STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964828	**06/28/2016**
NAME OF PROVIDER OR SUPPLIER **IONIE'S ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **3447 ALISSA COURT** **ORLANDO, FL 32808**	

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

0000 Initial Comments

On a re-licensure survey was conducted at Ionie's Assisted Living Facility (license # 9336). Deficient Practice was identified during the survey.

0008 Admissions - Health Assessment

Based on record review and interview the facility did not obtain a complete and accurate AHCA form 1823, Resident Health Assessment for Assisted Living Facility, 2010 for 2 of 2 sampled residents (#1 and #2).

Findings:

Record review for Resident #1 revealed a AHCA from 1823 dated , the health care provider did not document the type of assistance the Resident required with his medications. That section was left Blank.

Record review for Resident #2 revealed AHCA form 1823 that was dated , the resident was required to have a new AHCA form 1823 completed every three years. Further record review revealed there was another AHCA form 1823 located in his record. The Health care provider did not date the form. There was no way to determine when the Health Assessment was completed.

On at 11:45 AM, the administrator reviewed the forms and confirmed the above findings.

Class

0030 Resident Care - Rights & Facility Procedures

Based on observations, record review and interview the facility failed to ensure a physician reviewed the use of half-bed rails for 1 of 2 sampled residents (#1) annually.

Findings:

Observations on at approximately 9:15 AM, revealed Resident #1 had half-bed rails on his bed.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964828	06/28/2016
NAME OF PROVIDER OR SUPPLIER **IONIE'S ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **3447 ALISSA COURT** **ORLANDO, FL 32808**	

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

Staff D said on [redacted] at 10 AM, Resident #1 received hospice services and was not capable of removing or avoiding the half-bed rails. She said he was bed bound and she had to turn him.

Record review for Resident #1 revealed there was no Health Care Providers order found for the half-bed rails.

On [redacted] at 2 PM, the administrator reviewed the record and said there was no half-bed rail order that was completed by the health care provider found in his record. She said she was not aware an order was required for the half-bed rails.

Class III

0077 Staffing Standards - Administrators

Based on Observations, Personnel Record Review, Background Screening Website Review, the Administrator who was responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents attempted to deceive the agency by using the identity of Staff B for Staff D.

Findings:

On [redacted] at 9:15 AM Staff A, the administrator and Staff D were observed working at the facility. The administrator was asked the name of the staff present and she gave her name. Staff D also gave the same name.
During a staff Interview, Staff D gave the same name again and said she had worked at the facility for 4 years.
During Personnel record review the administrator was asked to provide the personnel record for Staff D and she provided a record that did not include a Level II screening result.

A review of the background screening website on [redacted] at 3:30 PM revealed there was a picture. The picture was not person who was working at the facility whom the Administrator and Staff D said she was. This picture was a person whom had been observed working at the facility in the past. At 3:30 PM on [redacted], Staff D was asked to look at the picture, she was asked if it was her. She said no it was not. She was asked her date of birth. The date of Birth did not match. Staff D was asked if the name on the level II was her name. She reviewed it and said yes that was her name. She was then informed that the

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964828	**06/28/2016**
NAME OF PROVIDER OR SUPPLIER **IONIE'S ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **3447 ALISSA COURT ORLANDO, FL 32808**	

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

picture was not her and she was not the person on the background screening result. Staff D then said oh yes that's me. She was informed at the time the she did not look anything like the person on the picture. She continued to say it was her.

On [redacted] at 3:40 PM Resident #6 who had resided at the facility for years reviewed the photo and gave the name as being Staff B, He was asked what was the name of the person working at the facility and he said he really did not know her name, he gave a name of what he thought her name was, however it was not the name of the person whom Staff D said she was.

