AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967604	07/25/2016
NAME OF PROVIDER OR SUPPLIER **GOOD HOPE OF PINELLAS**	STREET ADDRESS, CITY, STATE, ZIP CODE **7575 65TH WAY** **PINELLAS PARK, FL 33781**	

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

0000 Initial Comments

Assisted Living Facility

A complaint survey, (CCR# 2016006729), was conducted from - at Good Hope of Pinellas, located at 7575 65th Way, Pinellas Park, FL. Deficiencies were identified during the survey.

(License #11615)

0025 Resident Care - Supervision

Based on interview, record review, and observation, the facility failed to provide supervision to 2 out of 31 residents (Resident #1 and #8). Specifically, the facility failed to follow their elopement policies and procedures, left the residents at risk by leaving the supervision of the residents to employees who had not been trained in elopement policies and procedures, and who allowed 1 resident (Resident #8) to elope from the facility on to a major road. Additionally, the facility failed to supervise 1 out of 31 residents (Resident #1) who was a risk, who had 3 in less than 3 months, including a broken arm. The facility failed to maintain a written record of any illnesses that required acute medical attention.

Findings included:

On / at 9:00 AM an observation was made of Resident #1. She had on the left side of her face from underneath her eye, down to the cheekbone, and back to her ear. She had a on her right arm.
On at 9:00 AM an interview was conducted with Resident #1. Resident #1 stated she had been in the facility for 3 months, and had 3 times. She said she gets a lot, and has difficulty transferring. She stated she calls out for help but no one comes. Resident #1 stated staff has refused to help her when she asked. She stated she has asked for help to get to the to transfer and no one helps her. She said the staff will say they go down to check on her, but they don't. Resident #1 stated since she arrived at the facility in late she has had two black eyes, one to the right and the current one on the left, and she has broken her arm. The resident stated she when attempting to transfer from the bed to her wheelchair on one occasion. She stated she and was sent to the hospital for her arm. She was told there was nothing wrong with it and sent back. She went a second time and they told her it was a . She went a third time and the x-ray showed it was broken. She stated it had been about 3 weeks since the . She stated there have been no changes since she . The staff have not increased the amount of times they check on her, have not provided her with a call button or

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whistle to alert them she needs assistance. The facility does not have call buttons in the resident . She stated there have been no changes since she . The staff have not increased the amount of times they check on her, have not provided her with a call button or whistle to alert them she needs assistance. She stated even with her broken arm only Staff A is consistently willing to assist.
On a record review was conducted of the chart for Resident #1. Resident #1 was admitted to the facility on An AHCA Health Assessment form 1823 (1823) dated identified Resident #1 as a risk. The 1823 labeled her as independent with transfer... physician's Certification Statement dated stated Resident #1 " cannot ambulate " and can't " be safely transported by car/wheelchair van (seated during transport, w/out medical attendant or monitoring) " . Resident #1 was seen at the hospital for an orbital on . On Resident #1 was seen at the hospital for an elbow . A progress note from the Advanced Registered Nurse Practitioner (ARNP) dated stated the patient was falling, and noted facial . A progress note from the ARNP dated read " c/o right arm pain from approx 3 wks ago. Pain on inside of right arm, been to hospital X2. " Facial was noted. (Photos 52-57, 58-60))
A continued review of the chart showed a progress note dated / that read the resident " on the floor in her approx. 7:45 AM. She had a large bump over her left eye as well as her nose . " The initials are not of any current staff. A progress note dated / read that the resident " went to the hospital at noon. She was complaint for pain on her shoulder. " The note was signed by Staff A. A third progress note dated read that the resident " complain for pain on her right elbow Staff L call not emergency she went to ... " , however, the note was not completed and not signed. No additional documentation could be located regarding the visit to the hospital where the break was identified. No discharge documents were located in the chart.
On / a record review was attempted of the incident reports regarding the three separate unwitnessed with injury, including a or of bones or joints. No incident reports could be located.
On at 1:05 PM an interview was conducted with Staff B, who stated " no one checks on Resident #1. She " .
On an observation was made of the television in the sitting the front entrance, and across from the nursing station. The volume of the television was so high, that from Resident #1 ' s , it did not appear probable that anyone could hear Resident #1 call for assistance unless they were outside of her door.
On at 3:15 PM an interview was conducted with the Administrator. The Administrator stated she did not know how Resident #1 broke her arm. She was unable to locate any documentation in Resident #1 ' s chart regarding the arm. The Administrator could not locate any documentation regarding the second injury to Resident #1 ' s eye. The Administrator stated the staff check on Resident #1 frequently.
On at 1:49 PM an interview was conducted with Staff C. Staff C stated she " just learned "

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what the word elopement meant when Resident #8 eloped from the facility on . Staff C stated she was told by a visiting family member that Resident #8 had walked out of the building. Staff C stated she went out and saw Resident #8 " all the way down the street " . Staff C called the Administrator who did not answer. Staff C stated she called Staff A, who then came to assist with talking Resident #8 into returning to the facility. Staff C stated she did not contact the family, the Administrator, or fill out an incident report. Staff C stated she did not receive the elopement training that was in her employee file. Staff C was not aware of the facility ' s elopement policy and procedures. Staff C stated " I pray when I am on my shift that I am not alone, cuz (because) if it happens on my shift, I ' m screwed. "
On at 2:55 PM an interview was conducted with Staff A. Staff A stated she received a phone call from Staff C who stated Resident #8 had left the building and she needed help. She stated he had walked two blocks down and one up the major road. She stated the Administrator was not in the building. Staff A did not write it down in Resident #8 ' s chart, did not fill out an incident report, or inform the Administrator. Staff A did not know what the word elopement meant. Staff A was not aware of the facility ' s elopement policy and procedures.
On at 3:15 PM an interview was conducted with the Administrator. The Administrator was not aware Resident #8 had eloped from the facility. The Administrator stated no Adverse Incident Report was filed for the elopement. The Administrator was not able to the facility ' s elopement policy and procedures. " I haven ' t looked in it to read it and tell you. "
Class II

0026 Resident Care - Social & Leisure Activities

Based on interview, observation and record review, the facility failed to provide a minimum of 12 hours of activities per week.

Findings included:

On / at 8:35 AM a tour was conducted of the facility. No activities calendar was posted.
On / at 9:20 AM an interview was conducted with Resident #2. Resident #2 stated the facility does not currently have any activities. Resident #2 stated she would like to have some in the building, because she gets bored.
On at 9:52 AM an interview was conducted with Resident #3. Resident #3 stated he has lived in the facility for over 5 years. He stated they have not had activities in the facility for several months.
On at 11:58 AM an interview was conducted with the Administrator. The Administrator stated she was going to have a home health agency come in to provide activities for the residents as " part of their thing with residents " . The Administrator stated she was aware there were currently no activities in the building and she was not sure when an activities coordinator would be hired.

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On at 1:05 PM an interview was conducted with Staff B. Staff B stated there is no activities calendar and they have not had any activities in the facility for several months. She stated there have not been any activities in the facility since she started work.
On at 2:23 PM an interview was conducted with Resident #7. Resident #7 stated there is " nothing to do here ". He stated there are no activities in the building.
On at 2:55 PM an interview was conducted with Staff A. Staff A stated they do not have any activities now. She stated they " used to. " She stated " or was the last time they had activities. When the new owners took over they stopped the activities.

Class III

0030 Resident Care - Rights & Facility Procedures

Based on observation, interview and record review, the facility failed to honor resident rights, failed to protect the residents from by Staff, and failed to provide a safe and clean living environment. The facility placed residents at risk by allowing 4 out of 14 employees to work in the facility whose Level II background screening had not found them eligible. The facility placed residents at risk by allowing employees to work in the facility who did not have the required health screenings. The facility failed to ensure the residents are treated with respect and consideration and provided appropriate care and services. This was evidenced by the facility failure to provide prescribed pain medications to 2 out of 3 sampled residents (Resident #1 and 4).

Findings included:

On at 1:05 PM an interview was conducted with Staff B. Staff B stated she had witnessed the Administrator yell profanities at Resident #7 and threaten to him. She stated the Administrator " got in his face and screamed at him like a dog. "
On / at 2:23 PM an interview was conducted with Resident #7. He stated the Administrator was yelling and " cussing at me " . He stated he tries not to listen. She has done it before. He stated he was embarrassed because she did it where other people could hear. He said she yelled at him for something he didn ' t do.
On / at 9:52 AM an interview was conducted with Resident #3. He stated he witnessed Staff N yell at a lot of the residents.
On at 1:05 PM an interview was conducted with Staff B stated she witnessed Staff N yelling at several residents. She stated " I ' m not going to lie, she was rude. " Staff B stated Staff N didn ' t like to help the residents.
On at an interview was conducted with the Administrator. The Administrator stated Staff N was terminated for " being nasty " to the residents.

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On at 8:35 AM a tour was conducted of the facility. An observation was made of a toilet that did not flush in the to the kitchen. A public the hallway by the nursing on was locked. The Administrator stated it has been locked since the former Administrator left in stated she was not sure where the key was, but she would speak with maintenance. The staff not have any paper towels. A the back hallway had a strong odor of , had no toilet paper, and no paper towels.

On at 9:52 AM an interview was conducted with Resident #3. Resident #3 stated the toilet in his to be plunged once or twice a week to work. He stated the plunger is now missing. He was ministrator that they would replace his toilet, but that has not happened yet.

On at 1:49 PM an interview was conducted with Staff C. She stated there are currently 3 leaks in the kitchen. There are two over the stove, and one over the wooden prep table. Staff C stated the sink also leaks and a bucket has to be put under the sink.

On / at 2:50 PM an interview was conducted with the Administrator. The Administrator stated she was not aware of any leaks in the facility as she has been busy in her office.

An interview was conducted with Staff I on at 5:33 PM. Staff I stated there is a leak in the kitchen and one in the back of the facility.

On at 9:20 AM an interview was conducted with Resident #2. Resident #2 stated her from the vent when it rains. She stated if the rain is heavy, you can see leaks " everywhere ". There was a strong offensive odor in the Resident #2. She stated the odor was coming from the attached . She stated the toilet is clogged and needs repaired. Resident #2 stated the Administrator is aware it needs repaired.

On at 12:10 PM an interview was conducted with Resident #6. Resident #6 stated the facility only has one hot water heater. He stated there is not enough hot water for him to take a hot shower. He has to use warm water from his sink to wash " the parts that stink " in the morning.

On at 12:20 PM an interview was conducted with Resident #1. Resident #1 stated she does not have hot water in her shower. An observation was made of the shower in Resident #1 ' s shower was turned on to the hottest setting. The water began to warm up briefly, then went back to . The water never got warm again, and never became hot. The water was left running for over 5 minutes. The drain in the shower was not secured and had moved, leaving an opening/hazard in the floor of the shower for Resident #1. A large roach was observed between the , next to her dresser. Resident and the wall. A large roach was observed in Resident #1 ' s #1 stated the roach has been there for several weeks. (Photos 50-51, 61-62)

On at 12:38 PM an interview was conducted with Resident #5. Resident #5 stated the light in her not worked for weeks. She stated the toilet in her doesn ' t flush, and she and her have to use the public . She stated the to their been locked for several weeks.

