STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910826	01/08/2016
NAME OF PROVIDER OR SUPPLIER **DUNEDIN ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **534 HOWELL STREET** **DUNEDIN, FL 34698**	

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

0000 Initial Comments

Assisted Living Facility Complaints

Two complaint investigations (CCR# 2015013263 and CCR# 2015012393) were conducted at Dunedin Assisted Living from , 2015 through , 2016. Dunedin Assisted Living Facility had deficiencies at the time of the visit.

0030 Resident Care - Rights & Facility Procedures

Based on observation, interview, and record review, the facility failed to honor resident rights, failed to prevent or neglect, and failed to provide a safe and clean living environment. The facility placed residents at risk by allowing an employee to work in the facility who did not have a Level II background screening, test, or free from communicable statement.

Findings included:

On / at 8:00 AM a tour was made of the facility. Gnats were observed in the main dining area, the living area, and multiple resident . A spilled, sticky substance was observed on the floor of # between the the dresser. A brown substance believed to be feces was observed on a toilet seat in the shared between #13 and #14. Residents were observed standing at a counter to eat breakfast, as there were not enough seats for the residents. Resident in all three buildings were observed without soap or paper towels.

On / at 8:51 AM an interview was conducted with Resident #13. Resident #13 stated another resident has been having accidents in the shared defecates and urinates on the floor and the toilet seat. Resident #13 stated when staff is asked if they will clean the , Staff A stated " you live back there, you clean it up. " Resident #13 stated earlier this week he was given a piece of paper to sign saying he agreed he would pay his rent in cash. Resident #13 stated " they were very pushy " when they told him to sign the letter. He stated he did not feel he had a choice.

On / at 9:15 AM an interview was conducted with Resident #1. Resident #1 stated the facility staff control the toilet paper. Resident #1 stated the shared with 3 other residents. Resident #1 stated when staff is asked to replace the toilet paper because Resident #1 needs to use the , staff say they will get to it when they have time, and it normally takes an hour or more. Resident #1 stated that it is unfair and undignified to have to repeatedly request toilet paper. Resident #1 stated the shared one resident who has repeatedly had accidents where he defecated on the toilet seat or on the toilet seat or the floor. Resident #1 said she asked staff to clean up the , and was told she needed to clean it up herself, but they would not supply her with

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cleaning supplies. Resident #1 stated when she moved in to the assisted living facility she was told they would provide soap and paper towels, but they refuse to provide those items. Resident #1 stated she had to purchase her own soap to wash her hands. Resident #1 stated she was a witness to Staff G threatening Resident #3. Resident #1 stated she was told " If you keep making calls to the state you can find a new place to live. " Resident #1 is afraid of retaliation for talking to the Agency, the Department of Children & Families, or the Ombudsman.

On / at 9:54 AM an interview was conducted with Resident #2. Resident #2 stated Staff A has yelled at her and called her derogatory names in front of other residents and in private. Resident #2 stated she witnessed Staff G physically threaten Resident #3 outside in front of residents and the Administrator. Resident #2 stated nothing was done about Staff G threatening a resident. Resident #2 stated Staff G is threatening and intimidating and scares her.

On / at 10:24 AM an interview was conducted with Resident #9. Resident #9 stated she has been yelled at by staff in the facility. Resident #9 stated she was trying to do her laundry and staff yelled at her.

On / at 10:50 AM an interview was conducted with Resident #7. Resident #7 stated he was told he had to clean his own . He stated he does not know the last time the shower was cleaned. Resident #7 stated they are not provided with either soap or paper towels in the wash their hands. Resident #7 stated he asks for seconds at meals when he is still hungry, but he is normally told there is not enough food. Resident #7 stated he took a banana off of the counter and was yelled at by Staff A. He stated he has not tried to take anything since then.