The administrator was not present at the time and returned about 30 minutes later. The Administrator was informed of the findings when she returned. The administrator said that was the name staff D gave her. The Administrator was informed at the time she could not have given her Staff B's name because Staff B according to the residents was still employed at the Facility. She was asked to provide the personnel file for Staff D because she had intentionally given the surveyor the name of another staff for Staff D. The Administrator reached on the book shelf and gave the surveyor another staff file. The Administrator was told at the time, the Level II screening would be also checked on this employee files, she was informed if this was not Staff D personnel record to tell the truth. The Administrator said it was not. The administrator was asked the name of the staff and she could not give a name, she said she did not have a personnel record for the Staff.

At 4 PM, the administrator was asked to provide the Telephone number for Staff B and telephone call was made to Staff B and she was interviewed. Staff B was asked her name and said she was off for the Day. Staff B's name was the same name given by Staff D.
The administrator intentionally tried to deceive the agency, she was using the identity of Staff B for Staff D, Staff D was observed providing care, food and medications to the Residents of the facility without having any training's. The administrator did not have evidence that staff D had received health tests and Level II Screenings. The administrator did not maintain accurate staff schedules and menus and did not have the following training:

1. Resident rights in an assisted living facility and Recognizing and reporting resident , neglect, and [redacted]
2. Facility's resident elopement response policies and procedures
3. Safe food handling practices
4. Reporting adverse incidents, Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964828	06/28/2016
NAME OF PROVIDER OR SUPPLIER **IONIE'S ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **3447 ALISSA COURT** **ORLANDO, FL 32808**	

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

5. 3 hours of Providing Assistance with Activities of Daily Living and Resident needs and behavior
6. control before providing care to the residents.
7. Facility' s resident elopement response policies and procedures
8. The initial 4 hours training in providing assistance with self-administered medications and safe medication practices in an Assisted Living Facility (ALF)
9. and training
10. currently valid card that documented the completion courses in First Aid and
11. One hour of training in the facility's policies' and procedures regarding included in Rule 58A-5.0186, F.A.C.

The Administrator did not conduct a Level II background Screening for Staff B and D, she also did not obtain a and Freedom from communicable Statement from a health care provider Staff B and D.

Class III

0078 Staffing Standards - Staff

Based on Observations, Personnel record review, Background Screening Website and Interview, the facility failed to obtain for 2 of 4 staff (B and D) a statement from her health care provider documenting freedom from communicable including ( ).

Findings:

Personnel Record for Staff B hired in 2013 revealed there was no documentation to confirm she had obtained a statement from her Health Care Provider documenting Freedom from Communicable

On at 4:15 PM, the administrator said she was not aware that the freedom from communicable for Staff B was not in her personnel record.
On / at 9:15 AM Staff A, the administrator and Staff D were observed working at the facility. The administrator was asked the name of the staff present and she gave her name. Staff D also gave the same name.
During a staff Interview, Staff D gave the same name again and said she had worked at the facility for 4 years.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964828	**06/28/2016**
NAME OF PROVIDER OR SUPPLIER **IONIE'S ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **3447 ALISSA COURT ORLANDO, FL 32808**	

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

During Personnel record review the administrator was asked to provide the personnel record for Staff D and she provided a record that did not include a Level II screening result.
A review of the background screening website on at 3:30 PM revealed there was a picture. The picture was not person who was working at the facility whom the owner and Staff D said she was. This picture was a person whom had been observed working at the facility in the past. At 3:30 PM on Staff D was asked to look at the picture, she was asked if it was her. She said no it was not. She was asked her date of birth. The date of birth did not match. Staff D was asked if the name on the level II background screening was her name. She reviewed it and said yes that was her name. She was then informed that the picture was not her and she was not the person on the background screening result. Staff D then said oh yes that's me. She was informed at the time the she did not look anything like the person on the picture. She continued to say it was her.

On at 3:40 PM Resident #6 who had resided at the facility for years reviewed the photo and gave the name as being Staff B, He was asked what was the name of the person working at the facility and he said he really did not know her name, he gave a name of what he thought her name was, however it was not the name of the person whom Staff D said she was.