On at 10:41 AM a record review was conducted of the employee file for Staff D. Staff D had a printout of his Level II background screening in his file, dated . The printout read " screening in

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process " . A hand written note at the bottom of the page read " need additional info. Until then status will remain " in process " . (Photo 1)
On at 10:45 AM a record review was conducted of the time card for Staff D. Staff D last clocked in on / / at 2:58 PM and clocked out at 11:00 PM. (Photo 2)
On at 3:28 PM an interview was conducted with the Administrator. The Administrator stated Staff D was currently employed at the facility. The Administrator was asked if there was a more recent Level II background screening showing that Staff D is eligible. She stated " Doesn ' t look like it. This is it. "
On at 1:33 PM an interview was conducted with Staff D. Staff D stated he had worked on / from 3:00 PM to 11:00 PM. Staff D stated he is aware he his Level II background screening had not been cleared yet. He stated he is still employed and the facility is waiting for him to be found eligible.
On at 2:08 PM an interview was conducted with the Administrator and the Regional Manager. The Administrator stated Staff D is no longer employed at the facility and that she told him he was no longer employed on .
On at 2:32 PM an interview was conducted with Staff G. Staff G stated today was her first day at the facility. Staff G stated she had received a Level II background screening.
On at 4:05 PM an observation was made of Staff G as she passed medications. Staff G was observed alone in the medication the medications.
On at 5:01 PM a record review was conducted of the employee file for Staff G. No Level II background screening was observed in the employee file.
On at 5:01 PM an interview was conducted with the Administrator. The Administrator was asked where the Level II background screen was for Staff G. " I don ' t know. You don ' t give them time to get this stuff together? "
On / at 5:05 PM a review was conducted of the Agency for Health Care Administration background screening website for Staff G. The website read " A new screening is required "
In a continued interview with the Administrator on at 5:08 PM, the Administrator was informed Staff G was not able to work with residents until the Level II background screening was completed and she was found eligible.
On at 10:45 AM an interview was conducted with the Administrator. The Administrator stated Staff G has not worked since she was sent home on . The Administrator stated Staff G must have taken her time card home with her because she could not find it.
On at 11:05 AM an interview was conducted with Staff G over the phone. Staff G stated she had left her time card with the other time cards by the time clock, and she had worked the day before ( ) from 3:00 PM to 11:00 PM.
In a continued interview with the Administrator on at 11:12 AM, she admitted she had knowingly allowed Staff G to return to the facility and work with the residents after she had been informed by the Agency that the employee could not work in the facility with residents until after her

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background screening results showed her as eligible.
On at 11:15 AM the Administrator produced the time card and a record review was conducted of the time card for Staff G. Staff G worked on Saturday / from 6:58 AM until 3:08 PM. Staff G worked on Sunday from 3:10 PM until 11:11 PM. (Photo 3)
On at 11:17 AM a record review was conducted of the Agency for Health Care Administration background screening website. The Level II background screening for Staff G was still " in process. " Staff G had not yet been found eligible to work in the facility.
On at 5:05 PM an interview was conducted with the Administrator. The Administrator stated Staff H was working from 11:00 PM until 7:00 AM on / . The Administrator was not able to provide a last name at this time for Staff H, an application, an employee file, or a Level II background screening. The Administrator was informed Staff H could not work in the facility until she was found eligible.
On at 10:45 AM a record review was attempted of the time card for Staff H. The Administrator stated Staff H did not have a time card because she had not worked in the facility, as the Administrator had been told on / that Staff H had to have a Level II background screening prior to working and she did not have that yet.
On at 10:33 AM a record review was attempted of the employee file for Staff H. Staff H had no employee file. No Level II background screening was available for Staff H.
On at 11:12 AM an interview was conducted with the Administrator. The Administrator admitted she had allowed Staff H to return to the facility and work " a shift or two. " The Administrator agreed she had knowingly allowed Staff H to enter the facility and work with the residents after she had been informed by the Agency that the employee could not work in the facility with residents until after her background screening results showed her as eligible. Another request was made for the time card for Staff H but was not produced by the Administrator.
On at 11:10 AM the Regional Manager stated " we know she needs a new one " in regards to the Level II background screening for Staff H.
On at 12:10 PM an interview was conducted with Resident #6. Resident #6 stated Staff H works overnight and is very nice to him.
On at 1:32 PM a review was conducted of the Agency for Health Care Administration background screening website for Staff H. Two background screenings were located for the same name as Staff H. One of the screenings dated / was from a town close to the facility, but as no information was provided about this employee, it could not be verified through date of birth or social security number.
On at 10:25 AM a record review was conducted of the time card for Staff H produced by the Regional Manager. Staff H was documented as working from 11:00 PM until 7:00 AM on 07/12/2016, / , and . (Photo 4)
On / at 1:32 PM a review was conducted of the Agency for Health Care Administration background screening website for Staff A. The results read " a new screening is required. "

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Staff A was observed working in the facility on / on the 7:00 AM until 3:00 PM shift in her position as direct care staff and med tech.
On at 5:33 PM an interview was conducted with Staff I. Staff I stated he was scheduled to work the 11:00 PM to 7:00 AM shift tonight, . Staff I stated he had been and had called and informed the Interim Administrator that his background screening had been " kicked back " as not eligible. He stated she told him that his job was safe, and he has continued to work without break since he was found not eligible.
On at 5:40 PM a review was conducted of the Agency for Health Care Administration background screening website for Staff I. Staff I was found not eligible as of .
On at 6:15 PM an interview was conducted with the Administrator. The Administrator stated she was not aware Staff I did not have an eligible Level II background screening.
On at 10:41 AM a record review was conducted of the employee file for Staff C. Staff C had no statement in her file identifying her as free from communicable . Staff C had a examination dated .
On at 1:49 PM an interview was conducted with Staff C. Staff C stated she had been employed at the facility a little over 5 weeks.
On at 3:28 PM an interview was conducted with the Administrator. The Administrator stated she was not aware that Staff C did not have her free from communicable statement, and she was unable to find a more recent statement in the file. She stated she was not aware Staff C required a new examination.
On at 2:55 PM an interview was conducted with Staff A. Staff A stated on /2016 Resident #4 asked her how many he had left. She told him he had 39 left. Staff A stated she did not work on . When she returned to work on the morning of , the entire bottle of was missing. Staff A stated she called and reported it to the Administrator.
On at 3:15 PM an interview was conducted with the Administrator. The Administrator stated she was called about the missing for Resident #4. She went to the facility and was unable to locate the bottle. The Administrator then contacted the Interim Administrator. The Administrator stated she then contacted the employees and all of them said the medications were in the cart, and none of them knew anything about the missing medication. The Administrator stated she did not document any of her conversations. The Administrator did not conduct an investigation or contact the police. The staff were not retrained. The Administrator told them " to pay attention to the cart. " The Administrator stated she did not contact Resident #4 ' s primary care physician.
On at 2:08 PM an interview was conducted with the Administrator. The Administrator stated Staff A had called the pharmacy, and she was told the prescription could not be filled until after . The Administrator was aware Resident #4 had not received his pain medication since . As of the date of survey, the Administrator still had not contacted the primary care physician, or sent him out to the hospital to assess his pain level.
An interview was conducted with Resident #1 on at 9:00 AM. She stated she asks for her

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n medication and does not always receive it. She stated Staff A gives it to her as requested, but other oloyees do not. She stated she is told by some employees that they already gave her the medication n she knows they didn ' t. She stated she believes she has . missing.
a record review was conducted of the Individual Resident ' s Controlled Substance
ord for Resident #1. The prescription was for 10-325 mg, to be given 1 tablet by mouth
r times a day as needed for pain. The record showed it started with 120 pills. Pill #115 was given by
ff I to Resident #1 on / at 10:00 PM. The next 6 pills were blank. There was no signature and
time provided. Pill #108 was provided by Staff A on / at 8:00 AM. No explanation was
vided as to where the pills #114 through #109 had gone. (Photo 44)

ass II

32 Resident Care - Elopement Standards

ased on interview and record review, the facility failed to ensure the safety of 31 out of 31 residents in e facility. Specifically, the facility failed to follow its own elopement policy and procedure, and put the sidents in the facility at risk by leaving the residents in the care of untrained staff, leading to the opement of 1 out of 31 sampled residents (Resident #8) on to a busy street.

ndings included:

n at 1:05 PM an interview was conducted with Staff B. Staff B stated she did not receive e elopement training that was in her employee file dated / . Staff B stated the Interim dministrator came in to a mandatory meeting and stated the " state gave me 14 days to correct ' , so veryone was going to have trainings put in their files. Staff B was told she was not to take them out of e folder or copy them, they were the property of the facility.
n at 1:49 PM an interview was conducted with Staff C. Staff C stated she " just learned " hat the word elopement meant when Resident #8 eloped from the facility on . Staff C stated he was told by a visiting family member that Resident #8 had walked out of the building. Staff C stated he went out and saw Resident #8 " all the way down the street " . Staff C called the Administrator who id not answer. Staff C stated she called Staff A, who then came to assist with talking Resident #8 into eturning to the facility. Staff C stated she did not contact the family, the Administrator, or fill out an ncident report. Staff C stated she did not receive the elopement training that was in her employee file. taff C was not aware of the facility ' s elopement policy and procedures. Staff C stated " I pray when I m on my shift that I am not alone, cuz (because) if it happens on my shift, I ' m screwed. "
n at 2:40 PM an interview was conducted with Staff E. Staff E did not know what the word lopement meant. Staff E was not able to the facility ' s elopement policy and procedure. Staff . stated she did not receive the elopement training in her employee file dated .

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On at 2:55 PM an interview was conducted with Staff A. Staff A stated she received a phone call from Staff C who stated Resident #8 had left the building and she needed help. She stated he had walked two blocks down and one up the major road. She stated the Administrator was not in the building. Staff A did not write it down in Resident #8 ' s chart, did not fill out an incident report, or inform the Administrator. Staff A did not know what the word elopement meant. Staff A was not aware of the facility ' s elopement policy and procedures.
On at 3:14 PM a record review was conducted of the facility ' s elopement policy and procedures. The policy stated " Elopement is when a resident leaves the facility without following the facility ' s policy and procedures. " It further stated " Family members, or in the absence of any family, other responsible persons will be notified by the Administrator or Designee after the search and within one hour of determining that the resident has eloped/ is missing. " The elopement policy read " Effective , 2004, per 429.41 (1)(a) 3 F.S. , all licensed Assisted Living Facilities shall conduct a minimum of two (2) resident elopement prevention and response drills per year. Therefore in compliance with required laws regarding elopement drills, this facility shall conduct two (2) drills per year in order to reduce/eliminate risk exposures to missing residents in order to protect the safety and well-being of the residents, subsequently preventing resident elopements. " The policy further stated " In the event that a resident, after admission is determined to be at risk for elopement by facility staff, this information shall be documented in the resident record. In addition, the record will have the following information ... Printed name, facility name, address and telephone number on person. " (Photos 28-30)
In a continued record review of the elopement policy, the policy read " after the resident is found the direct care staff in charge ...shall conduct a thorough investigation, evaluation/assessment, and follow-up. " Per the elopement policy, the staff should receive the elopement training during new hire orientation and annual in-service training. The policy additionally states on a bi-monthly basis, resident social/leisure activities shall include reviews of the facility ' s elopement policy and procedures
On / at 3:15 PM an interview was conducted with the Administrator. The Administrator was not aware Resident #8 had eloped from the facility. The Administrator stated no incident report or Adverse Incident Report was filed for the elopement. The Administrator was not able to the facility ' s elopement policy and procedures. " I haven ' t looked in it to read it and tell you. " The Administrator stated elopement drills had not been conducted " even when I worked here before I didn ' t know of them doing any of that. " The Administrator stated Resident #8 was not an elopement risk. The Administrator was shown an elopement form for Resident #8. The Administrator was not aware Resident #8 had previously eloped from the building. The Administrator stated no investigation, evaluation, assessment or follow-up had been conducted in regards to Resident #8's elopement.
On at 5:33 PM an interview was conducted with Staff I. Staff I stated he did not receive training on elopement that was in his employee file dated
On at 11:13 AM an interview was conducted with Staff D. Staff D stated he did not receive the elopement training that is in his employee file dated
On at 12:41 PM an observation was made of Resident #8. Resident #8 did not have an

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identification bracelet or necklace on.
On at 12:41 PM an interview was conducted with Resident #8. Resident #8 was asked if he had anything in his pockets with his name, the facility name, and telephone number on it. Nothing was located.

Class II

0052 Medication - Assistance with Self-Admin

Based on record review, observation, and interview, the facility failed to provide medications to 4 out of 7 (Resident #5, 15, 16, and 17) sampled residents at the prescribed time. The facility failed to notify the primary care physician's office when medications went missing from 1 out of 1 (Resident #4) sampled residents.

