #2 and #13's pureed foods were prepared by the cook. The cook placed the pureed meals in bowls on the kitchen counter waiting for the staff to serve them to these two residents.

The surveyor notified Staff A at 1:45 p.m. that the food is ready for these two residents to be served. Staff A put the food bowls onto plates and walked away.
Observation showed the food was still sitting on the kitchen counter at 2:30 p.m. After surveyor intervention at 2:30 p.m., the staff served Residents #2 and #13 their lunch by 2:55 p.m.

AGENCY FOR HEALTH CARE ADMINISTRATION

PRINTED: 10/07/2015
FORM APPROVED

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On at 2:30 p.m., Staff D and Staff A both stated that they were taking care of Resident #22, who requires two people to assist with his needs. They were also taking care of other residents' toileting needs. Staff D had to take care of the medication pass. They both said they need one staff for medication pass and two staff for resident care needs. There were only two staff on this shift and they couldn't take care of all the resident needs timely.

3. Observations on throughout the course of the day showed no activities being offered. A review of the activity calendar located in the dining : "AM: daily news, games and puzzles, music" are scheduled in the morning.
On at 2:45 p.m., Staff D and Staff G both said they do not have any time to run these activities. It takes most of their time to provide activities of daily living for the residents and provide assistance for two meals. When they had three staff working on this shift, "everything ran much easier" and they were able to provide the scheduled activities.
Observation on from 9:00 a.m. through 2:30 p.m. showed the scheduled activities on the calendar were not offered. On the facility had added an agency pool staff person on the day and evening shifts. This additional help still did not allow staff to have time to provide activities.
4. On / at 10:22 a.m., Resident #8 said she needs assistance with her showers. Staff told her not to shower without assistance. She wants a shower every other day but only got two a week. "There are only 2 people working each night and have to wait and wait and wait."

On / at 11:10 a.m., Resident #24 said staff help her with showers, dressing and sometimes the . Sometimes they are "slow." She has to wait a little longer "maybe about 1/2 hour."

On at 12:25 p.m., Resident #6 said he always has to wait a long time to get his food (he is ordered a puree diet). He is the last to eat. There is not enough staff in the dining . He said for every meal everyone has to wait a long time to be served.

On at 10:20 a.m. Resident #29 said she has been here about 15 months. The night staff asleep on the couch. They (the administration) know about it.

On / at 3:30 p.m. and again on / at 2:15 p.m., a family member of Resident #25 said the resident used a walker when she moved in here, but now she is in a wheelchair, and is . She said Resident #25 was dropped on / / when transferring from her recliner to her wheelchair. Resident #25's knee was " and painful. The resident had a mobile x-ray done after the injury. Due to continued pain, Resident #25 was sent to an acute care hospital for further evaluation.
On at 3:45 p.m., the Administrator verified Resident #25's with injury occurred while under the care of facility staff. She verified she had not completed any reports about the incident.

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On / at 2:30 p.m., Staff I stated there is not enough staff to take care of laundry. Sometimes there is no cook and one of the direct people has to cook leaving one person on the floor through dinner.

On / at 2:35 p.m. Staff F stated there is not enough staff. We need 3 not 2. Two staff is a rush and we have to focus on medications, dining , laundry, and people.

5. A review of the staff schedule on revealed two direct care staff are scheduled for each shift. A cook is scheduled from 7:00 a.m. to 7:00 p.m. and a housekeeper was scheduled from 7:00 a.m. to 3:00 p.m. Monday through Friday. No additional staff were scheduled to replace the housekeeper on the weekends; thereby adding to the work load of the direct care staff. The Administrator did not appear on the schedule.

The staffing schedule was reviewed with the Administrator on and again on . On the cook was present for the noon meal, but not the supper meal. The surveyor discussed the lack of care and food service with the Administrator at 7:30 p.m. on / / and again at 2:30 p.m. on . The Administrator said 4 current residents required two-person assistance with activities of daily living and transferring. She admitted it would take another 2 staff to evacuate the remaining 25 residents in 13 minutes. The surveyor told the Administrator she must staff to meet the needs of the residents, including unplanned emergency needs.

On one agency pool staff person was placed on the day and evening shift. The services went quicker, but still no activities were provided to residents and Resident #2 was not assisted to eat until after all the other residents had eaten.

6. Personnel record review revealed:
a) 12 (Staff A, B, C, D, E, F, G, H, J, K, L, and N) of 13 persons employed as direct care staff or employed over 30 days lacked documentation of required training. Staff lacked training in control, activities of daily living and resident behaviors, resident rights, , neglect, and , elopement, emergencies, incident reports, or safe food handling.

b) 9 (Staff B, C, D, E, F, G, H, K, and M) of 10 direct care staff employed over 30 days failed to receive the training in the facility's policy and procedures for ( ) within 30 days of employment.

c) 2 (Staff D and G) of 6 unlicensed staff assisting with medications had failed to obtain the initial required 4 hours of training. Unlicensed untrained staff assisting with medications have the potential to effect the health and well-being of the residents.

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d) The facility failed to ensure at least one staff member per shift in the facility at all times who had completed courses in First Aid and ( ) and holds a currently valid card documenting completion of such courses. Review of personnel records revealed 13 (Staff A, B, C, D, E, F, G, I, J, K, L, N, and O) of 15 staff employed did not have First Aid and/or .

On / / at 7:30 p.m. the administrator stated the information in the staff files was all she had. She verified everything was filed in the folders. She said she knew Staff H had First Aid and recently and she was current also.

A review of the staff schedule showed 5 of 7 days when Staff H worked the 6:00 a.m. to 2:00 p.m. shift, the facility had coverage for that shift. All other scheduled shifts had no First Aid and coverage. The Administrator did appear on the staff schedule and the facility maintained no time sheets.

She verified the schedule had only 5 of the 21 shifts weekly where there was First Aid and coverage. She said she did not know if anyone else had the training. She admitted she had not planned the schedule for coverage.

Class II

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0081 Training - Staff In-Service

Based on record review and interview, the facility failed to ensure all direct care staff, plus staff who prepare and serve food, receive the required training for their job duties before providing direct care or within 30 days of employment for 12 (Staff A, B, C, D, E, F, G, H, J, K, L, and N) of 13 staff employed as direct care or employed over 30 days.
A culture where staff are not trained as required to perform their job duties from 2014 to 2015 has the potential to threaten the health and well-being of the residents.

The findings included:

1. Staff employment record review on and revealed the following:

a) Staff A was hired on / / as a direct care staff. Staff A had no documentation of training in control, yet was working as a direct care staff.

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b) Staff B was hired on as a direct care staff. Staff B had no documentation of training in control, activities of daily living (ADLs) and resident behaviors, resident rights, /neglect/and (ANE), elopement, emergencies, incident reports or safe food handling.

c) Staff C was hired on / / as a direct care staff. Staff C had no documentation of training in control, ADLs and resident behaviors, resident rights, ANE, or safe food handling.

d) Staff D was hired on as a direct care staff. Staff D had no documentation of training in control, ADLs and resident behaviors, resident rights, ANE, elopement, emergencies, incident reports or safe food handling.

e) Staff E was hired on as a direct care staff. Staff E had no documentation of training in control, ADLs and resident behaviors, resident rights, ANE, elopement, emergencies, incident reports or safe food handling.

f) Staff F was hired on as a direct care staff. Staff F had no documentation of training in resident behaviors, resident rights, ANE, elopement, emergencies, incident reports or safe food handling. Staff F did have a certificate for a 75-hour Home Health Aide training, but the certificate lacked the course content so could it could not be determined to meet the required training.