On / at 11:09 AM an interview was conducted with Resident #3. Resident #3 stated Staff G had physically threatened him on Monday, in front of several other residents and the Administrator. He stated the Administrator did not do anything. Resident #3 stated the Administrator uses Staff G to yell at people and take them to get money to pay their rent. Staff G stated the residents refer to Staff G as " The Enforcer. " Resident #3 stated he had asked staff if/when they would clean the shower or , and was told he had to clean the . Resident #3 stated he is not physically capable of scrubbing a shower stall or cleaning the floor. Resident #3 stated he cannot recall the last time the shower or toilet was cleaned in his . Resident #3 stated he has asked for soap and paper towels on multiple occasions, and he was told to hang a towel in the they could all share. Resident #3 stated when he moved in his contract stated the facility would provide soap and paper towels. Resident #3 stated he asked the Administrator today for soap and paper towels, and they were not provided. Resident #3 stated he saw Staff G in the front office opening his mail. Staff G was looking at one of his personal bills. Resident #3 stated he asked Staff G why he was opening his mail, and Staff G told him to " get the (expletive) out of the office. "

On / at 11:45 AM an interview was conducted with Resident #8. Resident #8 stated if a resident has an " accident " the staff yells at the resident. Resident #8 stated it is all of the staff who yells at them, not one specific staff member. Resident #8 stated the cleanliness of the facility has gone down since the new owners. He stated staff should be cleaning the they don ' t. Resident

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#8 stated he does not remember the last time a staff member cleaned the shower.
On __/__/__ at 12:07 PM an interview was conducted with Resident #5. Resident #5 stated the staff at the facility make fun of him and the other residents. Resident #5 stated Staff A specifically is mean to him. Resident #5 stated the facility does not provide soap or paper towels in the . He stated he provided his own bar of soap for the wash their hands.
On __/__/__ at 3:15 PM an interview was conducted with Resident #14. Resident #14 stated there are little gnats or fruit flies in her throughout the facility. Resident #14 stated many requests have been made for the facility to do something about them, but the flies persist.
On __/__/__ at 4:55 PM an interview was conducted with the Administrator. The Administrator stated Staff G does not work at the facility and never has. The Administrator stated Staff G had been driving residents to the bank for the first few months when they purchased the facility, but she denied he had been driving anyone in or . The Administrator stated Staff G did not have an employee file and had not had a test or statement that he was free from communicable . The Administrator denied that Staff G had threatened a resident, and said it " is a complete lie. " She stated the residents in the facility " are unstable " and " lie a lot. " The Administrator denied that any of the staff yell at the residents or call them names. The Administrator denied that residents are told to clean their own . The Administrator stated the staff clean the , but she did not know how frequently or when the are cleaned. The Administrator stated all of the resident have soap and paper towels. During an observation of one of the with the Administrator, she pointed out a trial size shampoo on a wooden shelf behind the toilet and said " there it is " indicating that was the soap the residents were supposed to use. The Administrator then pointed to a bottle of hand sanitizer and stated that was better than soap.
On __/__/__ at 5:27 PM the Administrator used a locked " staff " . It was observed to have two bars of soap, a scented bottle of hand soap with a pump, a full container of paper towels, and a large towel hanging on the towel rack.

Class II

0052 Medication - Assistance with Self-Admin

Based on record review, observation, and interview, the facility failed to provide medications to 1 out of 1 (Resident #5) sampled residents at the prescribed time.

Findings included:

On __/__/__ at 12:15 PM an interview was conducted with Resident #5. Resident # stated the staff are " shifty " with the times they provide medications. He stated his medication was prescribed for 11:00 AM and he still had not received it at 12:15 PM.

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On / at 2:14 PM a record review was conducted of the medication observation record (MOR) for Resident #5. The MOR had been initialed by Staff C. Resident #5 was prescribed two medications at 11:00 AM and two medications at 12:00 PM.
On / at 2:14 PM an interview was conducted with Staff C. Staff C stated " I went up and gave them to him about 20 minutes ago. "
On / at 5:08 PM an interview was conducted with the Administrator. The Administrator stated Staff C was aware that she had an hour before the prescribed time and an hour after the prescribed time to hand out the medication to the resident, and handing out the medication outside of the timeframe was "unacceptable."