Findings included:

On at 2:55 PM an interview was conducted with Staff A. Staff A stated on Resident #4 asked her how many he had left. She told him he had 39 left. Staff A stated she did not work on . When she returned to work on the morning of , the entire bottle of was missing. Staff A stated she called and reported it to the Administrator.
On at 3:15 PM an interview was conducted with the Administrator. The Administrator stated she was called about the missing for Resident #4. She went to the facility and was unable to locate the bottle. The Administrator then contacted the Interim Administrator. The Administrator stated she then contacted the employees and all of them said the medications were in the cart, and none of them knew anything about the missing medication. The Administrator stated she did not document any of her conversations. The Administrator did not conduct an investigation or contact the police. The staff were not retrained. The Administrator told them " to pay attention to the cart. " The Administrator stated she did not contact Resident #4 ' s primary care physician.
On at 4:08 PM a record review was attempted of the count sheet for the for Resident #4. The record could not be located. It was no longer in the book, or in the medication observation (MOR) records book.
On at 5:33 PM an interview was conducted with Staff I. Staff I stated he worked on Friday from 3:00 PM until 11:00 PM. Resident #4 asked him how many he had left, and Staff I was not able to locate the bottle. He stated he looked for the sheet in the book and couldn ' t find that either.
On at 2:08 PM an interview was conducted with the Administrator. The Administrator stated Staff A had called the pharmacy, and she was told the prescription could not be filled until after . The Administrator was aware Resident #4 had not received his pain medication

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since . As of the date of survey, the Administrator still has not contacted the primary care physician, or sent him out to the hospital to assess his pain level.
On at 12:18 PM an observation was conducted of Staff A as she assisted with medications. Staff A popped the medications into a soufflé cup and handed them to Resident #9. Staff A stated " here are your noon meds. " Staff A did not tell Resident #9 the name of the medication or the reason it was prescribed.
On at 12:22 PM an observation was conducted as Staff A assisted Resident #8 with medications. Staff A popped the medications into a soufflé cup and handed them to Resident #8. Staff A stated " I have your noon medicine. " Staff A did not tell Resident #8 the name of the medication or the reason it was prescribed.
On / at 3:30 PM an interview was conducted with the Administrator. The Administrator stated the correct procedure to assist with self-administration of medications is to read out the names of the medications to the resident and tell them the reason the medication was prescribed.
On at 4:05 PM an observation was made as Staff G assisted with the self-administration of medications. Staff G was observed in the medication , on her first day working in the facility, and without a Level II background screening, as she assisted with the 4:00 PM medications for Resident #9. Staff G placed all of the 4:00 PM medications and two medications prescribed for 8:00 PM into a soufflé cup. The Administrator walked in and asked if Staff G had kept the prefilled medication packet so that she could read off the names of the medication to each resident. The Administrator looked at the empty packets and noticed the 8:00 PM medications were included. She pulled out Resident #9 ' s medication and used the following day ' s 8:00 PM medications to determine which medications needed to be removed. She then placed those back in the medication packet and stapled it closed.
In a continued observation of Staff G as she assisted with medications, she was observed as she popped out medications for Resident #14. She placed them in a soufflé cup and signed the medication observation record (MOR). She then placed a piece of paper in the soufflé cup with his name, and turned the MOR to another resident. (Photo 31)
At 5:23 PM Staff G was observed as she assisted Resident #5 with her 4:00 PM medications. Staff G stated she was aware that medications were still being provided outside of the prescribed timeframe.
On at 5:33 PM an interview was conducted with Staff I. He stated the facility requires that the must be counted on each shift, and when he accepted the medication cart on multiple occasions the " narc count was off " . He stated he made a note of it.
On at 6:08 PM the Administrator was observed as she assisted several residents with their 4:00 PM medications. The Administrator stated she still had several residents left who had not yet received their medications.
On at 1:33 PM an interview was conducted with Staff D. Staff D stated he did not have the initial 4 hour training in assistance with self-administration of medication. Staff D stated he had been required to pass medications on 3 occasions. Staff D stated he was required to pass medications if he wanted to keep his job.

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On at 1:50 PM a record review was conducted of the Medication Observation Record (MOR) book. Staff D had signed the MOR on /__ for multiple residents. (Photos 6-10)

Class III

0054 Medication - Records

Based on record review, and interview, Staff failed to immediately update the medication observation record (MOR) for 4 out of 4 (Residents #15, #16, #17, and #18) sampled residents each time the medication is offered or administered.
Based on interview and record review, the facility failed to maintain accurate medication records for the residents. This was evidenced by facility failure to immediately update the Medication Observation Record (MOR) for 4 out of 4 (Residents #15, #16, #17, and #18) sampled residents, the failure to accurately maintain the Individual Controlled Substance Record for 2 of 3 sampled residents, (resident #1 and #4) prescribed by the physician for pain, and the facility was unable to confirm whether multiple residents received prescribed medications.

Findings included:

On a record review was conducted of the medication observation record (MOR) for Resident #17. was prescribed for 8:00 PM. No signature was observed on 7/3 or 7/4. was prescribed for 8:00 AM and 4:00 PM. No signature was observed for 8:00 AM on 7/4, 7/5, , and . No signature was observed at 4:00 PM for 7/3 and 7/4. Cranberry concentrate capsule was prescribed for 8:00 AM and 4:00 PM. No signature was observed for 8:00 AM on 7/4 and 7/5. No signature was observed for 4:00 PM on 7/3 and 7/4. was prescribed for 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. No signature was observed for 8:00 AM on 7/5, 12:00 PM on 7/5, 4:00 PM on 7/3 and 7/4, and 8:00 PM on 7/3 and 7/4. was prescribed for 7:00 AM. No signature was observed for 7/5. was prescribed for 8:00 AM and 4:00 PM. No signature was observed for 8:00 AM for 7/5 and for 4:00 PM for 7/3 and 7/4. was prescribed for 7:00 AM. No signature was observed for 7/4 and 7/5. was prescribed for 8:00 AM and 4:00 PM. No signature was observed for 8:00 AM for 7/5 and 4:00 PM for 7/3 and 7/4. No explanation was written on the back of the MOR for any of the missed doses. (Photo 40-43)
On at a record review was conducted of the MOR for Resident #16. was prescribed for 8:00 AM and 4:00 PM. No signature was observed for 8:00 AM on 7/2, 7/4, 7/5, or 7/8. No signature was observed for 4:00 PM on 7/3, 7/4, 7/5, 7/6, 7/7, 7/9, or was prescribed for 8:00 AM and 4:00 PM. No signature was observed for 8:00 AM on 7/2, 7/4, 7/5, or 7/8. No signature was observed for 4:00 PM on 7/3, 7/4, 7/5, 7/6, 7/7, or 7/9. was prescribed for 8:00 AM and 4:00 PM. No signatures were observed for 8:00 AM on 7/2, 7/4, 7/5, or 7/8. No signatures were

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observed for 4:00 PM on 7/3, 7/4, 7/5, 7/6, 7/7, or 7/9. was prescribed at 8:00 AM and 4:00 PM. No signature was observed for 8:00 AM on 7/2, 7/4/7/5, or 7/8. No signature was observed for 4:00 PM on 7/3, 7/4, 7/5, 7/6, 7/7, or 7/9. was prescribed for 8:00 PM. No signature was observed for 8:0 PM on 7/2 or 7/4. was prescribed for 7:00 AM. No signature was observed for 7:00 AM on 7/5. was prescribed for 8:00 PM. No signature was observed for 8:00 PM on 7/3, 7/4, 7/5, 7/6, 7/7, or 7/9. was prescribed for 8:00 PM. No signature was observec for 8:00 PM on 7/4 or 7/8. was prescribed for 8:00 AM and 4:00 PM. No signature was observed for 8:00 AM on 7/2, 7/5, or 7/8. No signature was observed on 4:00 PM on 7/4. was prescribed for 8:00 AM and 4:00 PM. No signature was observed for 8:00 AM on 7/5. No signature was observed for 4:00 PM on 7/4 or 7/5. was prescribed for 8:00 PM. No signature was observed for 8:00 PM on 7/4. No explanation was written on the back of the MOR for any missed doses. (Photos 38-39)
On at a record review was conducted of the MOR for Resident #18. was prescribed for 7:00 AM. No signature was observed for 7:00 AM on 7/5. was prescribed for 8:00 AM and 4:00 PM. No signature was observed for 8:00 AM on 7/5 or . No signature was observed for 4:00 PM on 7/4 or . was prescribed for 8:00 AM and 4:00 PM. No signature was observed for 8:00 AM on 7/2, 7/5, 7/8, or . No signature was observed for 4:00 PM on 7/3, 7/4, 7/5, 7/6, 7/7, 7/8, or . was prescribed for 8:00 AM and 4:00 PM. No signature was observed for 8:00 AM on 7/5 or . No signature was observed for 4:00 PM on 7/3, 7/4, 7/5, 7/6, 7/7, , or . was prescribed for 8:00 AM. No signature was observed on 7/4 or 7/9. was prescribed for 8:00 PM. No signature was observed at 8:00 PM on 7/3, 7/4, 7/5, 7/6, 7/7, 7/8, 7/9, , and . No explanation was written on the back of the MOR for any of the missed doses. (Photos 34-37)
The same type of concerns were noted on the MORs for multiple other residents of the facility
An interview was conducted with Resident #1 on at 9:00 AM. She stated she asks for her pain medication and does not always receive it. She stated Staff A gives it to her as requested, but other employees do not. She stated she is told by some employees that they already gave her the medication when she knows they didn ' t. She stated she believes she has missing.
On a record review was conducted of the Individual Resident ' s Controlled Substance Record for Resident #1. The prescription was for 10-325 mg, to be given 1 tablet by mouth four times a day as needed for pain. The record showed it started with 120 pills. Pill #115 was given by Staff I to Resident #1 on / at 10:00 PM. The next 6 pills were blank. There was no signature and no time provided. Pill #108 was provided by Staff A on at 8:00 AM. No explanation was provided as to where the pills #114 through #109 had gone. (Photo 44)
A record review was attempted on / of the Individual Resident ' s Controlled Substance Record for the missing for Resident #4. The record could not be located. The Administrator said she did not know where it was, and maybe the staff took it.
On at 4:06 PM an interview was conducted with the Administrator. The Administrator was shown at least 10 MORs with missing signatures, including the Individual Resident ' s Controlled

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Substance record where six pills were missing but no signature was observed. The Administrator stated " Yup, see? " The Administrator was asked how she knew the employees were giving the to the resident and not taking them, and she was not able to answer. The Administrator stated each med tech must count the at the beginning of the shift when they accept the medication cart, and they must document each time a is given using the Individual Resident ' s Controlled Substance record. The Administrator stated she was aware the facility employees were not filling out the MOR correctly. No retraining had been performed, arranged, or scheduled.
On at 5:33 PM an interview was conducted with Staff I. He stated the facility requires that the must be counted on each shift, and when he accepted the medication cart on multiple occasions the " narc count was off " . He stated he made a note of it.

Class III

0058 Pharmacy & Dietary: Uncorrected Deficiencies

Based on interview and record review, the facility received a Class II deficiency regarding the assistance with self-administration of medications.