On / at 11:53 a.m., Resident #14 stated that Resident #20 punched her in the mouth about 2 weeks ago and broke one of my . She never went to the hospital or the dentist. She went and told the Administrator and the Administrator didn't want her to call the police.

On at 1:30 p.m., Staff F said approximately 3 weeks ago this incident happened. She said Resident #14 was taunting Resident #20. She was bringing a tray from a resident to the kitchen. She told Resident #14 to stop taunting Resident #20. She saw Resident #20 get up from the table where he was sitting. She told him to sit back down and ignore Resident #14. She said she turned around and Resident #20 leaped over to Resident #14 and hit her in the jaw. She grabbed his arm too late. Resident #14 told Staff F she was going to call the police. Staff F stated there were no injuries. When asked about Resident #14's missing lower , she confirmed Resident #14 had all her before the incident.

A review of the incident report showed this altercation occurred on / between Resident #14 and #20. Staff F was the witness of this altercation. She wrote she had to "...pull them apart and everything was fine." A review of this incident report shows physician, law enforcement, registry, and residents representatives were not notified. Also there were no steps taken to prevent this from reoccurring.

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g) Staff G was hired on [illegible] as a direct care staff. Staff G had no documentation of training in [illegible] control, ADLs and resident behaviors, resident rights, ANE, elopement, emergencies, incident reports or safe food handling. Staff G did have a statement she had read the policies for [illegible] control, ADLs, resident rights, elopement, emergencies, and incident reports.

h) Staff H was hired on [illegible] as a direct care staff. Staff H had no documentation of training in elopement, emergencies, or incident reports.

i) Staff J was hired on [illegible] as a housekeeper. Staff J was observed on [illegible] and [illegible] preparing and/or serving food to residents. Staff J had no training in safe food handling.

j) Staff K was hired on [illegible] as a direct care staff. Staff K had no documentation of training in [illegible] control, ADLs and resident behaviors, resident rights, ANE, elopement, emergencies, incident reports or safe food handling.

k) Staff L was hired on [illegible] as a cook. Staff L had no documentation of training in elopement.

l) Staff N was hired on [illegible] as a cook. Staff N had no documentation of training in elopement, or safe food handling.

2. In an interview on [illegible] at 7:30 p.m., the Administrator said the information in the staff files was all she had. She confirmed everything was filed in the folders. She attributed the lack of staff training to the prior administrators and managers. She verified she did hire Staff A and did not ensure the required training was provided.

Class III

0082 Training - [illegible]

Based on personnel record review and staff interview, the facility failed to ensure all employees receive the required [illegible] training within 30 days of employment for 12 (Staff B, C, D, E, F, G, H, I, J, K, L, and N) of 13 staff employed over 30 days.
A culture where staff were not trained from [illegible] 2014 to [illegible] 2015 has the potential to threaten to the health and well-being of the residents.

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The findings included:

1. Staff employment record review on and revealed the following:

a) Staff B was hired on as a direct care staff. Staff B had no documentation of training in / .

b) Staff C was hired on / / as a direct care staff. Staff C had no documentation of training in / .

c) Staff D was hired on / as a direct care staff. Staff D had no documentation of training in / .

d) Staff E was hired on as a direct care staff. Staff E had no documentation of training in / .

e) Staff F was hired on as a direct care staff. Staff F had no documentation of training in / .

f) Staff G was hired on as a direct care staff. Staff G had no documentation of training in / .

g) Staff H was hired on / as a direct care staff. Staff H had no documentation of training in / .

h) Staff I was hired on as a direct care staff. Staff I had no documentation of training in / .

i) Staff J was hired on / as a housekeeper. Staff J had no documentation of training in / .

j) Staff K was hired on / as a direct care staff. Staff K had no documentation of training in / .

k) Staff L was hired on as a cook. Staff L had no documentation of training in / .

l) Staff N was hired on / / as a cook. Staff N had no documentation of training in / .

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2. In an interview on / / at 7:30 p.m., the Administrator said the information in the staff files was all she had. She confirmed everything was filed in the folders.

Class III

0083 Training - First Aid and

Based on schedules and personnel record review and staff interview, the facility failed to ensure at least one staff member per shift, who had completed courses in First Aid and ( ) and holds a currently valid card documenting completion of such courses, was in the facility at all times for 3 of 3 shifts, except 5 days a week when Staff H worked the 6:00 a.m. to 2:00 p.m. shift, or when the Administrator was in the building. Records show 13 (Staff A, B, C, D, E, F, G, I, J, K, L, N, and O) of 15 staff employed did not have current First Aid and/or .
A culture which does not ensure at least one staff 24 hours/seven days a week are trained in First Aid and is a direct threat to the health and well-being of the residents. The staff are trained to call 911, but were not trained to provide care in the interim while waiting for Emergency Medical Services ( ) to arrive.

The findings included:

1. On / / at 7:30 p.m. the Administrator said the information in the staff files was all she had. She verified everything was filed in the folders. She stated she knew Staff H had First Aid and recently and she was current also.

A review of the staff schedule showed 5 of 7 days when Staff H worked the 6:00 a.m. to 2:00 p.m. shift, so the facility had coverage for that shift. All other scheduled shifts did not provide First Aid/ coverage. The Administrator did not show on the staff schedule and the facility maintained no time sheets.

The Administrator verified the schedule only has 5 of 21 shifts weekly where there is First Aid and coverage. She said she did not know if anyone else had the training and admitted she had not planned the schedule for coverage.

2. On at 2;15 p.m. Staff C stated she would call 911 if the emergency was "bad enough." She would call the manager and family member, "we don't have a nurse." She said ( ) is "when you can't do chest compressions and stuff like that on them."

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On / at 2:10 p.m. Staff D said he would call 911 in an emergency or hospice if necessary.

On / at 2:35 p.m. Staff F said she would call 911 in and emergency and then family members. She would make copies of information needed and have it ready for ( ).

On at 2:28 p.m. Staff I said in an emergency like a tornado, she would keep residents safe and away from windows.

3. Staff personnel record review on and revealed the following:
a) Staff A was hired on as a direct care staff. Staff A had no documentation of training in First Aid and .

b) Staff B was hired on as a direct care staff. Staff B had no documentation of training in First Aid and .

c) Staff C was hired on / / as a direct care staff. Staff C had no documentation of training in First Aid.

d) Staff D was hired on as a direct care staff. Staff D had no documentation of training in First Aid and .

e) Staff E was hired on as a direct care staff. Staff E had no documentation of training in First Aid and .

f) Staff F was hired on / / as a direct care staff. Staff F had no documentation of training in First Aid and .

g) Staff G was hired on as a direct care staff. Staff G had no documentation of training in First Aid and .

h) Staff I was hired on as a direct care staff. Staff I had no documentation of training in First Aid and .

i) Staff J was hired on / as a housekeeper. Staff J had no documentation of training in First Aid and .

j) Staff K was hired on / as a direct care staff. Staff K had no documentation of training in First

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Aid and .

k) Staff L was hired on / as a cook. Staff L had no documentation of training in First Aid and .

l) Staff N was hired on / / as a cook. Staff N had no documentation of training in First Aid and .

m) Staff O was hired on / as a cook. Staff O had no documentation of training in First Aid and .

Class II

0084 Training - Assis Self-Admin Meds & Med Mgmt

Based on personnel record review and staff interview, the facility failed to ensure unlicensed staff assisting with medications had initial 4-hour training and maintained the 2-hour training up-dates annually for 2 (Staff D, and G) of 6 staff employed who assisted with medications. Unlicensed untrained staff assisting with medications have the potential to effect the health and well-being of the residents.