The administrator was not present at the time and returned about 30 minutes later. The Administrator was informed of the findings when she returned. The administrator said that was the name staff D gave her. The Administrator was informed at the time she could not have given her Staff B's name because Staff B according to the residents was still employed at the Facility. She was asked to provide the personnel file for Staff D because she had intentionally given the surveyor the name of another staff for Staff D. The Administrator reached on the book shelf and gave the surveyor another staff file. The Administrator was told at the time, the Level II screening would be also checked on this employee files, she was informed if this was not Staff D personnel record to tell the truth. The Administrator said it was not. The administrator was asked the name of the staff and she could not give a name, she said she did not have a personnel record for the Staff.

At 4 PM, the administrator was asked to provide the Telephone number for Staff B and telephone call was made to Staff B and she was interviewed. Staff B was asked her name and said she was off for the Day. Staff B's name was the same name given by Staff D.
The administrator intentionally tried to deceive the agency, she was using the identity of Staff B for Staff D and did not have evidence that Staff D had obtained a statement from her health care provider documenting freedom from communicable including .

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964828	**06/28/2016**
NAME OF PROVIDER OR SUPPLIER **IONIE'S ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **3447 ALISSA COURT ORLANDO, FL 32808**	

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

Class III

0079 Staffing Standards - Levels

Based on a review of staff schedules and interview, the facility did not maintain a written work schedule that reflected its 24-hour staffing pattern for a given time period.

Findings:

The administrator was asked to provide the last two weeks of her staffing schedule.
The administrator provided a schedule that was dated for the week of . On at 1:10 PM, the administrator said she did not have any other schedules available for review.
There was no way to determine whether the facility had the required staffing hours.

Class III

0080 Training - Core & Competency Test

Based on personnel record review and interview, the Administrator and Manger failed to have evidence that they had participated in 12 hours of continuing education in topics related to Assisted Living every 2 years.

Findings:

Personnel record review for Staff A, the administrator revealed there was only 9 hours of continuing education found in her record for the last 2 years.

On at 4:15 PM, the Administrator said she could only locate 9 hours of continuing education in her personnel record.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964828	06/28/2016
NAME OF PROVIDER OR SUPPLIER **IONIE'S ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **3447 ALISSA COURT** **ORLANDO, FL 32808**	

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

Class III

0081 Training - Staff In-Service

Based on Observations, Background Screening Website, personnel record review and interview the facility failed to have evidence that 1 of 4 sampled staff (D) received the required in- service training within 30 days of hire.

Findings:

On at 9:15 AM Staff A, the administrator and Staff D were observed working at the facility. The administrator was asked the name of the staff present and she gave her name. Staff D also gave the same name.
During a staff Interview, Staff D gave the same name again and said she had worked at the facility for 4 years.
During Personnel record review the administrator was asked to provide the personnel record for Staff D and she provided a record that did not include a Level II screening result.

A review of the background screening website on at 3:30 PM revealed there was a picture. The picture was not person who was working at the facility whom the owner and Staff D said she was. This picture was a person whom had been observed working at the facility in the past. At 3:30 PM on / Staff D was asked to look at the picture, she was asked if it was here. She said no it was not. She was asked her date of birth. The date of Birth did not match. Staff D was asked if the name on the level II was her name. She reviewed it and said yes that was her name. She was then informed that the picture was not her and she was not the person on the background screening result. Staff D then said oh yes that's me. She was informed at the time the she did not look anything like the person on the picture. She continued to say it was her.

On at 3:40 PM Resident #6 who had resided at the facility for years reviewed the photo and gave the name as being Staff B, He was asked what was the name of the person working at the facility and he said he really did not know her name, he gave a name of what he thought her name was, however it was not the name of the person whom Staff D said she was.

The administrator was not present at the time and returned about 30 minutes later. The Administrator

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964828	**06/28/2016**
NAME OF PROVIDER OR SUPPLIER **IONIE'S ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **3447 ALISSA COURT ORLANDO, FL 32808**	

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

was informed of the findings when she returned. The administrator said that was the name staff D gave her. The Administrator was informed at the time she could not have given her Staff B's name because Staff B according to the residents was still employed at the Facility. She was asked to provide the personnel file for Staff D because she had intentionally given the surveyor the name of another staff for Staff D. The Administrator reached on the book shelf and gave the surveyor another staff file. The Administrator was told at the time, the Level II screening would be also checked on this employee files, she was informed if this was not Staff D personnel record to tell the truth. The Administrator said it was not. The administrator was asked the name of the staff and she could not give a name, she said she did not have a personnel record for the Staff.