Class III

0054 Medication - Records

Based on observation, record review, and interview, Staff B failed to immediately update the medication observation record (MOR) for 3 out of 3 (Residents #6, #11, and #12) sampled residents each time the medication is offered or administered.

Findings included:

On / at 8:20 AM an observation was made of Staff B as she sat in the office signing her initials on the MOR for Resident #6, Resident #11, and Resident #12.
On / at 8:23 AM a record review was conducted of the MOR for Resident #6, Resident #11, and Resident #12. All three MORs had all of the morning medications initialed by Staff B.
On / at 8:25 AM an interview was conducted with Staff B. Staff B stated she had gone up to the house at the front of the property and " gave out the medications " and then she returned to the main building and " came back and filled out the MOR " . Staff B stated she had forgotten to sign the MOR.
On / at 5:08 PM an interview was conducted with the Administrator. The Administrator stated Staff B has had the appropriate training and not signing the MOR immediately after providing medications is " unacceptable. "

Class III

0079 Staffing Standards - Levels

Based on interview and record review, the facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern for a specified period of time.

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Findings included:

On / at 8:36 AM Staff A was overheard saying an employee had been told she could go home early last night, at 10:30 PM.
On / at 1:55 PM a record review was conducted of the weekly staffing schedule. Staff B was observed working in the facility on / at 8:25 AM. Staff B was scheduled on from 3:00 PM until 11:00 PM and 11:00 PM until 7:00 AM, and on / 11:00 PM until 7:00 AM. Staff C was observed in the facility at approximately 11:00 AM. Staff C was scheduled from 3:00 PM until 11:00 PM. Staff D was observed on the schedule for Thursday and Friday. Per the Administrator, Staff D had been terminated.
On / at 1:55 PM an interview was conducted with the Administrator. The Administrator stated the employees clock in, and that is how she keeps track of the staffing hours. The Administrator stated Staff A documents when employees come in late, leave early, or call in sick. The Administrator stated she does not write it down when there are changes in the schedule, and Staff A is in charge of all of the scheduling.
On / at 2:00 PM an interview was conducted with Staff A. Staff A stated yesterday Staff E had come in to work for Staff C. Staff A stated Staff F came to work early last night, so she allowed Staff E to leave. She stated she does not document anywhere when the staff leave early, come to work late, or switch schedules. Staff A stated the timeclock stopped working, so the time cards are not an accurate reflection of time worked.

Class III

0093 Food Service - Dietary Standards

Based on interview and record review, the facility failed to provide meals that were planned by a licensed or registered dietician and based on the USDA dietary guidelines for Americans. The facility failed to ensure that residents could eat meals at tables in the dining area.

Findings included:

On / at 8:00 AM an observation was conducted of the dining area of the facility during breakfast. There were two long tables observed, approximately 20 seats, with residents at all of the seats. Resident #10 and Resident #8 were observed standing at a counter eating breakfast. When those residents left, Resident #16 was observed standing at the counter eating breakfast.
On / at 9:15 AM an interview was conducted with Resident #1. Resident #1 stated they were promised a turkey dinner for Christmas, but the Administrator brought in goulash she had made at

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home. Resident #1 stated this week ' s meals are the best meals she has had since she arrived. Resident #1 stated the meals were small and seconds were normally not offered or provided. She stated she talked with Staff D and he stated he didn ' t have enough food to make the meals on the menu. Resident #1 stated the menu was hanging on the wall, but it was never followed. Resident #1 stated she purchased the supplies for brownies to be made for all 47 residents, brownie mix, eggs, and oil, and Staff D agreed to make them as a snack for the residents. Resident #1 stated the Administrator came in and removed all of the supplies and took them home with her. Resident #1 and Staff D had to tell the Administrator Resident #1 purchased it with her own money before the Administrator would return the items.