The findings included:

1. Staff personnel record review on / and / revealed the following:
a) Staff D was hired on as a direct care staff and is scheduled to provide medication assistance. Staff D had no documentation of the initial 4-hour medication training.

b) Staff G was hired on / as a direct care staff and is scheduled to provide medication assistance. Staff G had no documentation of the initial 4-hour medication training.

2. On / / at 7:30 p.m. the Administrator said the information in the staff files was all she had. She verified everything was filed in the folders. She said she identified the staff to pass medications on the schedule with an "m" after the shift time. She confirmed Staff D and Staff G are currently scheduled to assist residents with the medications.

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0090 Training -

Based on personnel record review and staff interview, the facility failed to ensure direct care staff received training in the facility's policy and procedures for ( ) within 30 days of employment for 9 (Staff B, C, D, E, F, G, H, K, and the Administrator) of 10 direct care staff employed over 30 days.
A culture which does not ensure the training of staff to follow a resident's advanced directives, including , has the potential to threaten to the health and well-being of the residents. It has the potential to cause undue suffering or an early of the resident against their expressed consent.

The findings included:

1. Staff employment record review on and revealed the following:
a) The Administrator was hired on as a direct care staff. The Administrator had no documentation of training in the facility's policy and procedure.

b) Staff B was hired on as a direct care staff. Staff B had no documentation of training in the facility's policy and procedure.

c) Staff C was hired on / as a direct care staff. Staff C had no documentation of training in the facility's policy and procedure.

d) Staff D was hired on / as a direct care staff. Staff D had no documentation of training in the facility's policy and procedure.

e) Staff E was hired on / as a direct care staff. Staff E had no documentation of training in the facility's policy and procedure.

f) Staff F was hired on / as a direct care staff. Staff F had no documentation of training in the facility's policy and procedure.

g) Staff G was hired on / as a direct care staff. Staff G had no documentation of training in the facility's policy and procedure.

h) Staff H was hired on / as a direct care staff. Staff H had no documentation of training in the facility's policy and procedure.

i) Staff K was hired on as a direct care staff. Staff K had no documentation of training in the

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facility's policy and procedure.

2. In an interview on at 7:30 p.m., the Administrator stated the information in the staff files was all she had. She verified everything was filed in the folders. The Administrator admitted she was not able to locate the facility's policy and procedure when asked on .

Class III

0092 Food Service - General Responsibilities

Based on observations, resident record reviews and staff interview, the administrator was responsible for total food service and failed to ensure the staff preparing and/or serving the meals served 3 (Residents #2, #6, and #13) of 3 residents their therapeutic diets which met the nutritional requirements.

The findings included:

1. Observation of the noon meal on revealed the meal being served was a hot dog with , baked beans, corn and jello. The approved menu showed BBQ pork, baked beans, coleslaw, and tapioca pudding with chocolate chips was to be served. The Administrator said they did not serve the BBQ pork because it was not thawed out, and they did not have coleslaw as the food shipment did not come in time. She said the cook called off today and she could not get anyone else to come in.
The Administrator said there are 3 people on a puree diet. The meal was observed to be served by the housekeeper. She provided one plate at a time as two caregivers asked for plates. The facility served all the residents in the dining meals plus the special requests and re-orders. At 2:00 p.m., after the dining were served, the staff began to serve the residents in their . The facility ran out of cooked vegetables for the last two people with regular diets. No substitutions were made.
Observation of the food preparation revealed the housekeeper did not know how to puree foods. A hot dog was put into a blender and blended into small chucks. The housekeeper put the baked beans in the blender and made a soupy paste. For the second plate, she was prompted by another staff to add water. She got a more puree consistence for the hot dog, but it still had residual lumps. She added water to both the beans and corn. The beans were very runny and corn was a watery corn-flavored liquid. This was served to Residents #2 and #13. **Pictures on file**
Observation of the food service on revealed Staff D and Staff F had gloves on during the noon meal. They handled the resident plates and touched their thumbs to the plate eating surface when delivering the plates to each resident. They were observed picking up the empty plates to return to the

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kitchen and delivering then next person's plate, without washing their hands. They were observed picking up glasses by placing their hand over the top of the glass and gripping the drinking surface of the glass. Observations were made of the lack of sanitary food service from 12:00 p.m. to 1:30 p.m. Staff continued going from soiled plates to clean plates, re-filling drinking glasses and serving drinks to residents, all with the same pair of gloves on and no hand washing. This continued until surveyor intervention. Then staff were observed changing gloves between deliveries, still without washing their hands.

Observation of the supper meal on / revealed the Supper meal began at 5:15 p.m. and was a biscuit with chip beef, mash potatoes, asparagus and cake. Since the housekeeper was off duty, only two staff were scheduled on the second shift. One staff became the cook and the second staff waited tables. Food service and resident care continued until 6:45 p.m. At 7:00 p.m. Resident #2, who is bedbound, had not been assisted to eat. The caregivers believed Resident #2 and #13 were on pureed diets. The caregiver/cook had prepared a tray for Resident #2. It contained mash potatoes and non-pureed chipped beef and ice cream. No substitution was made for the bread or vegetable. The food delivery was stopped while the chipped beef was pureed. Resident #2 was not served until 7:00 p.m.
** pictures on file**

2. A review of the Cycle 4 menu revealed the noon meal on was to be a cabbage roll, Scalloped Potatoes, marinated tomatoes and sherbet. The meal served was breaded pork, stuffing and green beans. Observation of the meal service revealed the cook was wearing gloves while preparing the plates for each resident. The cook touched the stove, pots and ladles, refrigerator, cabinet doors and door handles and the handles on the kitchen sink. The cook then proceeded to make 3 lunch meat sandwiches. The cook handled the sandwiches with the same gloves he had been wearing since the meal service began. He left deep finger impressions in all 3 sandwiches. The food production was stopped by the surveyor. After washing his hands and changing gloves, the cook made new sandwiches. ** Pictures on file**

Observation on at 2:55 p.m. showed staff serving Residents #2 and #13 lunch. At this time the facility was out of prepared food. An interview was conducted with Staff A at 2:55 p.m. on . She stated she is serving Residents #2 and #13 a dish of butterscotch pudding, a four ounce glass of tomato juice and two other four ounces glasses of different juices. No substitutions were made for the protein or starch.

A review of the Cycle 4 menu revealed the noon meal on was to be Parmesan chicken, garlic mash potatoes, broccoli and cauliflower. The meal served was pepperoni pizza and cake. No

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substitution was made for 3 ounces of chicken or the vegetable.

Observation on during lunch showed staff serving Residents #2 and #13 a cup of pureed chicken noodle soup, a cup of pudding and a glass of juice.

3. Observation on at 2:55 p.m. and on showed Resident #2 being served a pureed diet for lunch. A review of her health assessment dated shows there is no diet order on this assessment.

On at 3:30 p.m., the administrator reviewed Resident #2's record. She reported the hospice paperwork showed the resident is suppose to be on a diet.

4. A review of Resident #6's health assessment dated / shows he is prescribed a mechanical soft diet. Further review of his record showed there were no other diet ordered written in his record. Observations of the , / , and meals, he was served a pureed diet.

Class II

0093 Food Service - Dietary Standards

Based on observation, facility menu review, resident and staff interviews, the facility failed to serve food that is palatable, failed to served food on the menu, failed to made appropriate substitutions, failed to updated menus annually, and failed to have enough non-perishable food on hand according to their census.