At 4 PM, the administrator was asked to provide the Telephone number for Staff B and telephone call was made to Staff B and she was interviewed. Staff B was asked her name and said she was off for the Day. Staff B's name was the Same name given by Staff D.
The administrator intentionally tried to deceive the agency, she was using the identity of Staff B for Staff D and did not have evidence that Staff D had received the following training:

1. Resident rights in an assisted living facility, Recognizing and reporting resident , neglect, and
2. Facility's resident elopement response policies and procedures
3. Safe food handling practices
4. Reporting adverse incidents, Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation
5. 3 hours of Providing Assistance with Activities of Daily Living and Resident needs and behavior
6. control before providing care to the residents.
7. Facility' s resident elopement response policies and procedures

Class III

0082 Training -

Based on Observations, Background Screening Website review, personnel record review and interview the facility failed to have evidence that 2 of 4 sampled staff (C and D) had obtained the required and training within 30 days of employment.

Findings:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964828	**06/28/2016**
NAME OF PROVIDER OR SUPPLIER **IONIE'S ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **3447 ALISSA COURT ORLANDO, FL 32808**	

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

Personnel Record review for Staff C hired in 2011 had no documentation to confirm she had obtained a and training.
On at 4 PM, The Administrator said staff C had the training and she could not locate it.

On at 2 PM Staff D said she had worked at the facility for 4 years.
On at 9:15 AM Staff A, the administrator and Staff D were observed working at the facility. The administrator was asked the name of the staff present and she gave her name. Staff D also gave the same name.
During a staff Interview, Staff D gave the same name again and said she had worked at the facility for 4 years.
During Personnel record review the administrator was asked to provide the personnel record for Staff D and she provided a record that did not include a Level II screening result.

A review of the background screening website on at 3:30 PM revealed there was a picture. The picture was not person who was working at the facility whom the owner and Staff D said she was. This picture was a person whom had been observed working at the facility in the past. At 3:30 PM on Staff D was asked to look at the picture, she was asked if it was here. She said no it was not. She was asked her date of birth. The date of Birth did not match. Staff D was asked if the name on the level II was her name. She reviewed it and said yes that was her name. She was then informed that the picture was not her and she was not the person on the background screening result. Staff D then said oh yes that's me. She was informed at the time the she did not look anything like the person on the picture. She continued to say it was her.

On at 3:40 PM Resident #6 who had resided at the facility for years reviewed the photo and gave the name as being Staff B, He was asked what was the name of the person working at the facility and he said he really did not know her name, he gave a name of what he thought her name was, however it was not the name of the person whom Staff D said she was.

The administrator was not present at the time and returned about 30 minutes later. The Administrator was informed of the findings when she returned. The administrator said that was the name staff D gave her. The Administrator was informed at the time she could not have given her Staff B's name because Staff B according to the residents was still employed at the Facility. She was asked to provide the personnel file for Staff D because she had intentionally given the surveyor the name of another staff for Staff D. The Administrator reached on the book shelf and gave the surveyor another staff file. The Administrator was told at the time, the Level II screening would be also checked on this employee files,

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964828	06/28/2016
NAME OF PROVIDER OR SUPPLIER **IONIE'S ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **3447 ALISSA COURT** **ORLANDO, FL 32808**	

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

she was informed if this was not Staff D personnel record to tell the truth. The Administrator said it was not. The administrator was asked the name of the staff and she could not give a name, she said she did not have a personnel record for the Staff.