On [redacted] at 9:38 AM an interview was conducted with Resident #4. Resident #4 stated they received more food with the previous owner. Resident #4 stated they had adequate meals when the new owner took over, but the meals have become progressively smaller. Resident #4 stated the menu is hardly ever followed. Resident #4 stated this morning ' s breakfast of two waffles and two sausage links was not the normal breakfast they received, it was much better.

On [redacted] at 9:47 AM an interview was conducted with Resident #17. Resident #17 stated today ' s breakfast of waffles and sausage was good because they had not had waffles in a long time. Resident #17 stated earlier this week for breakfast she was given a piece of fried bologna on top of one fried egg. Resident #17 stated it was not enough for breakfast, and she is not a big eater. Resident #17 asked if there was enough food for seconds, and was told there was not.

On [redacted] at 9:54 AM an interview was conducted with Resident #2. Resident #2 stated she had talked with Staff D on many occasions about the food, and he had showed her the refrigerator, which was empty. Staff D stated he served what he could, but he had to work with what ingredients he had in the building. Resident #2 stated " this morning ' s breakfast was a first. " Resident #2 indicated the normal breakfast was hot or [redacted] cereal, or a fried egg that was brown. Resident #2 stated the facility does not provide salt or pepper either. Resident #2 stated she does not have the money to have to provide her own. Resident #1 stated for lunch one day this week she was offered turkey and cheese on a hot dog [redacted], nothing else. Resident #2 stated one day this week she was provided with 2 hot dogs and one hot dog [redacted]. Staff D told them he didn ' t have enough hot dog buns for everyone. Resident #2 stated some residents did not receive one hot dog [redacted].

On [redacted] at 10:24 AM an interview was conducted with Resident #9. Resident #9 stated she had received a piece of bologna and an egg for breakfast this week, and one day for lunch received a hot dog roll with turkey and cheese. Resident #9 stated it was not enough to eat.

On [redacted] at 10:37 AM an interview was conducted with Resident #18. Resident #18 stated this morning ' s breakfast was not normal. Resident #18 stated he asked for seconds, but they didn ' t have enough. Resident #18 stated they were served fried bologna earlier this week. " It was better than nothing, but barely. " Resident #18 stated Staff D frequently didn ' t have enough food to cook the meal that was on the menu, and didn ' t have enough food to give them all the same thing. Resident #18 stated " they make the same things over and over again, " and that the menu hanging up by the dining

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never followed.
On / at 10:50 AM an interview was conducted with Resident #7. Resident #7 stated the food has gone " downhill " in recent months. Resident #7 stated he had asked Staff D for seconds when he was still hungry, and had been told there was not enough food for seconds, that not all residents had been given first portions. Resident #7 stated he was hungry and saw bananas on the counter, and went to take one. Resident #7 stated he was yelled at by staff in front of other residents. Resident #7 stated " they hardly ever follow the menu. "
On / at 5:42 PM an interview was conducted with the Administrator. The Administrator stated she had purchased enough food for the facility to follow the menu and she ' d had enough food in the building, but Staff D was stealing food and throwing food out. The Administrator stated she had purchased food on Monday, but then Staff D threw it out before the Department of Children and Families Adult Protective Investigator (API) arrived. The Administrator provided a receipt for food purchased on , but it was not purchased until 1:31 PM.
On / at 3:10 PM an interview was conducted with a Department of Children and Families Adult Protective Investigator (API) who conducted an investigation at the assisted living facility on . The API stated there was no food at the facility when she arrived at noon. The API looked in the refrigerator and freezer in the kitchen, and looked in the pantry that had another freezer, and they were " bare " . The residents in the facility were given two hotdogs for lunch, but there were only 17 hot dog buns, so some residents received one hot dog , and some did not receive any. The menu was not followed. The residents told the API the menu is not normally followed and they had been provided with very little food since the new owner took over. The API interviewed Staff D, who stated he provides the Administrator with a grocery list to get all of the needed items for the menu, and the Administrator only brings back half of the list. The API interviewed the Administrator on , and the Administrator admitted she had not had time to go to the grocery store over the weekend. The Administrator was aware that there was not enough food in the facility to feed all of the residents an appropriate lunch. The API stated she instructed the Administrator to go purchase food and send her a copy of the receipt no later than 3:00 PM.