The findings included:

1. Observation of the noon meal on / revealed the noon meal being served was a hot dog with , baked beans, corn and jello. The menu showed BBQ pork, baked beans, coleslaw, and tapioca pudding with chocolate chips was to be served. The Administrator said they did not serve the BBQ pork because it was not thawed out, and they did not have coleslaw as the food shipment did not come in time. She said the cook called off today, and she could not get anyone else to come in. The facility served jello instead of pudding. The Administrator said there are 3 people on a puree diet. The meal was served by the housekeeper. She provided one plate at a time as two caregivers asked for plates. The facility served all the residents in the dining meals plus the special requests and re-orders. At 2:00 p.m., after the residents in the dining (except Resident #6's puree diet) were served, the staff began to serve the residents in their . The facility ran out of cooked vegetables

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for the last two people having regular diets.
Observation of food preparation found staff did not know how to puree a meal. The hot dog was put into a blender and blended into small chucks. The housekeeper put the baked beans in the blender and made a soupy paste. The second time she was prompted by another staff to added water and got a more puree consistency for hot dogs. She added water to both the beans and corn. The beans were very runny and corn was a watery corn-flavored liquid. This was served to Residents #2 and #13.
2. Observation of the supper meal on / / revealed the meal began at 5:15 p.m. and was a biscuit with chipped beef, mashed potatoes, asparagus, and cake. When the housekeeper left, only two staff remained scheduled on the second shift. One staff became the cook and the second staff waited tables. Food service and resident care continued until 6:45 p.m. At 7:00 p.m. Resident #2, who is bedbound, still had not been assisted to eat. The staff believed the resident was on a pureed diet. The caregiver/cook had prepared a tray with mashed potatoes and non-pureed chipped beef and ice cream. No substitution was made for the bread or vegetable. The food delivery was stopped until the chipped beef was pureed. Resident #2 was not served until 7:00 p.m.
** Photos on file **

3. A review of the Cycle 4 menu revealed the noon meal on was to be a 6 ounce cabbage roll, 1/2 cup of scalloped potatoes, 1/2 cup marinated tomatoes and 1/2 cup sherbet. The meal served was breaded pork, stuffing, and green beans.
Observation during the lunch meal on / showed about 10 residents remaining in the dining approximately 1:00 p.m. One resident asked for ice cream. The rest of the residents asked if they could have ice cream also. Staff served them ice cream. A review of the menu showed they were to be served sherbet. However, most of the residents left the dining were not offered any dessert.
Observation on / at 2:55 p.m. showed staff served Residents #2 and #13 lunch.
An interview was conducted with Staff A on / at 2:55 p.m. She said she was serving Residents #2 and #13 a dish of butterscotch pudding, a 4 ounce glass of tomato juice and two other 4 ounce glasses of different juices. No substitution was made for the protein or starch.

4. Observation on during lunch showed residents were served pizza and cake. A review of the menu showed: Parmesan chicken, mashed potatoes, broccoli and cauliflower. Residents #2 and #13 were served pureed chicken noodle soup, pudding, and a glass of juice. Pizza and chicken noodle soup were not on the menu board showing there was a substitution for this lunch. No substitution was made for the 3 ounces of chicken or the vegetable.

5. Interviews were conducted with residents throughout the course of the survey.
Resident #1 was interviewed on at 12:00 p.m. (right before lunch). She said the food is not great. The cooks in the kitchen keep changing. She does not enjoy it. The staff will make her a sandwich if she does not like what is being served. She said she eats a lot of sandwiches. Observation

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during lunch at 1:09 p.m. showed she was served her lunch. She stated the meat tasted "like a hard biscuit." The food was hardly warm. She requested to have a sandwich instead of the food being served.

Resident #8 was served her lunch at 1:18 p.m. on / . She stated (in reference to the food), "It could be warmer. The food does not taste good."

Resident #14 was interviewed during lunch on . She said she can't eat it. She has an abscessed . She says the stuffing was dry and and the meat was tough.

An interview was conducted with Resident #6 on at 12:25 p.m. He stated, "The food is terrible." He always has to wait along time to get his food. He is the last to eat. He stated, "There are not enough staff in the dining . For every meal everyone has to wait along time."

Resident #7 was interviewed on / at 10:00 a.m. She said a lot of the food was out of cans. The cook has changed many times. The resident said she did not like the food; the food was not good. She would like to have some real meat.

6. A review of Resident #2's Health Assessment dated showed there is no diet ordered on this assessment. Observation during lunch on at 2:55 p.m. showed the staff gave Resident #2 a pureed diet.
An interview was conducted with the Cook at this time. He said he gives Resident #2 a pureed diet.
An interview was conducted with the Administrator on / at 3:30 p.m. She reviewed Resident #2's health assessment and confirmed the diet order was not indicated on this assessment. She continued to review Resident #2's record and said she found an order for a diet from hospice.

Review of Resident #5's Health Assessment dated and Resident #25's Health Assessment dated revealed diet orders for "Calorie Controlled" diet.

A review of Resident #6's Health Assessment dated shows he is prescribed a mechanical soft diet. Further review of his record showed there was no other diet order written in his record. Observations of meals on / , / and showed he was served a pureed diet.

7. A review of the menus being used for , and showed the licensed dietitian reviewed the menu . An interview was conducted with the Administrator on at 2:15 p.m. She reviewed the menu and confirmed the date and stated she was not aware this menu was outdated. A review of the 4-cycle menus revealed only a regular menu, with instructions to follow for a low-fat/low , no-concentrated-sweets, or no-added-salt diets. The facility had no menu extension for

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Calorie Controlled, Mechanical Soft, or Puree diets. The administrator stated they have no recipes for any of the therapeutic diets only regular diet recipes.

8. An interview was conducted with the Administrator on at 9:00 a.m. She stated the resident census for this day was 29 residents. A review of the non-perishable emergency supply food shows the facility has powdered milk to make 35 quarts of milk. According to their census the facility need at least 43.5 quarts of milk. The facility had capacity to store 65 gallons of water but needed 87 gallons for the emergency plan.

Class II

0120 Fiscal - Financial Stabilitv

Based on record reviews and staff and family interviews, the facility failed to maintain accurate business records that identify, summarize, and classify funds received and expenses disbursed, using written accounting procedures and a recognized accounting system. The facility failed to notify the Agency of a change in financial viability within 7 days after occurrence. The facility failed to be administered on a sound financial basis, thereby not ensuring adequate resources to meet resident needs for all 29 residents, including incontinence supplies.

The findings included:

1. The facility had a court appointed receiver ordered on . The facility failed to notify the Agency until . The change of ownership application filed on included a financial prospectus which was insufficient and subsequently failed. The omissions re-submission also failed. On the Agency conducted a financial monitoring visit.

2. On at 11:30 a.m. the Administrator said she had been the administrator for 2 weeks. She said there was no accounting in the facility. She accepted checks and deposited them into the facility's business account. She did not keep a separate account for resident funds, but co-mingled all funds into the facility's business account.

The Administrator presented a binder in which she was recording the resident funds kept by the facility. For 2 (Residents #22 and #14) of 3 resident fund accounts reviewed, neither account had been credited for the personal funds which were not contractually owed to the facility.

The Administrator said she logs the monthly payment checks into a receipt book by check number only

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(without resident names) and occasionally makes a copy of the checks.

The Administrator verified the facility was a representative payee for Residents #20 and Resident #22. The Administrator said the facility had been the payee for these two residents since their respective admissions. In addition to these two, the Administrator verified the Social Security check for Resident #14 was also stamped and deposited in the facility account. She confirmed, the check was not made out to the facility as representative payee, but it was treated like it was. She said these checks were deposited in the one facility account from which all transactions are paid out.