At 4 PM, the administrator was asked to provide the Telephone number for Staff B and telephone call was made to Staff B and she was interviewed. Staff B was asked her name and said she was off for the Day. Staff B's name was the Same name given by Staff D.
The administrator intentionally tried to deceive the agency, she was using the identity of Staff B for Staff D and did not have evidence that Staff D had received the and AID training.

Class III

0083 Training - First Aid and

Based on Observations, Background Screening Website, personnel record review and interview, the facility failed to have evidence that a staff member who held a currently valid card that documented the completion courses in First Aid and was in the facility at all times.

Findings:

Review of personnel records revealed Staff D did not have documentation of completion of courses in First Aid and .

The administrator intentionally tried to deceive the agency, she was using the identity of Staff B for Staff D and did not have evidence that Staff D had obtained First Aid and and was left alone with the Residents.

Class III

0084 Training - Assis Self-Admin Meds & Med Mgmt

Based on Observations, Background Screening Website, personnel record review and interview , the facility had no evidence to confirm that 1 of 4 sampled unlicensed staff (D), who provided assistance with the resident's medications received the initial 4 hours training in providing assistance with self-administered medications and safe medication practices in an Assisted Living Facility (ALF) and the

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964828	06/28/2016
NAME OF PROVIDER OR SUPPLIER **IONIE'S ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **3447 ALISSA COURT** **ORLANDO, FL 32808**	

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

annual 2 hours of continuing education on providing assistance with self-administered medications and safe medication practices in an ALF for 1 of 4 sampled unlicensed staff (B).

Findings:

Personnel record review for staff B revealed there was a 4 hour training regarding Providing assistance with self-administered medications that was dated / . There was no documentation to confirm that she had received the annual 2 hours of continuing education on providing assistance with self-administered medications and safe medication practices in an ALF.

On at 4 PM, the administrator said Staff B assisted the Resident's with medication and she could not find the 2 hour annual medication training in her personnel record.

On at 9:15 AM Staff A, the administrator and Staff D were observed working at the facility. The administrator was asked the name of the staff present and she gave her name. Staff D also gave the same name.
During a staff Interview, Staff D gave the same name again and said she had worked at the facility for 4 years.

On at 12:30 PM Staff D removed the medication for Resident #1 from the locked medication cart. Resident #1 was bed bound and in his bed. Staff D read the label. removed the pill from the package and placed the cup in the resident hand. his hands were contracted, he was able to raise the cup to his mouth and place the pill in his mouth from the cup.

During Personnel record review the administrator was asked to provide the personnel record for Staff D and she provided a record that did not include a Level II screening result.
A review of the background screening website on at 3:30 PM revealed there was a picture. The picture was not person who was working at the facility whom the owner and Staff D said she was. This picture was a person whom had been observed working at the facility in the past. At 3:30 PM on Staff D was asked to look at the picture, she was asked if it was here. She said no it was not. She was asked her date of birth. The date of Birth did not match. Staff D was asked if the name on the level II was her name. She reviewed it and said yes that was her name. She was then informed that the picture was not her and she was not the person on the background screening result. Staff D then said oh yes that's me. She was informed at the time the she did not look anything like the person on the picture. She continued to say it was her.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964828	**06/28/2016**
NAME OF PROVIDER OR SUPPLIER **IONIE'S ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **3447 ALISSA COURT ORLANDO, FL 32808**	

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

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The administrator was not present at the time and returned about 30 minutes later. The
The administrator intentionally tried to deceive the agency, she was using the identity of Staff B for Staff D and did not have evidence that Staff D had obtained the initial 4 hours training in providing assistance with self-administered medications and safe medication practices in an ALF. Staff D was assisting the residen's with the Self-Administration of their medications.

Class III

0090 Trainina -

Based on Observations, Background Screening Website, personnel record review and interview, the facility staff who provided direct care to the residents did not received at least one hour of training in the facility's policies' and procedures regarding included in Rule 58A-5.0186, F.A.C. within 30 days after employment for 1 of 4 sampled staff (Staff D).