Findings included:

On at 2:55 PM an interview was conducted with Staff A. Staff A stated on /2016 Resident #4 asked her how many he had left. She told him he had 39 left. Staff A stated she did not work on . When she returned to work on the morning of , the entire bottle of was missing. Staff A stated she called and reported it to the Administrator.
On at 3:15 PM an interview was conducted with the Administrator. The Administrator stated she was called about the missing for Resident #4. She went to the facility and was unable to locate the bottle. The Administrator then contacted the Interim Administrator. The Administrator stated she then contacted the employees and all of them said the medications were in the cart, and none of them knew anything about the missing medication. The Administrator stated she did not document any of her conversations. The Administrator did not conduct an investigation or contact the police. The staff were not retrained. The Administrator told them " to pay attention to the cart. " The Administrator stated she did not contact Resident #4 ' s primary care physician.
On at 4:08 PM a record review was attempted of the count sheet for the for Resident #4. The record could not be located. It was no longer in the book, or in the medication observation (MOR) records book.
On at 5:33 PM an interview was conducted with Staff I. Staff I stated he worked on Friday from 3:00 PM until 11:00 PM. Resident #4 asked him how many he had left, and Staff I was not able to locate the bottle. He stated he looked for the sheet in the book and couldn ' t find

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that either.
On at 2:08 PM an interview was conducted with the Administrator. The Administrator stated Staff A had called the pharmacy, and she was told the prescription could not be filled until after . The Administrator was aware Resident #4 had not received his pain medication since . As of the date of survey, the Administrator still had not contacted the primary care physician, or sent him out to the hospital to assess his pain level.
On at 12:18 PM an observation was conducted of Staff A as she assisted with medications. Staff A popped the medications into a soufflé cup and handed them to Resident #9. Staff A stated " here are your noon meds. " Staff A did not tell Resident #9 the name of the medication or the reason it was prescribed.
On at 12:22 PM an observation was conducted as Staff A assisted Resident #8 with medications. Staff A popped the medications into a soufflé cup and handed them to Resident #8. Staff A stated " I have your noon medicine. " Staff A did not tell Resident #8 the name of the medication or the reason it was prescribed.
On at 3:30 PM an interview was conducted with the Administrator. The Administrator stated the correct procedure to assist with self-administration of medications is to read out the names of the medications to the resident and tell them the reason the medication was prescribed.
On at 4:05 PM an observation was made as Staff G assisted with the self-administration of medications. Staff G was observed in the medication , on her first day working in the facility, and without a Level II background screening, as she assisted with the 4:00 PM medications for Resident #9. Staff G placed all of the 4:00 PM medications and two medications prescribed for 8:00 PM into a soufflé cup. The Administrator walked in and asked if Staff G had kept the prefilled medication packet so that she could read off the names of the medication to each resident. The Administrator looked at the empty packets and noticed the 8:00 PM medications were included. She pulled out Resident #9 ' s medication and used the following day ' s 8:00 PM medications to determine which medications needed to be removed. She then placed those back in the medication packet and stapled it closed.
In a continued observation of Staff G as she assisted with medications, she was observed as she popped out medications for Resident #14. She placed them in a soufflé cup and signed the medication observation record (MOR). She then placed a piece of paper in the soufflé cup with his name, and turned the MOR to another resident. (Photo 31)
At 5:23 PM Staff G was observed as she assisted Resident #5 with her 4:00 PM medications. Staff G stated she was aware that medications were still being provided outside of the prescribed timeframe.
On at 5:33 PM an interview was conducted with Staff I. He stated the facility requires that the must be counted on each shift, and when he accepted the medication cart on multiple occasions the " narc count was off " . He stated he made a note of it.
On at 6:08 PM the Administrator was observed as she assisted several residents with their 4:00 PM medications. The Administrator stated she still had several residents left who had not yet received their medications.

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On at 1:33 PM an interview was conducted with Staff D. Staff D stated he did not have the initial 4 hour training in assistance with self-administration of medication. Staff D stated he had been required to pass medications on 3 occasions. Staff D stated he was required to pass medications if he wanted to keep his job.
On at 1:50 PM a record review was conducted of the Medication Observation Record (MOR) book. Staff D had signed the MOR on /__ for multiple residents. (Photos 6-10)
On a record review was conducted of the medication observation record (MOR) for Resident #17 was prescribed for 8:00 PM. No signature was observed on 7/3 or 7/4. was prescribed for 8:00 AM and 4:00 PM. No signature was observed for 8:00 AM on 7/4, 7/5, , and . No signature was observed at 4:00 PM for 7/3 and 7/4. Cranberry concentrate capsule was prescribed for 8:00 AM and 4:00 PM. No signature was observed for 8:00 AM on 7/4 and 7/5. No signature was observed for 4:00 PM on 7/3 and 7/4. was prescribed for 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. No signature was observed for 8:00 AM on 7/5, 12:00 PM on 7/5, 4:00 PM on 7/3 and 7/4, and 8:00 PM on 7/3 and 7/4. was prescribed for 7:00 AM. No signature was observed for 7/5. was prescribed for 8:00 AM and 4:00 PM. No signature was observed for 8:00 AM for 7/5 and for 4:00 PM for 7/3 and 7/4. was prescribed for 7:00 AM. No signature was observed for 7/4 and 7/5. was prescribed for 8:00 AM and 4:00 PM. No signature was observed for 8:00 AM for 7/5 and 4:00 PM for 7/3 and 7/4. No explanation was written on the back of the MOR for any of the missed doses. (Photo 40-43)
On at a record review was conducted of the MOR for Resident #16. was prescribed for 8:00 AM and 4:00 PM. No signature was observed for 8:00 AM on 7/2, 7/4, 7/5 or 7/8. No signature was observed for 4:00 PM on 7/3, 7/4, 7/5, 7/6, 7/7, 7/9, or . was prescribed for 8:00 AM and 4:00 PM. No signature was observed for 8:00 AM on 7/2, 7/4, 7/5, or 7/8. No signature was observed for 4:00 PM on 7/3, 7/4, 7/5, 7/6, 7/7, or 7/9. - was prescribed for 8:00 AM and 4:00 PM. No signatures were observed for 8:00 AM on 7/2, 7/4, 7/5, or 7/8. No signatures were observed for 4:00 PM on 7/3, 7/4, 7/5, 7/6, 7/7, or 7/9. was prescribed at 8:00 AM and 4:00 PM. No signature was observed for 8:00 AM on 7/2, 7/4/7/5, or 7/8. No signature was observed for 4:00 PM on 7/3, 7/4, 7/5, 7/6, 7/7, or 7/9. was prescribed for 8:00 PM. No signature was observed for 8:0 PM on 7/2 or 7/4. was prescribed for 7:00 AM. No signature was observed for 7:00 AM on 7/5. , was prescribed for 8:00 PM. No signature was observed for 8:00 PM on 7/3, 7/4, 7/5, 7/6, 7/7. or 7/9. was prescribed for 8:00 PM. No signature was observed for 8:00 PM on 7/4 or 7/8. was prescribed for 8:00 AM and 4:00 PM. No signature was observed for 8:00 AM on 7/2, 7/5, or 7/8. No signature was observed on 4:00 PM on 7/4. was prescribed for 8:00 AM and 4:00 PM. No signature was observed for 8:00 AM on 7/5. No signature was observed for 4:00 PM on 7/4 or 7/5. was prescribed for 8:00 PM. No signature was observed for 8:00 PM on 7/4. No explanation was written on the back of the MOR for any missed doses. (Photos 38-39)
On / at a record review was conducted of the MOR for Resident #18. was prescribed for 7:00 AM. No signature was observed for 7:00 AM on 7/5. was

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prescribed for 8:00 AM and 4:00 PM. No signature was observed for 8:00 AM on 7/5 or . No signature was observed for 4:00 PM on 7/4 or was prescribed for 8:00 AM and 4:00 PM. No signature was observed for 8:00 AM on 7/2, 7/5, 7/8, or . No signature was observed for 4:00 PM on 7/3, 7/4, 7/5, 7/6, 7/7, 7/8, or was prescribed for 8:00 AM and 4:00 PM. No signature was observed for 8:00 AM on 7/5 or . No signature was observed for 4:00 PM on 7/3, 7/4, 7/5, 7/6, 7/7, , or . was prescribed for 8:00 AM. No signature was observed on 7/4 or 7/9. was prescribed for 8:00 PM. No signature was observed at 8:00 PM on 7/3, 7/4, 7/5, 7/6, 7/7, 7/8, 7/9, , and . No explanation was written on the back of the MOR for any of the missed doses. (Photos 34-37)

The same type of concerns were noted on the MORs for multiple other residents of the facility

An interview was conducted with Resident #1 on at 9:00 AM. She stated she asks for her pain medication and does not always receive it. She stated Staff A gives it to her as requested, but other employees do not. She stated she is told by some employees that they already gave her the medication when she knows they didn ' t. She stated she believes she has missing.

On a record review was conducted of the Individual Resident ' s Controlled Substance Record for Resident #1. The prescription was for 10-325 mg, to be given 1 tablet by mouth four times a day as needed for pain. The record showed it started with 120 pills. Pill #115 was given by Staff I to Resident #1 on at 10:00 PM. The next 6 pills were blank. There was no signature and no time provided. Pill #108 was provided by Staff A on at 8:00 AM. No explanation was provided as to where the pills #114 through #109 had gone. (Photo 44)

On at 4:06 PM an interview was conducted with the Administrator. The Administrator was shown at least 10 MORs with missing signatures, including the Individual Resident ' s Controlled Substance record where six pills were missing but no signature was observed. The Administrator stated " Yup, see? " The Administrator was asked how she knew the employees were giving the to the resident and not taking them, and she was not able to answer. The Administrator stated each med tech must count the at the beginning of the shift when they accept the medication cart, and they must document each time a is given using the Individual Resident ' s Controlled Substance record. The Administrator stated she was aware the facility employees were not filling out the MOR correctly. No retraining had been performed, arranged, or scheduled.

Class III

0077 Staffing Standards - Administrators

Based on observation, interview and record review, the facility administrator failed to provide adequate oversight and supervision of the facility staff to ensure they received the appropriate training to provide care and services to all residents. This was evidenced by the failure to adequately monitor current facility practices for administration of controlled medications, failure to thoroughly investigate an identified drug

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NAME OF PROVIDER OR SUPPLIER GOOD HOPE OF PINELLAS	STREET ADDRESS, CITY, STATE, ZIP CODE 7575 65TH WAY PINELLAS PARK, FL 33781	

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

diversion (Resident #1) within the facility, and failure to coordinate and conduct timely re-training of staff providing assistance with medication. Additionally, the facility administrator failed to prevent of the residents, failed to appropriately train the facility staff to perform their required duties, and failed to follow the facility ' s elopement policy following a resident elopement.

Findings included:

On at 8:35 AM a list was provided of all current employees for the facility. There were 12 employees on the list.
On at 8:40 AM a record review was conducted of the employee roster for the facility on the Agency for Health Care Administration Care Provider Background Screening Clearinghouse website. No employees were listed under the facility ' s employee roster.
On at 8:42 AM an interview was conducted with the Administrator. The Administrator was not aware of the Background Screening Clearinghouse.
On at 10:41 AM a record review was conducted of the employee file for Staff D. Staff D had a printout of his Level II background screening in his file, dated . The printout read " screening in process " . A hand written note at the bottom of the page read " need additional info. Until then status will remain " in process " . (Photo 1)
On at 10:45 AM a record review was conducted of the time card for Staff D. Staff D last clocked in on / at 2:58 PM and clocked out at 11:00 PM. (Photo 2)
On at 3:28 PM an interview was conducted with the Administrator. The Administrator stated Staff D was currently employed at the facility. The Administrator was asked if there was a more recent Level II background screening showing that Staff D is eligible. She stated " Doesn ' t look like it. This is it. "
On at 1:33 PM an interview was conducted with Staff D. Staff D stated he had worked on / from 3:00 PM to 11:00 PM. Staff D stated he is aware he his Level II background screening had not been cleared yet. He stated he is still employed and the facility is waiting for him to be found eligible.
On at 2:32 PM an interview was conducted with Staff G. Staff G stated today was her first day at the facility. Staff G stated she had received a Level II background screening.
On at 5:01 PM a record review was conducted of the employee file for Staff G. No Level II background screening was observed in the employee file.
On at 5:01 PM an interview was conducted with the Administrator. The Administrator was asked where the Level II background screen was for Staff G. " I don ' t know. You don ' t give them time to get this stuff together? "
On at 5:05 PM a review was conducted of the Agency for Health Care Administration background screening website for Staff G. The website read " A new screening is required " .
In a continued interview with the Administrator on / at 5:08 PM, the Administrator was