The Administrator verified there was no surety bond as required.

Attempts were made to get payment records and bills for each resident. Spread sheets were finally obtained on from the management company, but only showed partial money collections by month from 2015 to 2015.

The Administrator and management company Consultant verified the facility has no ongoing accounting for each resident since their admission through 2015.

a) A review of the safekeeping documentation revealed Resident #22 had $24.00 deposited in the safekeeping accounting since his admission on . The resident was charged for haircuts and nail trimming and owed the facility a balance of $26.00.

Resident #22 receives $1,057.00 a month from Social Security. The check is made out to Gulf Winds ALF as the representative payee. A review of the contract revealed Resident #22 was to pay the facility $700.00 a month with an additional $1,100.00 from the Health Maintenance Organization. This amount would leave a balance of $357 each month for the resident. Which leaves $1,785.00 unaccounted for.

On the administrator said she just deposits the whole check. She had not realized the entire amount was not owed to the facility and should be credited to the resident for spending money. She was observed to immediately write "$1785" at the top of the safekeeping form for Resident #22.

She further said the facility pays for Resident #22's medications monthly. A review of the pharmacy statement for revealed the resident's year to date medication expense totaled $266.83, leaving $1518.17 unaccounted for.

b) A review of safekeeping documentation showed Resident #14 debits for hair care. As of the account shows a negative balance of $20.00 and no money.

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A review of the contract signed revealed Resident #14 was to pay $600.00 to the facility and the Health Maintenance Organization would pay $1,200.00 a month. A rate change notification on revealed the contracted amount was lowered from $1,800.00 a month to $1,200.00 a month for a semi-private .

On , financial spread sheets from 2015 through 2015 showed the facility was collecting $1,724.00 a month and documenting a debit of $76.00 a month for lack of payment.

As of , the facility should have refunded $185.90 for the decrease in rent due to living in a semi-private . Also the facility should not have collected the $524.00 for or .
The safekeeping documentation showed a debit of $20.00 and no deposit of the funds from to , leaving $1,233.90 unaccounted for and due Resident #14.

The Administrator, said she did not realize the money was not due the facility. She said she deposited the checks and the facility paid for the resident's medications ($24.66 a month).
A review of the pharmacy invoice obtained on revealed the resident's year-to-date medication expense was $206.42. That amount plus the $20.00 for beauty salon services, would leave a credit balance of $1,007.48 which was unaccounted for.

c) A review of Resident #18's contract dated / revealed the contract amount was $1,600.00 monthly. A review of the financial spread sheets from 2015 to 2015 revealed the resident is being charged $2,200.00 a month. This would constitute an overpayment of $600.00 a month.

d) A review of Resident #2's contract dated and revealed the contract amount was $2,500.00 monthly. A review of the financial spread sheets from 2015 to 2015 revealed the facility is charging the resident $3,400.00 a month. This is an overcharge of $900.00 a month without contractual right or a $5,400.00 overpayment.

On / the facility submitted a statement from Resident #2's bank trust showing the $3,400.00 has been paid monthly since . These 35 overpayments would amount to $31,500.00.

e) A review of Resident #19's contract revealed the contract was executed on / . The contract amount was $1,950.00 a month. Review of the facility accounting spread sheets from 2015 to 2015 revealed the resident is being charged $2,000.00 a month. No rate increase notice was present in the resident's record. This amounts to a $50.00 a month rate increase without contractual right.

f) A review of Resident #30's contract revealed the signatures were not dated. The contract showed

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Resident #30 was to pay $800.00 a month and the Health Maintenance Organization (HMO) was to pay $1,100.00 a month. A review of the financial spread sheets revealed the facility had been collecting $1,900.00 from the resident and $1,100.00 from the HMO since 2015 at least.

3. On at 3:30 p.m. and again on at 2:15 p.m., a family member of Resident #25 said she buys incontinence supplies for her mother, but they disappear. She said she had brought in 3 packs and hid them under her bed. She came back a week later and they were all gone, even the hidden ones. She said a staff member told her she needed to hid them better. She said she was told that "pull-ups" are provided by the facility. She brings them for her mother, but now they are disappearing.

4. On at 2:10 p.m. Staff D said they run out of adult briefs and garbage bags. He admitted he took adult briefs from another resident, but does not remember who. He used shopping bags for trash.

On at 2:28 p.m. Staff I said she runs out of adult briefs sometimes. She will tell facility and they put in an order. She admitted she will borrow briefs from other residents and return one when the order comes.

Class II

0123 Fiscal - Resident Trust Funds

Based on interviews and record review, the facility failed to obtain/maintain a separate bank account for resident funds and co-mingled the resident funds with the facility funds for 3 (Residents #14, #20 and #22) of 3 residents the facility was acting as representative payee/cashier for and reviewed for safekeeping of funds.

The findings included:

1. On / from 11:30 a.m. to 6:30 p.m. during the financial review, the Administrator verified the facility was a representative payee for 2 residents (Residents #20 and #22). The Administrator said the facility had been the payee for these two residents since admission. The Administrator verified the check for Resident #14 was stamped like the other two Social Security checks and deposited. She said although the check is not made out to the facility as representative payee, it was treated like it was. She verified these checks are deposited in the one facility account from which all transactions are paid out.

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2. A review of the safekeeping documentation revealed Resident #22 had no money deposited in the safekeeping accounting since admission on /, except for $24.00. The resident was charged for haircuts and nail trimming and owed the facility a balance of $26.00. Resident #22 receives $1,057.00 from Social Security monthly.

A review of the contract revealed Resident #22 was to pay the facility $700.00 a month, with an additional $1,100.00 from the Health Maintenance Organization. This amount would leave a balance of $357 a month for the resident. From / to , this leaves $1,785.00 unaccounted for.

On from 11:30 a.m. to 6:30 p.m. during the financial review, the Administrator said she just deposits the whole check. She had not realized the entire amount was not owed to the facility and should be credited to the resident for spending money. She was observed to immediately write "$1785" at the top of the safekeeping form for Resident #22.

The Administrator said the facility pays for Resident #22's medications monthly. A review of the pharmacy statement for / revealed the resident's year-to-date medication expense totaled $266.83, leaving $1,518.17 unaccounted for.

3. A review of safekeeping documentation showed Resident #14 has debits for hair care. As of the account shows a negative balance of $20.00 and no money.

A review of the contract signed revealed Resident #14 was to pay $600.00 to the facility and the Health Maintenance Organization would pay $1,200.00 a month.

A rate change notification revealed the contracted amount was lowered on / from $1,800.00 a month to $1,200.00 a month, for a semi-private .

Financial spread sheets from through 2015 show the facility was collecting $1,724.00 a month and documenting a debit of $76.00 a month for lack of payment. As of the facility should have refunded $185.90 for the decrease in rent due to living in a semi-private . Also the facility should not have collected the $524.00 for or .

The safekeeping documentation showed a debit of $20.00 and no deposit of the funds from to , leaving $1,233.90 unaccounted for and due to Resident #14.

The Administrator said she did not realize the money was not due the facility. She said she deposits the check and the facility pays for the resident's medications monthly ($24.66 a month).

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A review of the pharmacy invoice obtained on revealed the resident's year-to-date medication expense was $206.42, plus the $20.00 for beauty salon services. This leaves a credit of $1,007.48 unaccounted for.

On at 11:53 a.m. Resident #14 said she does not get any money here. She has to beg the Administrator for cigarettes. She said at another facility she got spending money, but not here. They take my whole social security check.

