RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Homewood Lodge Assisted Living Facility
430 SE Mills Street
Mayo, FL 32066

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by representative(s) of this office.

Enclosed is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call this office at (386) 462-6201.

Sincerely,

Kriste J. Mennella
Field Office Manager

KJM/amw
Enclosure

XG90

Alachua Field Office
14101 N W Hwy 441, Suite 800
Alachua, FL 32615-5669
Phone:(386) 462-6201, Fax:(386) 418-5300
AHCA.MyFlorida.com

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968666	05/18/2016
NAME OF PROVIDER OR SUPPLIER **HOMEWOOD LODGE ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **430 SE MILLS ST MAYO, FL 32066**	

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

0000 Initial Comments

On through , a biennial re-licensure survey was conducted at Homewood Lodge Assisted Living Facility, facility license number 12528. Deficient practice was identified during the survey.

0008 Admissions - Health Assessment

Based on record review and interview, according to the Health Assessment, AHCA Form 1823, the facility failed to obtain and document omitted information for 2 of 2 residents reviewed of 23 residents on the current census (Resident # 3, Resident #9).

Findings:

1.) On , a record review was conducted on Resident #3's 1823 health assessment dated, . It was observed to be missing the following information:

a. Pg. 1 The facility failed to indicate nursing/treatment/ service requirements.

b. Pg. 2 Section 1: Ambulation: Check box does not indicate the extent to which the individual is able to perform the activity of daily living. Bathing: The extent and type of supervision that is required is omitted.

c. Pg. 5: Name of the recipient or guardian, signature of the recipient or guardian, name of the administrator or designee, signature of administrator or designee are blank.

d. Pg. 5 The question: "Does the facility intend to use this form to satisfy the Medicaid assessment for assistive care services?" is blank.

On at 12:02 PM an interview was conducted with the Administrator who confirmed that Resident #3's health assessment (AHCA Form 1823) has omitted information on page 1, page 2 and page 5.

2.) On , a record review of the health assessment AHCA form 1823 dated for Resident #9. It was observed to be missing the following information:

a. Pg. 1 physical or sensory limitations, nursing/treatment/ service requirements.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968666	**05/18/2016**
NAME OF PROVIDER OR SUPPLIER **HOMEWOOD LODGE ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **430 SE MILLS ST MAYO, FL 32066**	

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

b. Pg. 2 bathing: Check box does not indicate the extent to which the individual is able to perform the activity of daily living. Self Care: Check box does not indicate the extent to which the individual is able to perform the activity of daily living.

c. Pg. 3 Preparing Meals: Comments are blank and do not indicate the extent and type of assistance that is required. Shopping: Comments are blank and do not indicate the extent and type of assistance that is required. Handling Personal Affairs: Comments are blank and do not indicate the extent and type of assistance that is required. Handling Financial Affairs: Comments are blank and do not indicate the extent and type of assistance that is required.

d. Pg. 5 name of the recipient or guardian, signature of the recipient or guardian, name of the administrator or designee, signature of administrator or designee are blank.

e. Pg. 5 The question: " Does the facility intend to use this form to satisfy the Medicaid assessment for assistive care services? " is blank.

On [redacted] at 12:02 PM an interview was conducted with the Administrator who confirmed that Resident #9's health assessment (AHCA Form 1823) has omitted information on page 1, page 2, page 3 and page 5.

Class III

0055 Medication - Storage and Disposal

Based on observation, interview, and record review, the facility failed to ensure medications were secured in a centrally located locked cabinet, cart, or other storage receptacle for a resident residing in a secured, memory care unit for 1 of 23 residents observed (Resident #9).

Findings:

On [redacted] at 10:20 AM, during the initial tour, a bottle of [redacted] Rubbing [redacted] was observed sitting on the table in [redacted] # [redacted] where Resident #9 resided. (Photographic evidence obtained)

On [redacted] at 11:04 AM, an interview was conducted with Staff D. Staff D reported this ([redacted] Rubbing [redacted]) is hers (Resident #9). Staff D was asked, "Should it be there?" Staff D stated, "No."

On [redacted], a review of the policy and procedure as provided by the Administrator effective

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968666	05/18/2016
NAME OF PROVIDER OR SUPPLIER **HOMEWOOD LODGE ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **430 SE MILLS ST MAYO, FL 32066**	

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

and revised on Storage of Medication revealed: Per procedure for storage of medication, medication may be centrally stored if the resident is forgetful or disoriented and is not capable of taking medications as prescribed or if a physician signs on the Form 1823 that the resident needs assistance with self-administration of medications, the medications will be kept in the locked medication cart at all times. Resident #9 resides in a memory care unit and does require assistance with self-administration with medications according to the health assessment, AHCA FORM 1823 dated .