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informed Staff G was not able to work with residents until the Level II background screening was completed and she was found eligible.
On at 10:45 AM an interview was conducted with the Administrator. The Administrator stated Staff G has not worked since she was sent home on . The Administrator stated Staff G must have taken her time card home with her because she could not find it.
On at 11:05 AM an interview was conducted with Staff G over the phone. Staff G stated she had left her time card with the other time cards by the time clock, and she had worked the day before (/ /) from 3:00 PM to 11:00 PM.
In a continued interview with the Administrator on at 11:12 AM, she admitted she had knowingly allowed Staff G to return to the facility and work with the residents after she had been informed by the Agency that the employee could not work in the facility with residents until after her background screening results showed her as eligible.
On at 11:15 AM the Administrator produced the time card and a record review was conducted of the time card for Staff G. Staff G worked on Saturday from 6:58 AM until 3:08 PM. Staff G worked on Sunday / / from 3:10 PM until 11:11 PM. (Photo 3)
On at 11:17 AM a record review was conducted of the Agency for Health Care Administration background screening website. The Level II background screening for Staff G was still " in process. " Staff G had not yet been found eligible to work in the facility.
On at 5:05 PM an interview was conducted with the Administrator. The Administrator stated Staff H was working from 11:00 PM until 7:00 AM on / . The Administrator was not able to provide a last name at this time for Staff H, an application, an employee file, or a Level II background screening. The Administrator was informed Staff H could not work in the facility until she was found eligible.
On / at 10:45 AM a record review was attempted of the time card for Staff H. The Administrator stated Staff H did not have a time card because she had not worked in the facility, as the Administrator had been told on that Staff H had to have a Level II background screening prior to working and she did not have that yet.
On at 10:33 AM a record review was attempted of the employee file for Staff H. Staff H had no employee file. No Level II background screening was available for Staff H.
On at 11:12 AM an interview was conducted with the Administrator. The Administrator admitted she had allowed Staff H to return to the facility and work " a shift or two. " The Administrator agreed she had knowingly allowed Staff H to enter the facility and work with the residents after she had been informed by the Agency that the employee could not work in the facility with residents until after her background screening results showed her as eligible. Another request was made for the time card for Staff H but was not produced by the Administrator.
On / at 11:10 AM the Regional Manager stated " we know she needs a new one " in regards to the Level II background screening for Staff H.
On at 12:10 PM an interview was conducted with Resident #6. Resident #6 stated Staff H

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works overnight and is very nice to him.
On at 10:25 AM a record review was conducted of the time card for Staff H produced by the Regional Manager. Staff H was documented as working from 11:00 PM until 7:00 AM on / / , / / , and . (Photo 4)
On at 1:32 PM a review was conducted of the Agency for Health Care Administration background screening website for Staff A. The results read " a new screening is required. " Staff A was observed working in the facility on on the 7:00 AM until 3:00 PM shift in her position as direct care staff and med tech.
On at 5:33 PM an interview was conducted with Staff I. Staff I stated he was scheduled to work the 11:00 PM to 7:00 AM shift tonight, . Staff I stated he had been and had called and informed the Interim Administrator that his background screening had been " kicked back " as not eligible. He stated she told him that his job was safe, and he has continued to work without break since he was found not eligible.
On at 5:40 PM a review was conducted of the Agency for Health Care Administration background screening website for Staff I. Staff I was found not eligible as of .
On at 6:15 PM an interview was conducted with the Administrator. The Administrator stated she was not aware Staff I did not have an eligible Level II background screening.
On at 10:30 AM a record review was conducted of the employee file for Staff F. Staff F had a Level II background screening printed in her file dated / / . A review of the employment application for Staff F showed the application date was . The last employment listed on her application prior to working at the facility ended / .
On at 1:32 PM a review was conducted of the Agency for Health Care Administration background screening website for Staff F. Staff F had been found eligible on .
On at 1:40 PM an interview was conducted with the Administrator. The Administrator was not aware that Staff F was required to obtain a new Level II background screening following a 90 day break in service.
On at 10:41 AM a record review was conducted of the employee file for Staff L. No certificate for the four-hour assistance with self-administration of medication training was located in his file. The most recent two-hour update in self-administration of medication training was dated .
On at 3:28 PM an interview was conducted with the Administrator. The Administrator stated Staff L passes medications. " When I was here before he was handing out meds. He ' s been handing out meds as long as he ' s been here, then he went in the kitchen. All that stuff was already going on " before she took over as Administrator.
On at 11:13 AM an interview was conducted with Staff L. Staff L stated he was aware that his medication training has expired and he needs the update. He stated he was still required to pass out medications without the training update. Staff L stated he sometimes works alone overnight, and he has to pass out the PRN medications.

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On at 10:41 AM a record review was conducted for the file for Staff I. Staff I had received his annual two-hour update for the assistance with self-administration of medications on
On at 3:28 PM an interview was conducted with the Administrator. The Administrator stated Staff I is a " med tech. " When told that his training was out of date, she stated " It is? "
On / at 5:33 PM an interview was conducted with Staff I. Staff I stated this past weekend Resident #4 asked him how many of his pain killer was in the drawer, and he could not find that medication. Staff I stated there have been so many issues with the count being " off " or the MORs " messed up " that he is now refusing to pass medications. Staff I was aware that he was not up to date with his training. He stated the Administrator was aware of it, but he was required to pass medications if he wanted to keep his job. Staff I stated he is sometimes alone on the overnight shift.
On at 10:41 AM a record review was conducted of the employee file for Staff C. Staff C had no statement in her file identifying her as free from communicable . Staff C had a tuberculosis examination dated .
On at 1:49 PM an interview was conducted with Staff C. Staff C stated she had been employed at the facility a little over 5 weeks.
On at 3:28 PM an interview was conducted with the Administrator. The Administrator stated she was not aware that Staff C did not have her free from communicable statement, and she was unable to find a more recent statement in the file. She stated she was not aware Staff C required a new examination.
On at 10:41 AM a record review was conducted of the employee file for the Administrator. The Administrator had the following trainings in the employee file dated : control/Universal Precautions, and Facility Sanitation procedures (1 hour); Resident behavior and needs and assistance with the activities of daily living (3 hours); Elopement (1 hour); Reporting major incidents, adverse incidents, and facility emergency procedures (2 hours); Residents rights, and reporting neglect and (2 hours); training (1 hour); National and safe food handling (2 hours); fire safety (1 hour).
On at 3:28 PM an interview was conducted with the Administrator. The Administrator was unable to the facility ' s elopement policy. The Administrator was asked what she learned in the one-hour training on Fire Safety, and she replied " Everybody run? " The Administrator stated she did not receive the trainings that were in her file dated .
On at 1:05 PM an interview was conducted with Staff B. Staff B stated she did not receive the elopement training that was in her employee file dated / . Staff B stated the Interim Administrator came in to a mandatory meeting and stated the " state gave me 14 days to correct " , so everyone was going to have trainings put in their files. Staff B was told she was not to take them out of the folder or copy them, they were the property of the facility.
On at 1:49 PM an interview was conducted with Staff C. Staff C stated she " just learned " what the word elopement meant when Resident #8 eloped from the facility on . Staff C stated she was told by a visiting family member that Resident #8 had walked out of the building. Staff C stated

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she went out and saw Resident #8 " all the way down the street " . Staff C called the Administrator who did not answer. Staff C stated she called Staff A, who then came to assist with talking Resident #8 into returning to the facility. Staff C stated she did not contact the family, the Administrator, or fill out an incident report. Staff C stated she did not receive the elopement training that was in her employee file. Staff C was not aware of the facility ' s elopement policy and procedures. Staff C stated " I pray when I am on my shift that I am not alone, cuz (because) if it happens on my shift, I ' m screwed. "

On at 2:55 PM an interview was conducted with Staff A. Staff A stated she received a phone call from Staff C who stated Resident #8 had left the building and she needed help. She stated he had walked two blocks down and one up the major road. She stated the Administrator was not in the building. Staff A did not write it down in Resident #8 ' s chart, did not fill out an incident report, or inform the Administrator. Staff A did not know what the word elopement meant. Staff A was not aware of the facility ' s elopement policy and procedures.

On at 3:15 PM an interview was conducted with the Administrator. The Administrator was not aware Resident #8 had eloped from the facility. The Administrator stated no incident report or Adverse Incident Report was filed for the elopement. The Administrator was not able to the facility ' s elopement policy and procedures. " I haven ' t looked in it to read it and tell you. " The Administrator stated elopement drills had not been conducted " even when I worked here before I didn ' t know of them doing any of that. " The Administrator stated Resident #8 was not an elopement risk. The Administrator was shown an elopement form for Resident #8. The Administrator was not aware Resident #8 had previously eloped from the building. The Administrator stated no investigation, evaluation, assessment or follow-up had been conducted in regards to Resident #8 ' s elopement.

On at 12:41 PM an observation was made of Resident #8. Resident #8 did not have an identification bracelet or necklace on.

On at 12:41 PM an interview was conducted with Resident #8. Resident #8 was asked if he had anything in his pockets with his name, the facility name, and telephone number on it. Nothing was located.

On at 2:55 PM an interview was conducted with Staff A. Staff A stated on Resident #4 asked her how many he had left. She told him he had 39 left. Staff A stated she did not work on . When she returned to work on the morning of , the entire bottle of was missing. Staff A stated she called and reported it to the Administrator.

On at 3:15 PM an interview was conducted with the Administrator. The Administrator stated she was called about the missing for Resident #4. She went to the facility and was unable to locate the bottle. The Administrator then contacted the Interim Administrator. The Administrator stated she then contacted the employees and all of them said the medications were in the cart, and none of them knew anything about the missing medication. The Administrator stated she did not document any of her conversations. The Administrator did not conduct an investigation or contact the police. The staff were not retrained. The Administrator told them " to pay attention to the cart. " The Administrator stated she did not contact Resident #4 ' s primary care physician.

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On at 4:08 PM a record review was attempted of the Individual Resident ' s Controlled Substance Record for the ' for Resident #4. The record could not be located. It was no longer in the book, or in the medication observation (MOR) records book.
On at 5:33 PM an interview was conducted with Staff I. Staff I stated he worked on Friday from 3:00 PM until 11:00 PM. Resident #4 asked him how many he had left, and Staff I was not able to locate the bottle. He stated he looked for the sheet in the book and couldn ' t find that either.
On at 2:08 PM an interview was conducted with the Administrator. The Administrator stated Staff A had called the pharmacy, and she was told the prescription could not be filled until after . The Administrator was aware Resident #4 had not received his pain medication since . As of the date of survey, the Administrator still has not contacted the primary care physician, or sent him out to the hospital to assess his pain level.
An interview was conducted with Resident #1 on at 9:00 AM. She stated she asks for her pain medication and does not always receive it. She stated Staff A gives it to her as requested, but other employees do not. She stated she is told by some employees that they already gave her the medication when she knows they didn ' t. She stated she believes she has missing.
On a record review was conducted of the Individual Resident ' s Controlled Substance Record for Resident #1. The prescription was for 10-325 mg, to be given 1 tablet by mouth four times a day as needed for pain. The record showed it started with 120 pills. Pill #115 was given by Staff I to Resident #1 on / at 10:00 PM. The next 6 pills were blank. There was no signature and no time provided. Pill #108 was provided by Staff A on / at 8:00 AM. No explanation was provided as to where the ' pills #114 through #109 had gone. (Photo 44)
On at 4:06 PM an interview was conducted with the Administrator. The Administrator was shown at least 10 MORs with missing signatures, including the Individual Resident ' s Controlled Substance record where six pills were missing but no signature was observed. The Administrator stated " Yup, see? " The Administrator was asked how she knew the employees were giving the to the resident and not taking them, and she was not able to answer. The Administrator stated each med tech must count the at the beginning of the shift when they accept the medication cart, and they must document each time a is given using the Individual Resident ' s Controlled Substance record. The Administrator stated she was aware the facility employees were not filling out the MOR correctly. No retraining had been performed, arranged, or scheduled.
On at 9:00 AM an observation was made of Resident #1. She had on the left side of her face from underneath her eye, down to the cheekbone, and back to her ear. She had a on her right arm.
On at 9:00 AM an interview was conducted with Resident #1. Resident #1 stated she had been in the facility for 3 months, and had 3 times. She said she gets a lot, and has difficulty transferring. She stated she calls out for help but no one comes. Resident #1 stated staff has refused to help her when she asked. She stated she has asked for help to get to the to transfer and no

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one helps her. She said the staff will say they go down to check on her, but they don ' t. The resident stated she when attempting to transfer from the bed to her wheelchair on one occasion. She stated she and was sent to the hospital for her arm. She was told there was nothing wrong with it and sent back. She went a second time and they told her it was a . She went a third time and the x-ray showed it was broken. She stated it had been about 3 weeks since the .