Class II

0125 Fiscal - Suretv Bonds

Based on staff interviews and record review, the facility failed to obtain and maintain a surety bond for twice the amount of money handled for 2 (Residents #20 and #22) of 2 residents the facility was acting as representative payee for and 1 other resident (Resident #14) who the facility was receiving/cashing the Social Security check for.

The findings included:

1. On during the financial review from 11:30 a.m. to 6:30 p.m., the Administrator verified the facility was a representative payee for 2 residents (Residents #20 and #22). The Administrator stated the facility had been the payee since admission for these two residents. She verified the facility had no surety bond in any amount.

Record review showed Resident #20 was admitted on and re-admitted on . A review of Resident #20's Social Security check revealed the check was issued to "Gulf Winds ALF for [Resident #20]". The monthly check amount was $748.00.

Record review showed Resident #22 was admitted on . A review of Resident #22's Social Security check revealed the check is issued to "Gulf Winds ALF for [Resident #22]". The monthly check amount is $1,057.00.

2. Record review showed Resident #14 was admitted on . A review of Resident #14's Social Security check revealed the check is issued to Resident #14. The monthly check amount is $524.00.

3. On from 11:30 a.m. to 6:30 p.m. during the financial monitoring review, the Administrator

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verified the check for Resident #14 is stamped like the other two Social Security checks and deposited. She verified, although the check is not made out to the facility as representative payee, it is treated like it is. The check was not given to Resident #14 to cash or to sign over.

Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observation, residents and staff interviews, the facility failed to provide residents a safe living environment free of hazards, ensure the air conditioner is in good working order and provide residents safety.

The findings included:

1. Observations on from 11:30 a.m. to 8:30 p.m. and on and from 9:00 a.m. through 4:00 p.m. found two unsecured tanks in the main lobby of the facility. These unsecured tanks pose a hazard. If knocked over, they have the potential to crack and become projectiles endangering all building occupants.

2. An interview was conducted with Resident #7 on at 10:00 a.m. She stated the air conditioner has been broken. It was hot in her hallway. She said she had obstructed . She told the surveyor to look at her clock because it shows it was 80 degrees.

Observation at that time showed the clock displayed 80 degrees. Later that day, the temperature was taken in the west hallway. At 3:30 p.m. on the thermometer showed 80 degrees.

An interview was conducted with the administrator on at 3:35 p.m. She stated the air conditioner was not working well. The company hired to fix the air conditioner was at the facility on and was continuing to fix it.

3. An interview was conducted with Resident #8 at 10:22 a.m. on . She said she does not like her . When the floor gets wet, it is "very slippery." She said she told the facility about it. She said staff (unidentified) said they will have to get a mat but nothing has happened at this time. She also said she needs another grab bar to step out of the shower. She asked the staff about this also. She said the staff said they will get it for her, but she does not have another grab bar for the shower.

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Observation of her the time of the interview showed there was no mat on the , no extra grab bar near the exit/entrance of the shower, and the toilet paper holder was missing.

4. Observation of the floors on / at 3:30 p.m. showed there were multiple tears in the linoleum on the floor located in the television area. The flooring at the facility front entrance was discolored. The discoloration appeared to be from biogrowth below the flooring. Observation of the carpet in the west wing activity area found it very dirty.
Further observation revealed the telephone in the front lobby had a long cable running from the telephone around the corner and into the kitchen phone plug. This has the potential to be a trip hazard.
** photos on file**

Class III

0163 Records - Resident. Penalties for Alteration

Based on record review, observation and interview, the facility failed to ensure that facility records were accurately recorded and not fraudulently altered or falsified for 2 (Residents #5 and #14) of 29 residents reviewed.

The findings included:

1. On / a review of docoments for Resident #5 failed to find a signed contract. A blank unsigned contract was in the resident's record. Resident #5 was admitted on .

On at approximately 6:30 p.m. the Administrator asked the resident to come to the office area. When Resident #5 arrived he was told his contract was unsigned and incomplete. He stated he could pay $800.00 a month and would keep $200.00 for expenses. The balance was paid by the Health Maintenanec Organization. The Administrator arranged to sign the contract the next day.

The contract signed and faxed to the Agency Field Office on / . The contract showed $2,200.00 a month. The contract was falsely dated by the Administrator.

2. In an interview on / at 11:53 a.m., Resident #14 said she had been hit in the mouth by Resident #20. At 1:20 p.m. Staff F said she had witnessed the altercation between Resident #14 and #20. Staff F said she had completed the incident report and left it on the clip board.
In an interview on / at 12:45 p.m., the Administrator said she could not find the report of the incident. She said she would have Staff F re-write the report. Staff F was observed sitting at a desk writing the report. At 1:30 p.m. an incident report was provided to the surveyor. A review of the incident

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report revealed it was signed and dated at 10:30 a.m., not dated when it was written.

Class II

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0165 Risk Mgmt & QA: Adverse Incident Report

Based on record review and interviews, the facility failed to submit Day 1 or Day 15 Adverse Incident reports for 2 (Residents #5 and #25) of 2 adverse incidents which met reporting requirements.

The findings included:

1. On at 2:30 p.m., Staff I said Resident #5 left the facility and went down the road about 2 or 3 weeks ago. This happened on 2nd shift. Staff I said the resident did not notify anyone he was leaving the facility. He was not able to go down the road in a safe manner. Staff I said she called 911 and drove her car north on Venice Avenue. She found him and stopped him. The ambulance brought him back to the facility. The Administrator was called and she was informed of this incident.

On at 3:00 p.m., the Administrator said an Adverse Incident report was not written on Resident #5's elopement. She said she just learned how to do Adverse Incident reports. A review of Resident #5's record showed there was no documentation of him eloping from the facility.

2. In an interview on at 3:30 p.m., Resident #25's family member revealed Resident #25 was dropped by a staff member about 3 weeks prior. The resident's knee was and painful. The resident had a mobile x-ray done after the injury. Due to continued pain, Resident #25 was sent to an acute care hospital for further evaluation. There was no record of the injury and no Adverse Incident Day 1 or Day 15 report filed with the Agency, even though the injury occurred while being assisted by the facility staff.

On at 3:45 p.m. the Administrator, verified Resident #25's with injury occurred while under the care of a facility caregiver. She admitted neither a Day 1 Adverse Incident nor an investigation for the Day 15 report had been completed and submitted by the facility.

Class III

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0167 Resident Contracts

Based on record reviews, and interviews, the facility failed to execute all resident contracts at the time of admission or prior thereto and/or ensure rates are not increased without 30 days prior written notice for 9 (Residents #2, #5, #17, #19, #20, #21, #22, #24, #26) of current 29 residents and 1 (Resident #30) of 6 discharged residents reviewed for refunds. The facility failed to provide a full refund timely for 1 (Resident #35) of 6 discharged residents reviewed for refunds.

The findings included:

1. On / / a review of Resident #2's file revealed two contracts dated and , both for $2,500.00 a month. There were no rate increase notices in the file.

A review of the financial spread sheets from 2015 to 2015 revealed the facility was collecting $3,400.00 a month. This would be an overpayment of $5,400.00.
On / the facility submitted a statement from Resident #2's bank trust showing the $3,400.00 had been paid monthly since / . These 35 overpayments would amount to $31,500.00.

2. On a review of Resident #5's file failed to find a signed contract. A blank unsigned contract was in the resident's record. Resident #5 was admitted on .

On at approximately 6:30 p.m. the Administrator asked the resident to come to the office area. When Resident #5 arrived he was told his contract was unsigned and incomplete. He stated he could pay $800.00 a month and would keep $200.00 for expenses. The Administrator arranged to sign the contract the next day.