Class III

0123 Fiscal - Resident Trust Funds

Based on interview and record review, the facility failed to keep the resident funds separate from the facility funds.

Findings included:

On / at 4:09 PM a record review was conducted of the resident fund log. The Administrator

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stated each resident has their own page in the resident fund log, and she writes down on each residents ' page how much was deposited into the bank on their behalf.
On / at 4:09 PM an interview was conducted with the Administrator. The Administrator stated the resident funds were kept in the same account as the facility funds. The Administrator stated she was not aware that the resident funds were not to be kept in the same bank account as the facility's funds.

Class III

0167 Resident Contracts

Based on interview and record review, the facility failed to honor the resident contracts which stated the facility would provide soap, paper towels, and housekeeping services.

Findings included:

On / at 8:00 AM a tour was made of the facility. Gnats were observed in the main dining area, the living area, and multiple resident . A spilled, sticky substance was observed on the floor of # between the the dresser. A brown substance that appeared to be feces was observed on a toilet seat in the shared between #13 and #14. Resident in all three buildings were observed without soap or paper towels.
On / at 3:30 PM a record review was conducted for the resident contracts of five residents; Resident #3, Resident #5, Resident #7, Resident #15, and Resident #13. All five contracts stated " provisions of all linen, towels, soap and toilet paper " and " housekeeping services " will be provided.
On / at 8:51 AM an interview was conducted with Resident #13. Resident #13 stated another resident has been having accidents in the shared defecates and urinates on the floor and the toilet seat. Resident #13 stated when staff is asked if they will clean the , Staff A stated " you live back there, you clean it up. " Resident #13 stated he has had to clean his multiple occasions.
On / at 9:15 AM an interview was conducted with Resident #1. Resident #1 stated when she moved in to the assisted living she was told they would provide soap and paper towels, but they refuse to provide those items. Resident #1 stated she had to purchase her own soap to wash her hands. Resident #1 stated the shares with three other residents has one resident who has repeatedly had accidents where he defecated on the toilet seat or on the toilet seat or the floor. Resident #1 said she asked staff to clean up the , and was told she needed to clean it up herself, but they would not supply her with cleaning supplies.
On / at 10:50 AM an interview was conducted with Resident #7. Resident #7 stated he was told he had to clean his own . He stated he does not know the last time the shower was cleaned. Resident #7 stated residents are not provided with either soap or paper towels in the

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to wash their hands.
On / at 11:09 AM an interview was conducted with Resident #3. Resident #3 stated he had asked staff if/when they would clean the shower or , and was told he had to clean the . Resident #3 stated he is not physically capable of scrubbing a shower stall or cleaning the floor. Resident #3 stated he cannot recall the last time the shower or toilet was cleaned in his . Resident #3 stated he has asked for soap and paper towels on multiple occasions, and he was told to hang a towel in the they could all share. Resident #3 stated when he moved in his contract stated the facility would provide soap and paper towels. Resident #3 stated he asked the Administrator today for soap and paper towels, and they were not provided.
On / at 4:55 PM an interview was conducted with the Administrator. The Administrator stated the facility has honored the contracts with all of the residents, and that the facility does provide soap and paper towels in every well as housekeeping services. The Administrator stated no one has ever told any of the residents to clean a .

Class III

Z815 Backaround Screenina: Prohibited Offenses

Based on interview and record review, the facility failed to ensure that 1 out of 6 sampled employees (Staff G) had a Level II background screening prior to having direct contact with residents.