On a record review was conducted of the chart for Resident #1. An AHCA Health Assessment form 1823 (1823) dated identified Resident #1 as a risk. The 1823 labeled her as independent with transferring. A Physician ' s Certification Statement dated stated Resident 1 " cannot ambulate " and can ' t " be safely transported by car/wheelchair van (seated during transport, w/out medical attendant or monitoring) " . Resident #1 was seen at the hospital for an orbital on . On Resident #1 was seen at the hospital for an elbow . A progress note from the Advanced Registered Nurse Practitioner (ARNP) dated stated the patient was falling, and noted facial . A progress note from the ARNP dated read " c/o right arm pain from approx 3 wks ago. Pain on inside of right arm, been to hospital X2. " Facial was noted. (Photos 52-57, 58-60)

A continued review of the chart showed a progress note dated that read the resident ' on the floor in her approx. 7:45 AM. She had a large bump over her left eye as well as her nose . " The initials are not of any current staff. A progress note dated read that the resident " went to the hospital at noon. She was complaint for pain on her shoulder. " The note was signed by Staff A. A third progress note dated read that the resident " complain for pain on her right elbow Staff L call not emergency she went to " , however, the note was not completed and not signed. No additional documentation could be located regarding the visit to the hospital where the break was identified. No discharge documents were located in the chart.

A record review was attempted of the incident reports regarding the three separate unwitnessed with injury, including a or of bones or joints. No incident reports could be located.

On at 1:05 PM an interview was conducted with Staff B, who stated " no one checks on Resident #1. She ".

On at 3:15 PM an interview was conducted with the Administrator. The Administrator stated he did not know how Resident #1 broke her arm. She was unable to locate any documentation in Resident #1 ' s chart regarding the arm.

On at 1:05 PM an interview was conducted with Staff B. Staff B stated she had witnessed the Administrator yell profanities at Resident #7 and threaten to him. She stated the Administrator "got in his face and screamed at him like a dog."

On at 2:23 PM an interview was conducted with Resident #7. He stated the Administrator was yelling and " cussing at me ". He stated he tries not to listen. She has done it before. He stated he was embarrassed because she did it where other people could hear. He said she yelled at him for something he didn ' t do.

On at 9:52 AM an interview was conducted with Resident #3. He stated he witnessed Staff N

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yell at a lot of the residents.
On at 1:05 PM an interview was conducted with Staff B stated she witnessed Staff N yelling at several residents. She stated "I'm not going to lie, she was rude." Staff B stated Staff N didn't like to help the residents.
On at an interview was conducted with the Administrator. The Administrator stated Staff N was terminated for "being nasty" to the residents.

Class II

0078 Staffing Standards - Staff

Based on record review and interviews the facility failed to provide documentation that 1 out of 5 employees (Staff C) had written documentation from a health care provider the staff member was free of signs or symptoms of communicable within the required 30 days of date of hire; the facility failed to ensure that 1 out of 5 employees (Staff C) provided annual documentation of a negative examination. Additionally, the facility failed to ensure that staff was trained and qualified to perform their duties. Specifically, training certificates were observed in employee files, however, staff were unable to policies and procedures regarding the trainings, and confirmed they never received the training.

Findings included:

On at 10:41 AM a record review was conducted of the employee file for Staff C. Staff C had no statement in her file identifying her as free from communicable Staff C had a examination dated
On at 1:49 PM an interview was conducted with Staff C. Staff C stated she had been employed at the facility a little over 5 weeks.
On at 3:28 PM an interview was conducted with the Administrator. The Administrator stated she was not aware that Staff C did not have her free from communicable statement, and she was unable to find a more recent statement in the file. She stated she was not aware Staff C required a new examination.
On at 10:41 AM a record review was conducted of the employee file for the Administrator. The Administrator had the following trainings in the employee file dated control/Universal Precautions, and Facility Sanitation procedures (1 hour); Resident behavior and needs and assistance with the activities of daily living (3 hours); Elopement (1 hour); Reporting major incidents, adverse incidents, and facility emergency procedures (2 hours); Residents rights, and reporting neglect and (2 hours); training (1 hour); National and safe food handling (2 hours); fire safety (1 hour).

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On at 3:28 PM an interview was conducted with the Administrator. The Administrator was unable to the facility ' s elopement policy. The Administrator was asked what she learned in the one-hour training on Fire Safety, and she replied " Everybody run? " The Administrator stated she did not receive the trainings that were in her file dated .

On at 1:05 PM an interview was conducted with Staff B. Staff B stated she did not receive the trainings that were in her employee file dated I/ . Staff B stated the Interim Administrator came in to a mandatory meeting and stated the " state gave her 14 days to correct " , so everyone was going to have trainings put in their files. She was told she was not to take them out of the folder or copy them, they were the property of the facility.

On / at 10:41 AM a record review was conducted of the employee file for Staff C. The following trainings were observed in her file and all were dated : control/Universal Precautions, and Facility Sanitation procedures (1 hour); Resident behavior and needs and assistance with the activities of daily living (3 hours); Elopement (1 hour); Reporting major incidents, adverse incidents, and facility emergency procedures (2 hours); Residents rights, and reporting neglect and (2 hours); training (1 hour); National and safe food handling (2 hours); fire safety (1 hour). Staff C also received training in First Aid and on (Photos 11-19)

On at 1:49 PM an interview was conducted with Staff C. Staff C stated she did not receive any of the trainings that were in her employee file dated , except for First Aid and . Staff C stated in regards to elopement training, she " just learned what it meant. Pray when I am on my shift that I am not the only one. Because if it happens on my shift, I ' m screwed. "

On at 10:41 AM a record review was conducted of the employee file for Staff D. Staff D had the following trainings in his employee file dated : control/Universal Precautions, and Facility Sanitation procedures (1 hour); Resident behavior and needs and assistance with the activities of daily living (3 hours); Elopement (1 hour); Reporting major incidents, adverse incidents, and facility emergency procedures (2 hours); Residents rights, and reporting neglect and (2 hours); training (1 hour); National and safe food handling (2 hours); fire safety (1 hour).

On at 1:33 PM an interview was conducted with Staff D. Staff D stated he had not received any of the trainings in his employee file dated . Staff D stated he had also been required to pass medications on three separate occasions without the four hour assistance with self-administration of medication training.

On at 10:41 AM a record review was conducted of the employment file for Staff E. Staff E had the following trainings all dated : control/Universal Precautions, and Facility Sanitation procedures (1 hour); Resident behavior and needs and assistance with the activities of daily living (3 hours); Elopement (1 hour); Reporting major incidents, adverse incidents, and facility emergency procedures (2 hours); Residents rights, and reporting neglect and (2 hours); training (1 hour); National and safe food handling (2 hours); fire safety

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(1 hour).(Photos 20-27)
On at 2:40 PM an interview was conducted with Staff E. Staff E stated she did not receive any of the trainings that are in her file dated . Staff E stated the Interim Administrator came to an employee meeting and said the state gave her 14 days to correct. She stated the Interim Administrator put training forms in the employee files. No trainings were given. Staff E did not know what the word elopement meant, was not aware of the facility ' s policy, stated she did not know what an adverse incident was, was not aware of the facility ' s emergency procedures, and she did not know what fire safety was.
On at 10:41 AM a record review was conducted of the employee file for Staff I. Staff I had the following trainings all dated : control/Universal Precautions, and Facility Sanitation procedures (1 hour); Resident behavior and needs and assistance with the activities of daily living (3 hours); Elopement (1 hour); Reporting major incidents, adverse incidents, and facility emergency procedures (2 hours); Residents rights, and reporting neglect and (2 hours); training (1 hour); National and safe food handling (2 hours); fire safety (1 hour).
On at 5:33 PM an interview was conducted with Staff I. Staff I stated he did not receive any of the trainings in his filed dated
On at 10:41 AM a record review was conducted for the employee file of Staff L. Staff L had the following trainings in his file dated : control/Universal Precautions, and Facility Sanitation procedures (1 hour); Resident behavior and needs and assistance with the activities of daily living (3 hours); Elopement (1 hour); Reporting major incidents, adverse incidents, and facility emergency procedures (2 hours); Residents rights, and reporting neglect and (2 hours); training (1 hour); National and safe food handling (2 hours); fire safety (1 hour).
On at 11:13 AM an interview was conducted with Staff L. Staff L stated he did not have any of the trainings that were in his file dated . He stated the Interim Administrator handed them out at the meeting and did not provide any training. He said she stated " just say you have these trainings. "

Class II

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. Additionally, the facility failed to ensure the minimum staffing hours were met for the current census.

Findings included:

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On a review was conducted of the facility ' s staffing schedule. Staff B was scheduled from 11:00 AM until 7:00 PM. That was crossed out and handwritten was " 9-5 " . Staff L was scheduled from 7:00 AM until 3:30 PM. That was crossed out and handwritten was the name of Staff B. Staff N was on the schedule from 7:00 AM until 3:00 PM. No cooks or housekeeper was scheduled on Saturday.
On an interview was conducted with the Administrator. The Administrator stated Staff B was covering for Staff L who called in sick. She was not able to explain how Staff B could both work on the floor as direct care staff and work in the kitchen. The Administrator stated Staff N had been terminated, and Staff C was going to cover the 7:00 AM to 3:00 PM shift for Staff N. Staff C was on the schedule for 3:00 pm until 11:00 PM. The Administrator stated the new employee that she hired today will cover the 3:00 PM until 11:00 PM shift. The Administrator had begun her duties as the Administrator the previous Monday ( ). She was still on the schedule as direct care staff. The Administrator crossed off her name and wrote in the name of Staff O. She stated Staff O had been hired to take over the schedule the Administrator had worked. The Administrator was asked how many weekly staffing hours were required for the current census of 31. The Administrator stated " 40? Two staff per shift? " The Administrator was not keeping track of the hours worked by direct care staff. The Administrator could not verify how many hours had been worked for the most recent week.
On at 11:13 AM an interview was conducted with Staff L. Staff L stated he sometimes works alone overnight. He stated he does not know until he gets to work. He said the schedule doesn ' t reflect who actually works. He stated he gets to work and there will be a new person who was hired that day working with him. He said he sometimes has to work in both the kitchen and on the floor as direct care staff because the Administrator did not schedule enough employees.
On at 1:49 PM an interview was conducted with Staff C. Staff C stated she was scheduled from 3:00 PM until 11:00 PM by herself on Sunday / . She stated during this time she was expected to provide direct care to the residents, cook dinner to be served at 4:30 PM, assist with medications to be provided at 4:00 PM, and prepare the evening snack. She stated another employee agreed to stay and assist with dinner. Staff C stated she was not able to take a break because she was the only one in the building from 4:30 PM until 11:00 PM. She said there are two residents who require two people to change them. She stated " luckily they were both in the hospital Sunday " . She stated the current staffing does not allow the employees to perform their jobs well. She stated it was unrealistic to think one employee can do all of those things alone. She commented that the schedule is not always correct, and the schedule starting on / is not yet posted. She stated she leaves in an hour, not knowing if she is working the following day or not.
On at 5:33 PM an interview was conducted with Staff I. He stated the facility is " short staffed " , and when working the 3:00 PM to 11:00 PM shift as direct care staff, he has had to cook dinner while trying to pass medications on multiple occasions. He stated the Administrator would not want to work a shift, so she would hire someone " out of the blue " and they would be working within 12 hours. He said he shows up every day not knowing if he is working alone or not. He stated " you can ' t

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go by the schedule. "

Class III

0084 Trainina - Assis Self-Admin Meds & Med Mamt

Based on interview and record review, the facility failed to ensure that 2 out of 6 employees (Staff D, Staff L) had completed the 4 hour initial training in assistance with self-administration of medication, and 2 out of 6 employees (Administrator, Staff I) obtained the 2 hour training update for assistance with self-administration of medication.