The contract signed and faxed to the surveyor on showed $2,200.00 a month. The contract was falsely dated / , by the Administrator.

3. On a review of Resident #17's contract revealed a blank contract. This resident has no contract on , although he was admitted on / .

4. On a review of Resident #19's records revealed an admission date of / . Review of the contract revealed it was executed on . This is one month post admission. The contract amount was $1,950.00 a month.

Review of the facility financial spread sheets from 2015 to 2015 revealed the resident is being charged $2,000.00 a month. No rate increase notice was present in the resident's record. This

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amounts to a $50.00 a month rate increase without contractual right.

5. On a review of Resident #20's contract revealed the contract dated / / was signed by the resident only. No facility representative had executed the contract.

6. On / / a review of Resident #21's contract revealed a contract for $1,000.00 a month. This contract was not signed by either party, when admitted on / or since.

7. On / / a review of Resident #22's record revealed an admission date of / / . Review of the contract revealed a contract for $1,800.00 executed on / . That date was 4 days post admission. The contract specified the resident would pay $700.00 and the Health Maintenance Organization would pay $1,100.00 monthly.
Observation on / revealed a Social Security Check in the amount of $1,057.00 payable to Gulf Winds ALF. The facility was acting as the representative payee for this resident.
A review of the facility financial spread sheets from 2015 to 2015 and the deposit slip for 's check, revealed the facility was keeping the total amount. This amounts to a $357.00 monthly charge without contractual right. The facility overcharged the resident $1,785.00 since admission.

8. On / / a review of Resident #24's contract revealed no amount specified on the contract. The blank contract was signed by both parties on , the date of admission.

9. On / / a review of Resident #26's contract revealed a blank contract signed on by both parties. The resident was admitted on / .

10. On / a review of Resident #30's contract revealed the signatures were not dated. The contract showed Resident #30 was to pay $800.00 a month and the Health Maintenance Organization was to pay $1,100.00 a month. A review of the financial spread sheets from 2015 to 2015 revealed the facility had been collecting $1,900.00 from the resident and $1,100.00 from the HMO. This amounts to an $1,100.00 a month overcharge without contractual rights.

11. On / at 7:00 p.m. to 8:45 p.m. the Administrator, said she had only been the administrator for 2 weeks. She said she had completed the Core Training 2 years prior and recently completed an up-date. She verified she had barely begun to try to organize the resident's records. She said she had begun pulling the contracts out of the individual's record to place them in one binder for all residents. She said she did not feel the staff or third party providers needed access to the business contract. She attributed the incomplete contracts to prior administrators. She stated she did not know the amount each resident was to pay each month. She produced a list of resident names with the contract amounts

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911992	09/24/2015
NAME OF PROVIDER OR SUPPLIER GULF WINDS	STREET ADDRESS, CITY, STATE, ZIP CODE 2745 VENICE AVENUE EAST VENICE, FL 34292	

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

hand written. She said she had gotten this list from the subcontracted Management Company and assumed it was correct.

12. A review of Resident #35's refund and contract information revealed the resident was admitted on / and a contract was signed for $2,400.00 a month. Review of the facility financial spread sheets from 2015 to 2015 revealed the resident was paying $2,000.00 a month. The resident was discharged on / to a skilled nursing home. In review, $2,000.00 divided by 31 days in = $64.52 per day, times 23 days (remaining days in) = $1,438.96 owed as refund. The refund was due on / . On refund information was requested from the Administrator at 1:00 p.m. Check #1133 written on / for $593.00 was provided on / . A balance of $845.96 would still be due the resident.

On / at 11:30 a.m. the Management Company corporate person assigned to refunds revealed it had not been her job duty to cut refund checks before. The manager (of the subcontracted Management Company) formerly took care of that. She said she used the figures given to her by the Administrator, not the facility financial spread sheets showing what was actually received. She will check with the facility to get the income spread sheets needed for accurate refunding and cut a second check if needed.

Class II

Z815 Background Screening: Prohibited Offenses

Based on record review and interview, the facility failed to ensure each staff hired had an eligible level II background screening without a 90 day break in service for 4 (Staff B, E, J, and O) of 15 staff employed.

The findings included:

1. Staff B was hired as a caregiver on . Record review revealed a level II background screening dated . Staff B had worked as a caregiver from / to without a background screening .

Staff E was hired as a caregiver on / . There was no background screening on file.

Staff J was hired as a caregiver on . There was no background screening on file.

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SUMMARY STATEMENT OF DEFICIENCIES
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Staff O was hired as a cook on /. Record review on revealed the level II background screening was "awaiting privacy policy" and could not be viewed to see if the staff had passed the background screening. Upon arrival at the facility on Staff O was observed working in the kitchen, going into the food storage area which is housed on the short hall with 6 resident .

2. On at 7:00 p.m. to 8:45 p.m. the Administrator, said she had only been the administrator for 2 weeks. She said she had completed the Assisted Living Facility Core Training 2 years prior and recently completed an up-date. She expressed not wishing to retake the course again.

On at 9:30 a.m. the administrator, verified she had hired Staff O and presented the surveyor with a background screening marked "awaiting privacy policy." The Administrator was unable to tell if the employee had an eligible background screening. She did not know how to remove the notation to be able to see the results of the screening. The facility was observed to have no computer available to check screenings. The Administrator said the subcontracted Management Company checks the screenings and faxes the results to her. All the other hiring she attributed to prior administrators.

Unclassified

Z816 Background Screening-Compliance Attestation

Based on record review and interview, the facility failed to ensure each staff hired had an eligible level II background clearance without a 90 day break in service for 9 (Staff A, C, D, F, G, H, K, M, and N) of 15 staff employed.

The findings included:

1. Staff A was hired as a caregiver on / /. Record review revealed a level II background screening dated / . A review of the application revealed employment as a bartender from 2013 to 2014 and private duty employment from 2014 to 2015. Staff A had not worked for an eligible employer since being screened in 2013. No re-screening had been done.

Staff C was hired as a caregiver on / /. Record review revealed a level II background screening dated / . A review of the application showed employment at an assisted living facility (ALF) from 2011 to 2012 and then employment with a home health agency from 2013 to hire. The application documents a 5 month break in service from 2012 to 2013 with no re-screening.

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

Staff D was hired as a caregiver on . Record review revealed a level II background screening dated . A review of the application showed employment at an ALF and a restaurant with no reference checks and no dates of employment. Employment since / had not be verified to ensure there was no break in service. No re-screening had been completed.

Staff F was hired as a caregiver on . Record review revealed a level II background screening dated . A review of the application revealed employment at an ALF from "2014 to 2015." The facility had not obtained a reference check to ensure there was no break in service. No re-screening had been completed.

Staff G was hired as a caregiver on . Record review revealed a level II background screening dated / . A review of the application revealed employment at an ALF from 2011 to 2013. A second employment at an ALF was dated 2014 to 2014. This left a break in service of 7 months from 2013 to of 2014, plus a break of 4 months from 2014 to hire on / / .

Staff H was hired as a caregiver on / . Record review revealed a level II background screening dated / . A review of the application revealed employment in 2014 and 2014 through 2015 with nothing prior. No re-screening had been obtained prior to employment.

Staff K was hired as the housekeeper on . Record review revealed a level II background screening dated . A review of the application revealed no employment history. No reference checks had been done. No re-screening had been completed.

Staff L was hired as a cook on . Record review revealed a level II background screening dated . A review of the application revealed no employment history and no reference checks. No re-screening had been done.

Staff N was hired as a cook on . Record review revealed a level II background screening dated / . A review of the application revealed employment at an ALF from 2014 to 2015. Employment from 2015 to 2015 was at a local Grocery Store. No re-screening had been done.