Class III

0092 Food Service - General Responsibilities

Based on observation and interview, the facility dietary designee failed to perform her duties in a sanitary manner while preparing lunch for 23 of 23 residents of the facility.

Findings:

On at 11:50 AM, during the Food Services Dining Review, Staff E was observed touching butter to transfer it from the butter knife to the rice each time she prepared a resident ' s plate. She was wearing gloves, but she moved about in the kitchen touching other surfaces (counters, plates in the dish dryer) while wearing the same gloves in between servings without washing her hands or changing gloves.

On at 11:56 AM, an interview was conducted with Staff E who was serving the lunch. When asked if she realized that she was touching the butter and touching other items in the kitchen without changing gloves or washing, she asked the question, "I'm supposed to change my gloves between everything?"

Class III

0093 Food Service - Dietary Standards

Based on record review, observation, and interview, the facility failed to maintain a substitution log on file for 6 months for regular and therapeutic menus.

Findings:

On a record review was conducted of menus and the substitution log. The facility failed to provide a copy of the substitution log upon request.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968666	05/18/2016
NAME OF PROVIDER OR SUPPLIER **HOMEWOOD LODGE ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **430 SE MILLS ST MAYO, FL 32066**	

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

On [redacted] at 12:10 PM, an interview was conducted with Staff E. Staff E was asked if the facility keeps a log of the substitutions, and she reported, "No we just change it on board."

On [redacted] at 12:10 PM, an interview was conducted with The Administrator who stated, "No Ma'am. I don't actually keep a log." She later apologized for not keeping a substitution log.

On [redacted], a record review of the menu was conducted, and it was determined through observation at 11:50 AM during the Food Services Dining Review that the dinner menu was being served for lunch.

On [redacted] at 12:15 PM an interview was conducted with the Administrator: She stated, "We switch dinner and lunch."

Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observation, interview, and record review, the facility failed to provide a safe and clean living environment for 23 of 23 residents.

Findings:

1. During the initial tour of the facility on [redacted] at 10:00 AM, it was observed the carpets in the living [redacted], hallways, and the memory care unit were discolored and stained (photographic evidence obtained).

An interview was conducted with the Administrator on [redacted] at 10:52 AM. She confirmed the carpets in the Memory Care Unit, hallways and living [redacted] stained and needed to be cleaned.

2. During the initial tour of the facility on [redacted] at 10:00 AM, it was observed the shower [redacted] Lilac Circle had a large yellow substance on the floor in front of the shower. The shower mat lying on the floor of the shower had black debris on it (photographic evidence obtained).

An interview was conducted with the Administrator on [redacted] at 3:52 PM. She confirmed there was a yellow substance on the floor and there was a black substance on the shower mat. She stated she wasn't sure when the shower was used last and she further stated there was no housekeeper today.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968666	05/18/2016
NAME OF PROVIDER OR SUPPLIER **HOMEWOOD LODGE ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **430 SE MILLS ST MAYO, FL 32066**	

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

3. An observation of the [redacted] was conducted on [redacted] at 12:45 PM. The toilet was observed to have a large black ring on the inside of the toilet bowl. Additionally the base of the toilet had dark substances on it and the floor around the toilet was discolored (Photographic evidence obtained).

An interview conducted with Resident #5 on [redacted] at 12:45 PM, who stated he had to remind staff he has been in his [redacted] for 3 weeks and he has not had his toilet or [redacted] yet.

An interview was conducted with the Administrator on [redacted] at 3:22 PM. She stated she was aware of the condition of Resident #5 [redacted]. She confirmed it needed to be cleaned.

A review of the "Employee Duties Checklist" for "Hall A" and "Hall B" revealed no cleaning task for [redacted].

An interview was conducted with the Administrator on [redacted] at 12:30 PM. She stated the housekeeping routine did not have a cleaning schedule for [redacted] because it used to be an office. She stated it was her mistake the routine was not correct.

Class III

Z816 Background Screening-Compliance Attestation

Based on record review and interview, the facility failed to obtain compliance attestations for 3 of 4 staff reviewed (Staff A, B and C).

Findings:

A review of Staff A, B and C's personnel records revealed no Affidavit of Compliance with Background Screening Requirements (AHCA recommended form 3100-0008) was completed.

An interview was conducted with the Administrator on [redacted] at 1:05 PM. She confirmed that an Affidavit of Compliance with Background Screening Requirements was not completed for Staff A, B and C.

Unclassified