Findings included:

On at 10:41 AM a record review was conducted of the employee file for Staff D. No documentation was located for the 4 hour assistance with self-administration of medication training.
On at 1:33 PM an interview was conducted with Staff D. Staff D stated he did not have the initial 4 hour training in assistance with self-administration of medication. Staff D stated he had been required to pass medications on 3 occasions. Staff D stated he was required to pass medications if he wanted to keep his job.
On at 1:50 PM a record review was conducted of the Medication Observation Record (MOR) book. Staff D had signed the MOR on for multiple residents. (Photos 6-10)
On at 10:41 AM a record review was conducted of the employee file for Staff L. No certificate for the four-hour assistance with self-administration of medication training was located in his file. The most recent two-hour update in self-administration of medication training was dated

On at 3:28 PM an interview was conducted with the Administrator. The Administrator stated Staff L passes medications. " When I was here before he was handing out meds. He ' s been handing out meds as long as he ' s been here, then he went in the kitchen. All that stuff was already going on " before she took over as Administrator.
On at 11:13 AM an interview was conducted with Staff L. Staff L stated he was aware that his medication training has expired and he needs the update. He stated he was still required to pass out medications without the training update. Staff L stated he sometimes works alone overnight, and he has to pass out the PRN medications.
On at 10:41 AM a record review was conducted of the employee file for the Administrator. The Administrator ' s most recent two hour update for assistance with the self-administration of medication was on
On from 5:30 PM until 6:15 PM an observation was made of the Administrator as she assisted with the self-administration of medications to the residents in the facility. During this time, there

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were no other employees in the building qualified to assist with the self-administration of medications.
On at 6:00 PM an interview was conducted with the Administrator. The Administrator stated she is current with her updates on training for assistance with the self-administration of medications.
On at 10:41 AM a record review was conducted for the file for Staff I. Staff I had received his annual two-hour update for the assistance with self-administration of medications on .
On at 3:28 PM an interview was conducted with the Administrator. The Administrator stated Staff I is a " med tech. " When told that his training was out of date, she stated " It is? "
On at 5:33 PM an interview was conducted with Staff I. Staff I stated this past weekend Resident #4 asked him how many of his pain medication was in the drawer, and he could not find that medication. Staff I stated there have been so many issues with the count being " off " or the MORs "messed up" that he is now refusing to pass medications. Staff I was aware that he was not up to date with his training. He stated the Administrator was aware of it, but he was required to pass medications if he wanted to keep his job. Staff I stated he is sometimes alone on the overnight shift.

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.

Findings included:

On at 8:35 AM an observation was made that no menu was posted in the facility. A menu was observed hanging in the kitchen. The lunch for Tuesday was (4 oz.) pork chop, (1 cup) scallop potato (1 cup) green beans (1/2 cup) gelatin (8 oz.) beverage/water. An observation was made of the noon meal. The residents were served a hot dog on a , baked beans, and cheese puffs. (Photo 32 and 33)
On at 9:20 AM an interview was conducted with Resident #2. Resident #2 stated they are served hot dogs " all the time " as well as chicken. She stated she is and supposed to be on a diet. She stated they give her too many and she has told the Interim Administrator and the Administrator several times.
On / a record review was conducted of the AHCA Health Assessment form 1823 (1823) for Resident #2. The most recent 1823 dated identified Resident #2 as requiring a " diet " under the category " Special Diet Instructions. " (Photos 45-49)
An interview was conducted with Resident #3 on at 9:52 AM. Resident #3 stated they used to provide soup with dinner, but they stopped a few months ago. He stated they are served a lot of hot dogs, chicken nuggets, and cheese puffs. He stated they do not post a menu, and if they are following

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one " we don ' t know about it. " He stated they get a lot of the same protein two meals in a row. He stated they are served chicken for lunch and dinner frequently. He said fish is on the menu, but they never get fish. He said he has to eat fairly heavy meals to keep his l sugar at appropriate levels. He stated both he and Resident #5 are .

On at 11:58 AM an interview was conducted with the Administrator. The Administrator stated " we have never had a menu posted here. " The Administrator stated the Interim Administrator and the owner are responsible for ordering food. The Administrator was not aware of a substitution log. She did not know if they had been using one. She stated the residents told her they like hot dogs.

at 1:05 PM an interview was conducted with Staff B. Staff B stated she is currently working as the cook from 7:00 AM until 3:00 PM. She did not get any training other than Staff L showing her how to cook a few different meals. She stated the residents get hot dogs a lot. She said at night they don ' t have anyone scheduled to cook dinner, so she prepares something prior to leaving, and that is the quickest thing to feed the residents. The evening direct care staff have to cook dinner or warm it up in addition to their duties. She said pork chops are on the menu but there are none in the freezer. She stated she is not even trying to use to the menu. She checks the refrigerator and freezer and determines what she has enough of to feed the residents. She stated soup of the day is listed for each dinner, but they haven ' t had soup in a long time. She said she served hot dogs today, but he only had 24 hot dogs for 31 residents, so she made some chicken nuggets as well. She said they also received chicken nuggets for dinner last night. She had not heard of the substitution log and she was not using one. She stated only Resident #3 is ; there are no others in the facility.

On at 1:49 PM an interview was conducted with Staff C. Staff C stated " you don t follow a menu. You go in there and figure out what you can cook. " She stated they have run out of sugar, creamer, and food. She stated she has had to purchase food with her own money.

On at 11:13 AM an interview was conducted with Staff L. Staff L stated he tried to follow the menu but he didn ' t have the correct food in the building. He stated " the residents had to eat. " He stated fish is on the menu but they never have it. He further stated he questioned the Interim Administrator " why did you buy corn dogs when corn dogs aren ' t on the menu? " He also told her she had not purchased the food he needed to follow the menu, and she told him " do what you can. "

Class III

0163 Records - Resident. Penalties for Alteration

Based on interview and record review, the facility failed to have valid, accurate training documentation free from alteration, for 7 of 9 sampled staff (Administrator, Staff B, Staff C, Staff D, Staff E, Staff I, and Staff L).

Findings included:

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On at 10:41 AM a record review was conducted of the employee file for the Administrator. The Administrator had the following trainings in the employee file dated : control/Universal Precautions, and Facility Sanitation procedures (1 hour); Resident behavior and needs and assistance with the activities of daily living (3 hours); Elopement (1 hour); Reporting major incidents, adverse incidents, and facility emergency procedures (2 hours); Residents rights, and reporting neglect and (2 hours); training (1 hour); National and safe food handling (2 hours); fire safety (1 hour).
On at 3:28 PM an interview was conducted with the Administrator. The Administrator was unable to the facility ' s elopement policy. The Administrator was asked what she learned in the one-hour training on Fire Safety, and she replied " Everybody run? " The Administrator stated she did not receive the trainings that were in her file dated .
On at 1:05 PM an interview was conducted with Staff B. Staff B stated she did not receive the trainings that were in her employee file dated / . Staff B stated the Interim Administrator came in to a mandatory meeting and stated the " state gave her 14 days to correct " , so everyone was going to have trainings put in their files. She was told she was not to take them out of the folder or copy them, they were the property of the facility.
On at 10:41 AM a record review was conducted of the employee file for Staff C. The following trainings were observed in her file and all were dated : control/Universal Precautions, and Facility Sanitation procedures (1 hour); Resident behavior and needs and assistance with the activities of daily living (3 hours); Elopement (1 hour); Reporting major incidents, adverse incidents, and facility emergency procedures (2 hours); Residents rights, and reporting neglect and (2 hours); training (1 hour); National and safe food handling (2 hours); fire safety (1 hour). Staff C also received training in First Aid and on Photos 11-19)
On at 1:49 PM an interview was conducted with Staff C. Staff C stated she did not receive any of the trainings that were in her employee file dated , except for First Aid and . Staff C stated in regards to elopement training, she " just learned what it meant. Pray when I am on my shift that I am not the only one. Because if it happens on my shift, I ' m screwed. "
On at 10:41 AM a record review was conducted of the employee file for Staff D. Staff D had the following trainings in his employee file dated : control/Universal Precautions, and Facility Sanitation procedures (1 hour); Resident behavior and needs and assistance with the activities of daily living (3 hours); Elopement (1 hour); Reporting major incidents, adverse incidents, and facility emergency procedures (2 hours); Residents rights, and reporting neglect and (2 hours); training (1 hour); National and safe food handling (2 hours); fire safety (1 hour).
On / at 1:33 PM an interview was conducted with Staff D. Staff D stated he had not received any of the trainings in his employee file dated . Staff D stated he had also been required to

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pass medications on three separate occasions without the four hour assistance with self-administration of medication training.
On at 10:41 AM a record review was conducted of the employment file for Staff E. Staff E had the following trainings all dated : control/Universal Precautions, and Facility Sanitation procedures (1 hour); Resident behavior and needs and assistance with the activities of daily living (3 hours); Elopement (1 hour); Reporting major incidents, adverse incidents, and facility emergency procedures (2 hours); Residents rights, and reporting neglect and (2 hours); training (1 hour); National and safe food handling (2 hours); fire safety (1 hour). (Photos 20-27)
On at 2:40 PM an interview was conducted with Staff E. Staff E stated she did not receive any of the trainings that are in her file dated . Staff E stated the Interim Administrator came to an employee meeting and said the state gave her 14 days to correct. She stated the Interim Administrator put training forms in the employee files. No trainings were given. Staff E did not know what the word elopement meant, was not aware of the facility ' s policy, stated she did not know what an adverse incident was, was not aware of the facility ' s emergency procedures, and she did not know what fire safety was.
On at 10:41 AM a record review was conducted of the employee file for Staff I. Staff I had the following trainings all dated / : control/Universal Precautions, and Facility Sanitation procedures (1 hour); Resident behavior and needs and assistance with the activities of daily living (3 hours); Elopement (1 hour); Reporting major incidents, adverse incidents, and facility emergency procedures (2 hours); Residents rights, and reporting neglect and (2 hours); training (1 hour); National and safe food handling (2 hours); fire safety (1 hour).
On at 5:33 PM an interview was conducted with Staff I. Staff I stated he did not receive any of the trainings in his filed dated .
On at 10:41 AM a record review was conducted for the employee file of Staff L. Staff L had the following trainings in his file dated : control/Universal Precautions, and Facility Sanitation procedures (1 hour); Resident behavior and needs and assistance with the activities of daily living (3 hours); Elopement (1 hour); Reporting major incidents, adverse incidents, and facility emergency procedures (2 hours); Residents rights, and reporting neglect and (2 hours); training (1 hour); National and safe food handling (2 hours); fire safety (1 hour).
On at 11:13 AM an interview was conducted with Staff L. Staff L stated he did not have any of the trainings that were in his file dated / . He stated the Interim Administrator handed them out at the meeting and did not provide any training. He said she stated " just say you have these trainings. "

Class II

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0165 Risk Mgmt & QA: Adverse Incident Report

Based on record review and interviews, the facility failed to file the required adverse incident report to the agency for an adverse incident for 2 out of 3 (Residents #1 and #8) sampled residents, including an elopement, within one day business day.