2. In an interview on at 7:00 p.m. to 8:45 p.m. the Administrator, said she had only been the administrator for 2 weeks. She said she had completed the ALF Core Training 2 years prior and recently completed an up-date. She expressed not wishing to retake the course again. She verified she had

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SUMMARY STATEMENT OF DEFICIENCIES
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hired Staff A without checking references. She did not realize Staff A's prior employment was at employers who are not required to do level II background screening (therefor constitute a break in eligible employment). All other hires she attributed to prior administrators. Staff A, D, F, H, K, M, and N were employed since the court appointment of the Receiver.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Heidi Jones, Administrator
SWOF LLC, dba as Gulf Winds
2745 Venice Avenue East
Venice, FL 34292

Dear .. Jones:

This letter reports the findings of a Financial Monitoring inspection survey conducted on / to , 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 the time frames instructed below.

The inspection resulted in findings of non-compliance in the following areas:
St - A - 0008 - 429.26(4-6) FS; 58A-5.0181(2) FAC - Admissions - Health Assessment Class III
St - A - 0010 - 429.26(1&9) FS; 58A-5.0181(4) FAC - Admissions - Continued Residency Class III
St - A - 0025 - 429.26(7) FS; 58A-5.0182(1) FAC - Resident Care - Supervision Class II
St - A - 0026 - 58A-5.0182(2) FAC - Resident Care - Social & Leisure Activities Class III
St - A - 0030 - 58A-5.0182(6) FAC; 429.28(1-2) FS - Resident Care - Rights & Facility Procedures Class II
St - A - 0031 - 58A-5.0182(7) FAC - Resident Care - Third Party Services Class III
St - A - 0052 - 58A-5.0185 (3) - Medication - Assistance With Self-Admin Class II
St - A - 0077 - 429.176 FS; 58A-5.019(1) FAC - Staffing Standards - Administrators Class III
St - A - 0078 - 58A-5.019(2) FAC - Staffing Standards - Staff Class III
St - A - 0079 - 58A-5.019(3) FAC - Staffing Standards - Levels Class II
St - A - 0081 - 58A-5.0191(2) FAC - Training - Staff In-Service Class III
St - A - 0082 - 58A-5.0191(3) FAC - Training - / Class III
St - A - 0083 - 58A-5.0191(4) FAC - Training - First Aid And Class II
St - A - 0084 - 58A-5.0191(5) FAC - Training - Assist Self-Admin Meds & Med Mgmt Class III
St - A - 0090 - 58A-5.0191(11) FAC - Training - Class III
St - A - 0092 - 58A-5.020(1) FAC - Food Service - General Responsibilities Class II

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St - A - 0093 - 58A-5.020(2) FAC - Food Service - Dietary Standards Class II
St - A - 0120 - 429.17(3) FS: 429.275(1)58A-5.021(1) FAC - Fiscal - Financial Stability Class II
St - A - 0123 - 429.27(3-4) FS; 58A-5.021(2) FAC - Fiscal - Resident Trust Funds Class II
St - A - 0125 - 429.27(2) FS; 58A-5.021(3) FAC - Fiscal - Surety Bonds Class III
St - A - 0152 - 58A-5.023(3) FAC - Physical Plant - Safe Living Environ/other Class III
St - A - 0163 - 429.49 FS - Records - Resident, Penalties For Alteration Class II
St - A - 0165 - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC - Risk Mgmt & QA; Adverse Incident Report Class III
St - A - 0167 - 58A-5.025 FAC - Resident Contracts Class II
St - A - Z815 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses Unclassified
St - A - Z816 - 408.809(2) FS - Background Screening-Compliance Attestation Unclassified

Directed Corrective Actions:
The Assisted Living Facility is required to:
The Agency has determined that the facility's staffing has not met the residents' needs and the facility is immediately required to provide increased direct care staff. During the all shifts, continuously 24 hours a day, the facility must employ 4 direct care staff members. The facility must also ensure that at least one staff member who is currently trained in first aid and ( ) is always on shift. **This requirement is to be met immediately upon receipt of this letter.**

All facility staff having contact with and providing direct care to residents **INCLUDING THE ADMINISTRATOR** must be re-trained on control, reporting adverse incidents, emergency procedures, resident rights and recognizing , neglect and of adults, resident behaviors and needs, assistance with activities of daily living, safe food handling practices, elopement polices and procedures, / , policy and procedures. This training must be provided by a representative or approved provider of the Department of Elder Affairs. The documentation of each training must include: title of the training program; subject matter of the training program; training program agenda; number of hours of each training; trainee's names, dates of participation, and location of the training program; and the training provider's name, dated signature and credentials, and the professional license number, if applicable. The facility must maintain required written personnel documents including staffing schedule, time cards or time sheets to demonstrate compliance **You must initiate contact and schedule this training within 7 days (by) of receipt of this letter.**

The Administrator shall retake the ALF Core training and Core Examination **within 30 days (by) of the receipt of this letter or contact the Field Office if this time frame cannot be meet.**

All facility staff **including the Administrator** will provide a statement of Freedom from Communicable including from a Health Care Provider **within 30 days (by**

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, 2015

) of receipt of this letter.

All staff providing assistance with self-administration of medications to residents must be re-trained in correctly providing assistance with self-administration of medication. The training shall be conducted by a licensed consultant pharmacist using the curriculum provided by the Department of Elder Affairs. The licensed consultant pharmacist must provide a full audit and review of all medication systems in the Assisted Living Facility and ensure all medications are maintained and provided in a safe manner. This must include a competency evaluation for all staff providing medications or attending medication re-training. The consultant's recommened corrective action plan shall be provided and monthly corrective action plan up-dates provided to the facility and Agency. **This training must be scheduled within 7 days (by) of the date of this letter. The audit and action plan must be completed within 7 days (by) of this letter.**

Absolutely no staff without a current valid Level 2 background screening, without a 90 day break in service, shall appear on the schedule or have any contact with residents of the facility, resident property or resident living areas. Evidence of verification of prior employment dates must be present in each employee file before staff appear on the schedule or have any contact with residents of the facility, resident property or resident living areas. **This requirement is to be met immediately upon receipt of this letter.**

The facility must employee a Registered Dietitian (RD) licensed in the State of Florida, who will completely audit and evaluate the food service. The RD will train all staff responsible for or assisting with food preparation in therapeutic diets and consistencies. The RD will ensure food preparation staff are competent in all aspects of food service in an ALF. The RD and Administrator will audit all resident files to ensure the appropriate diet is prescribed and implemented for each resident. The RD's recommened corrective action plan and monthly corrective action plan up-dates shall be provided to the facility and Agency. **The audit and action plan must be completed within 7 days (by) of this letter.**

The **Administrator** must audit facility financial documentation, resident trust fund documentation and each resident chart for the last contract. Absolutely no rate can be increased without a 30 day prior written notice of rate increase. The Administrator will audit all payments back to and reimburse all residents for non-contractual fees retained from that date forward. The facility shall maintain on site, written business records using generally accepted accounting principals which accurately reflect the facility's assets and liabilities and income and expenses. The facility will develop a written plan to address all financial concerns both business and resident related. A separate bank account is required for facility funds apart from the resident funds. **This requirement is to be meet within 7 days (by) of receipt of this letter.**

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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 contact . Laura Manville, Survey and Certification Support Branch, at (727) 552-1955; or Jon Seehawer, RN, Field Office Manager Area 8, at 239-338-1315.

Sincerely,

Jon Seehawer, RN
Field Office Manager

D7JR

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