Findings:

On at 9:15 AM Staff A, the administrator and Staff D were observed working at the facility providing care to the resident's. The administrator was asked the name of the staff present and she gave her name. Staff D also gave the same name.
During a staff Interview, Staff D gave the same name again and said she had worked at the facility for 4 years.

On at 4 PM, the administrator said Staff B assisted the Resident's with medication and she could not find the 2 hour annual medication training in her personnel record.
On at 9:15 AM Staff A, the administrator and Staff D were observed working at the facility. The administrator was asked the name of the staff present and she gave her name. Staff D also gave the same name.
During a staff Interview, Staff D gave the same name again and said she had worked at the facility for 4 years.

On at 11 AM, a staff interview was conducted with Staff D. She was asked if she knew what a

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964828	**06/28/2016**
NAME OF PROVIDER OR SUPPLIER **IONIE'S ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **3447 ALISSA COURT** **ORLANDO, FL 32808**	

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

( ) was. Staff D appeared and said "it is something about if a resident isn't it?". She said she did not know what a was.

During Personnel record review the administrator was asked to provide the personnel record for Staff D and she provided a record that did not include a Level II screening result.
A review of the background screening website on at 3:30 PM revealed there was a picture. The picture was not person who was working at the facility whom the owner and Staff D said she was. This picture was a person whom had been observed working at the facility in the past. At 3:30 PM on Staff D was asked to look at the picture, she was asked if it was here. She said no it was not. She was asked her date of birth. The date of Birth did not match. Staff D was asked if the name on the level II was her name. She reviewed it and said yes that was her name. She was then informed that the picture was not her and she was not the person on the background screening result. Staff D then said oh yes that's me. She was informed at the time the she did not look anything like the person on the picture. She continued to say it was her.

On at 3:40 PM Resident #6 who had resided at the facility for years reviewed the photo and gave the name as being Staff B, He was asked what was the name of the person working at the facility and he said he really did not know her name, he gave a name of what he thought her name was, however it was not the name of the person whom Staff D said she was.

The administrator was not present at the time and returned about 30 minutes later. The Administrator was informed of the findings when she returned. The administrator said that was the name staff D gave her. The Administrator was informed at the time she could not have given her Staff B's name because Staff B according to the residents was still employed at the Facility. She was asked to provide the personnel file for Staff D because she had intentionally given the surveyor the name of another staff for Staff D. The Administrator reached on the book shelf and gave the surveyor another staff file. The Administrator was told at the time, the Level II screening would be also checked on this employee files, she was informed if this was not Staff D personnel record to tell the truth. The Administrator said it was not. The administrator was asked the name of the staff and she could not give a name, she said she did not have a personnel record for the Staff.

At 4 PM, the administrator was asked to provide the Telephone number for Staff B and telephone call was made to Staff B and she was interviewed. Staff B was asked her name and said she was off for the Day. Staff B's name was the Same name given by Staff D.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964828	06/28/2016
NAME OF PROVIDER OR SUPPLIER **IONIE'S ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **3447 ALISSA COURT** **ORLANDO, FL 32808**	

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

The administrator intentionally tried to deceive the agency, she was using the identity of Staff B for Staff D and did not have evidence that Staff B had received at last one hour of training in the facility's policies' and procedures regarding included in Rule 58A-5.0186, F.A.C. within 30 days after employment.

Class III

0093 Food Service - Dietary Standards

Based on menu review, observations and interview, the facility did not maintain accurately dated menus as served for 6 months.

Findings:

Observations of the menu posted on the refrigerator revealed it was dated through . The days of the menu were noted as starting on Sunday through Saturday. A review of a calendar revealed the following:

was a Saturday (not Sunday) and 7/1 was Friday. The dates did not match the actual day of the week. The entire month of was not dated according to the days of the week
The the menus were dated 5-4- ; - and -6/3 , these dates did not match the day of the week, there were was on two menus
There were only two menus for dated - and - the dates did not match the day of the week
For there was a menu dated - and -
For 2-7- and - no other for -These were incorrectly dated
For - Sunday to Sunday- - - These dated reflected a Sunday to Sunday menu days on the Menu were Sunday through Saturday.
The Administrator reviewed the menus on at 2 PM and confirmed they were not dated correctly. She could not menus for the last 6 months that were accurate.