Findings included:

On / at 12:52 PM a request was made for the employee file for Staff G. Staff G did not have an employee file for review.
On / at 9:15 AM an interview was conducted with Resident #1. Resident #1 stated Staff G drove her to several different locations on , to pick up cash so that she could pay the facility cash for rent.
On / at 9:54 AM an interview was conducted with Resident #2. Resident #2 stated Staff G drove her to the bank after she moved in on , so that she could pick up cash to pay the facility. Resident #2 stated Staff G is the only one with the key to the toilet paper holders, and they have to ask him when they need the toilet paper replaced.
On / at 8:51 AM an interview was conducted with Resident #13. Resident #13 stated he was given a 45-day notice. Staff G told Resident #13 that if he " was good " that Staff G would rescind the 45-day notice.
On / at 11:09 AM an interview was conducted with Resident #3. Resident #3 stated Staff G comes to the facility up to five days a week, and many of those days he is at the facility all day. Resident #3 stated Staff G brought over pizza and handed it out to the residents one day this week.

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On / / at 3:15 PM an interview was conducted with Resident #14. Resident #14 stated she had lived in the facility for about a month. She stated Staff G had driven her to the bank to get money out to pay her rent in cash.

On / / at 4:54 PM a review was conducted of the Agency for Health Care Administration background screening unit website. Staff G was determined " Not Eligible " for Medicaid Provider Enrollment on . Staff G was determined " Not Eligible " in the remaining three categories on / .

On / / at 4:55 PM an interview was conducted with the Administrator. The Administrator stated Staff G is not an employee in the facility, and that he never has been. The Administrator was aware that Staff G did not pass the Level II background screening. The Administrator stated that the residents are " unstable " and " lie a lot " when they said that Staff G was at the facility frequently. The Administrator stated Staff G brings things to the facility and delivers food. The Administrator stated Staff G used to drive residents to the bank back in and , but she denied that he had done that in or .

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Assisted Living of Dunedin
dba Dunedin Assisted Living Facility
Attn: Maryla Hawekotte, Administrator
534 Howell Street
Dunedin, FL 34698

Dear . Hawekotte:

This letter reports the findings of a complaint survey conducted , 2015 by representatives of the Agency for Health Care Administration. 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 request as directives below:

The inspection resulted in findings of non-compliance in the following areas:

A 0030 – Resident Care – Rights & Facility Procedures - The facility failed to honor resident rights, failed to prevent or neglect, and failed to provide a safe and clean living environment. The facility placed residents at risk by allowing an employee to work in the facility who did not have a Level II background screening, test, or free from communicable statement.

Z815 – Background Screening; Prohibited Offenses - The facility failed to ensure that all employees had a Level II background screening prior to having direct contact with residents.

You are directed to comply with the following requirements:

1). The facility must ensure all staff who provide services to the residents have a valid Level II background screening and have been found "eligible". This must be completed **immediately**.

2). The facility must obtain for the Administrator and all employees, at least 2 hours of training on Resident Rights provided by the Long-Term Care Ombudsman Program, or a provider approved by the Department of Children and Families or Long-Term Care Ombudsman Program. Documentation of this training must be maintained in each employee's file in the facility for review by the Agency. This must be completed by **, 2016.**

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
AHCA.MyFlorida.com

3). The facility must obtain for the Administrator and all employees training on the recognition of , neglect, and , using a provider approved by the Department of Children and Families or the Long-Term Care Ombudsman Program. Documentation of the training must be maintained in each employee's file in the facility for review by the Agency. This must be completed by , **2016**.

4). The facility must provide all services to residents specified in the resident agreement or required under the Resident Bill of Rights. This must include soap and towels in the resident and guest , and housekeeping services for resident living areas, including . The facility must have seating for all residents available at resident meals. This must be completed **immediately**.

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 **Paul Brown**, St. Petersburg Field Office, (727) 552-2000.

Sincerely,

Teresa Ryan RN

for Paul Brown
Health Facility Evaluator Supervisor

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