Class

Z814 Backaround Screenina Clearinahouse

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964828	**06/28/2016**
NAME OF PROVIDER OR SUPPLIER **IONIE'S ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **3447 ALISSA COURT ORLANDO, FL 32808**	

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

Based on the Personnel Record Review, The Agency's Background Screening Website and Interview, the facility did not obtain all of the employee Criminal history checks through the clearinghouse.

Findings:

Review of the Staff Schedule revealed there were 4 employees listed.
Review of the Agency's Background Screening website on at 3:30 PM revealed there were no employees listed on the facility's Employee's Roster.
On at 4 PM The Administrator confirmed the findings.

Unclassified

Z815 Backaround Screenina: Prohibited Offenses

Based on personnel record review. The background screening Website and interview, 2 of 4 sampled staff (B and D) were not in compliance with background screening requirements.

Findings:

Personnel record review for Staff B revealed there was no Level II screening results found in record.
Review of the Agency's Background Screening website on at 3:30 PM revealed it noted "a new screening is required."

On at 4:10 PM The administrator reviewed the results and confirmed the findings.

On at 9:15 AM Staff A, the administrator and Staff D were observed working at the facility. The administrator was asked the name of the staff present and she gave her name. Staff D also gave the same name.
During a staff Interview, Staff D gave the same name again and said she had worked at the facility for 4 years.

During Personnel record review the administrator was asked to provide the personnel record for Staff D and she provided a record that did not include a Level II screening result.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964828	**06/28/2016**
NAME OF PROVIDER OR SUPPLIER **IONIE'S ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **3447 ALISSA COURT** **ORLANDO, FL 32808**	

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

A review of the background screening website on / at 3:30 PM revealed there was a picture. The picture was not person who was working at the facility whom the owner and Staff D said she was. This picture was a person whom had been observed working at the facility in the past. At 3:30 PM on Staff D was asked to look at the picture, she was asked if it was here. She said no it was not. She was asked her date of birth. The date of Birth did not match. Staff D was asked if the name on the level II was her name. She reviewed it and said yes that was her name. She was then informed that the picture was not her and she was not the person on the background screening result. Staff D then said oh yes that's me. She was informed at the time the she did not look anything like the person on the picture. She continue to say it was her.

On at 3:40 PM Resident #6 who had resided at the facility for years reviewed the photo and gave the name as being Staff B, He was asked what was the name of the person working at the facility and he said he really did not know her name, he gave a name of what he thought her name was, however it was not the name of the person whom Staff D said she was.
The administrator was not present at the time and returned about 30 minutes later. The Administrator was informed of the findings when she returned. The administrator said that was the name staff D gave her. The Administrator was informed at the time she could not have given her Staff B's name because Staff B according to the residents was still employed at the Facility. She was asked to provide the personnel file for Staff D because she had intentionally given the surveyor the name of another staff for Staff D. The Administrator reached on the book shelf and gave the surveyor another staff file. The Administrator was told at the time, the Level II screening would be also checked on this employee files, she was informed if this was not Staff D personnel record to tell the truth. The Administrator said it was not. The administrator was asked the name of the staff and she could not give a name, she said she did not have a personnel record for the Staff.

At 4 PM, the administrator was asked to provide the telephone number for Staff B and telephone call was made to Staff B and she was interviewed. Staff B was asked her name and said she was off for the Day. Staff B's name was the same name given by Staff D.
The administrator intentionally tried to deceive the agency, she was using the identity of Staff B for Staff D and did not have evidence was in compliance with the background screening requirements an allowed the staff to provide care to the residents of the facility.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016
CERTIFIED MAIL/
RETURN RECEIPT

Administrator
Ionie's Assisted Living
3447 Alissa Court
Orlando, FL 32808

RE: Re-licensure

Dear Administrator:

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

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than 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 Lorraine Henry at -2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

XG90

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