Findings included:

On / at 1:49 PM an interview was conducted with Staff C. Staff C stated she " just learned " what the word elopement meant when Resident #8 eloped from the facility on . Staff C stated she was told by a visiting family member that Resident #8 had walked out of the building. Staff C stated she went out and saw Resident #8 " all the way down the street " . Staff C called the Administrator who did not answer. Staff C stated she called Staff A, who then came to assist with talking Resident #8 into returning to the facility. Staff C stated she did not contact the family, the Administrator, or fill out an incident report. Staff C stated she did not receive the elopement training that was in her employee file. Staff C was not aware of the facility ' s elopement policy and procedures. Staff C stated " I pray when I am on my shift that I am not alone, cuz (because) if it happens on my shift, I ' m screwed. "
On at 2:55 PM an interview was conducted with Staff A. Staff A stated she received a phone call from Staff C who stated Resident #8 had left the building and she needed help. She stated he had walked two blocks down and one up the major road. She stated the Administrator was not in the building. Staff A did not write it down in Resident #8 ' s chart, did not fill out an incident report, or inform the Administrator. Staff A did not know what the word elopement meant. Staff A was not aware of the facility ' s elopement policy and procedures.
On at 3:15 PM an interview was conducted with the Administrator. The Administrator was not aware Resident #8 had eloped from the facility. The Administrator stated no Adverse Incident Report was filed for the elopement. The Administrator was not able to the facility ' s elopement policy and procedures. " I haven ' t looked in it to read it and tell you. "
On / at 9:00 AM an observation was made of Resident #1. She had on the left side of her face from underneath her eye, down to the cheekbone, and back to her ear. She had a on her right arm.
On at 9:00 AM an interview was conducted with Resident #1. Resident #1 stated she had been in the facility for 3 months, and had 3 times. She said she gets a lot, and has difficulty transferring. She stated she calls out for help but no one comes. Resident #1 stated staff has refused to help her when she asked. She stated she has asked for help to get to the to transfer and no one helps her. She said the staff will say they go down to check on her, but they don ' t. The resident stated she when attempting to transfer from the bed to her wheelchair on one occasion. She stated she and was sent to the hospital for her arm. She was told there was nothing wrong with it and sent

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back. She went a second time and they told her it was a . She went a third time and the x-ray showed it was broken. She stated it had been about 3 weeks since the .
On a record review was conducted of the chart for Resident #1. An AHCA Health Assessment form 1823 (1823) dated identified Resident #1 as a risk. The 1823 labeled her as independent with transferring. A Physician ' s Certification Statement dated stated Resident 1 " cannot ambulate " and can ' t " be safely transported by car/wheelchair van (seated during transport, w/out medical attendant or monitoring) " . Resident #1 was seen at the hospital for an orbital on . On / Resident #1 was seen at the hospital for an elbow . A progress note from the Advanced Registered Nurse Practitioner (ARNP) dated stated the patient was falling, and noted facial . A progress note from the ARNP dated read " c/o right arm pain from approx 3 wks ago. Pain on inside of right arm, been to hospital X2. " Facial was noted. (Photos)
A continued review of the chart showed a progress note dated that read the resident " on the floor in her approx. 7:45 AM. She had a large bump over her left eye as well as her nose ." The initials are not of any current staff. A progress note dated / read that the resident " went to the hospital at noon. She was complaint for pain on her shoulder. " The note was signed by Staff A. A third progress note dated / read that the resident " complain for pain on her right elbow Staff L call not emergency she went to " , however, the note was not completed and not signed. No additional documentation could be located regarding the visit to the hospital where the break was identified. No discharge documents were located in the chart.
A record review was attempted of the incident reports regarding the three separate unwitnessed with injury, including a or of bones or joints. No incident reports could be located.
On at 1:05 PM an interview was conducted with Staff B, who stated " no one checks on Resident #1. She ".
On at 3:15 PM an interview was conducted with the Administrator. The Administrator stated he did not know how Resident #1 broke her arm. She was unable to locate any documentation in Resident #1 ' s chart regarding the arm.

Class III

Z815 Background Screening: Prohibited Offenses

Based on interview and record review, the facility failed to ensure 6 out of 14 employees (Staff B, Staff D, Staff F, Staff G, Staff H, and Staff J) had a level II background screening and failed to ensure residents receive care and services safely, securely, and from persons who have not committed offenses that preclude them from employment for 2 out of 14 (Staff D and Staff I) records reviewed. This directly placed the residents at risk for exposure to persons whom the Florida Legislature has deemed inappropriate to provide care or services. Additionally, the Administrator allowed 2 employees (Staff G

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and Staff H) to continue to work after she was informed they did not have a Level II background screening.

Findings included:

On at 10:41 AM a record review was conducted of the employee file for Staff D. Staff D had a printout of his Level II background screening in his file, dated . The printout read " screening in process " . A hand written note at the bottom of the page read " need additional info. Until then status will remain " in process " . (Photo 1)
On at 10:45 AM a record review was conducted of the time card for Staff D. Staff D last clocked in on at 2:58 PM and clocked out at 11:00 PM. (Photo 2)
On at 3:28 PM an interview was conducted with the Administrator. The Administrator stated Staff D was currently employed at the facility. The Administrator was asked if there was a more recent Level II background screening showing that Staff D is eligible. She stated " Doesn ' t look like it. This is it. "
On at 1:33 PM an interview was conducted with Staff D. Staff D stated he had worked on from 3:00 PM to 11:00 PM. Staff D stated he is aware he his Level II background screening had not been cleared yet. He stated he is still employed and the facility is waiting for him to be found eligible.
On at 2:08 PM an interview was conducted with the Administrator and the Regional Manager. The Administrator stated Staff D is no longer employed at the facility and that she told him he was no longer employed on .
On at 2:32 PM an interview was conducted with Staff G. Staff G stated today was her first day at the facility. Staff G stated she had received a Level II background screening.
On at 4:05 PM an observation was made of Staff G as she passed medications. Staff G was observed alone in the medication the medications.
On at 5:01 PM a record review was conducted of the employee file for Staff G. No Level II background screening was observed in the employee file.
On at 5:01 PM an interview was conducted with the Administrator. The Administrator was asked where the Level II background screen was for Staff G. " I don ' t know. You don ' t give them time to get this stuff together? "
On at 5:05 PM a review was conducted of the Agency for Health Care Administration background screening website for Staff G. The website read " A new screening is required " .
In a continued interview with the Administrator on at 5:08 PM, the Administrator was informed Staff G was not able to work with residents until the Level II background screening was completed and she was found eligible.
On at 10:45 AM an interview was conducted with the Administrator. The Administrator stated Staff G has not worked since she was sent home on . The Administrator stated Staff G must

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have taken her time card home with her because she could not find it.
On at 11:05 AM an interview was conducted with Staff G over the phone. Staff G stated she had left her time card with the other time cards by the time clock, and she had worked the day before ( ) from 3:00 PM to 11:00 PM.
In a continued interview with the Administrator on / at 11:12 AM, she admitted she had knowingly allowed Staff G to return to the facility and work with the residents after she had been informed by the Agency that the employee could not work in the facility with residents until after her background screening results showed her as eligible.
On at 11:15 AM the Administrator produced the time card and a record review was conducted of the time card for Staff G. Staff G worked on Saturday / from 6:58 AM until 3:08 PM. Staff G worked on Sunday from 3:10 PM until 11:11 PM. (Photo 3)
On at 11:17 AM a record review was conducted of the Agency for Health Care Administration background screening website. The Level II background screening for Staff G was still " in process. " Staff G had not yet been found eligible to work in the facility.
On at 5:05 PM an interview was conducted with the Administrator. The Administrator stated Staff H was working / from 11:00 PM until 7:00 AM on . The Administrator was not able to provide a last name at this time for Staff H, an application, an employee file, or a Level II background screening. The Administrator was informed Staff H could not work in the facility until she was found eligible.
On at 10:45 AM a record review was attempted of the time card for Staff H. The Administrator stated Staff H did not have a time card because she had not worked in the facility, as the Administrator had been told on / that Staff H had to have a Level II background screening prior to working and she did not have that yet.
On at 10:33 AM a record review was attempted of the employee file for Staff H. Staff H had no employee file. No Level II background screening was available for Staff H.
On at 11:12 AM an interview was conducted with the Administrator. The Administrator admitted she had allowed Staff H to return to the facility and work " a shift or two. " The Administrator agreed she had knowingly allowed Staff H to enter the facility and work with the residents after she had been informed by the Agency that the employee could not work in the facility with residents until after her background screening results showed her as eligible. Another request was made for the time card for Staff H but was not produced by the Administrator.
On at 11:10 AM the Regional Manager stated " we know she needs a new one " in regards to the Level II background screening for Staff H.
On / at 12:10 PM an interview was conducted with Resident #6. Resident #6 stated Staff H works overnight and is very nice to him.
On at 1:32 PM a review was conducted of the Agency for Health Care Administration background screening website for Staff H. Two background screenings were located for the same name as Staff H. One of the screenings dated / was from a town close to the facility, but as no

AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967604	07/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HOPE OF PINELLAS	7575 65TH WAY PINELLAS PARK, FL 33781

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

information was provided about this employee, it could not be verified through date of birth or social security number.
On at 10:25 AM a record review was conducted of the time card for Staff H produced by the Regional Manager. Staff H was documented as working from 11:00 PM until 7:00 AM on , and . (Photo 4)
On at 1:32 PM a review was conducted of the Agency for Health Care Administration background screening website for Staff A. The results read " a new screening is required. " Staff A was observed working in the facility on on the 7:00 AM until 3:00 PM shift in her pos or ct care staff and med tech.
On at 5:33 PM an interview was conducted with Staff I. Staff I stated he was scheduled to work the 11:00 PM to 7:00 AM shift tonight, . Staff I stated he had been and had called and informed the Interim Administrator that his background screening had been kicked back " as not eligible. He stated she told him that his job was safe, and he has continued to work without break since he was found not eligible.
On at 5:40 PM a review was conducted of the Agency for Health Care Administration background screening website for Staff I. Staff I was found not eligible as of 06/ .
On at 6:15 PM an interview was conducted with the Administrator. The Administrator stated she was not aware Staff I did not have an eligible Level II background screening.

Unclassified

Z816 Background Screening-Compliance Attestation

Based on interview and record review, the facility failed to ensure that 2 out of 14 sampled employees (Administrator and Staff K) had a Level II background screening (BGS) after a 90 day break in service from a position that requires a Level II screening, and failed to ensure that all employees who require a Level II background screening had a signed compliance attestation form in their employee file.

Findings included:

On at 10:41 AM a record review was conducted of the employee file for the Administrator. The employment application in the file for the Administrator listed two employers, but did not list employment dates for either. The employment file did not list a date of hire. (Photo 5)
On at 11:36 AM a review was conducted of the Agency for Health Care Administration background screening website. The Administrator had been identified as eligible on /
On at 3:28 PM an interview was conducted with the Administrator. The Administrator stated she was hired as the Administrator the previous Monday ( ), and she had started working in the facility approximately two weeks prior. The Administrator could not provide an exact date of hire.

AGENCY FOR HEALTH CARE ADMINISTRATION

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HOPE OF PINELLAS	**7575 65TH WAY PINELLAS PARK, FL 33781**

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

On at 10:41 AM a record review was conducted of the employee file for Staff K. Staff K had a Level II background screening in her file dated / . The application showed that she was previously employed in a position requiring a Level II background screening from , 2016 to 2016.
On at 1:50 PM an interview was conducted with the Administrator. The Administrator stated Staff K began employment with the facility on / .
On at 10:41 AM a record review was conducted of the employee file for Staff I. The background screening printed in his employee file was dated . The last employment in his employee file ended on .
On at 3:28 PM an interview was conducted with the Administrator. The Administrator stated she was not aware that Staff I had a 90 day break in service, and was not aware that he should have obtained a new background screening.
On / at 10:30 AM a record review was conducted of the employee file for Staff F. Staff F had a Level II background screening printed in her file dated / . A review of the employment application for Staff F showed the application date was . The last employment listed on her application prior to working at the facility ended .
On at 1:32 PM a review was conducted of the Agency for Health Care Administration background screening website for Staff F. Staff F had been found eligible on .
On at 1:40 PM an interview was conducted with the Administrator. The Administrator was not aware that Staff F was required to obtain a new Level II background screening following a 90 day break in service.
On at 10:41 AM a record review was conducted of the employee file for the Administrator. The Administrator did not have a signed compliance attestation form in her employee file.
On at 10:41 AM a record review was conducted of the employee file for Staff C. Staff C did not have a signed compliance attestation form in her employee file.
On at 10:41 AM a record review was conducted of the employee file for Staff D. Staff D did not have a signed compliance attestation form in his employee file.
On at 5:01 PM a record review was conducted of the employee file for Staff G. Staff G did not have a signed compliance attestation form in her employee file.
On at 10:41 AM a record review was conducted of the employee file for Staff L. Staff L did not have a signed compliance attestation form in his employee file.
On / at 10:30 AM a record review was conducted of the employee file for Staff M. Staff M did not have a signed compliance attestation form in her employee file.
On at 1:40 PM an interview was conducted with the Administrator. The Administrator was not aware of the requirement to have a signed attestation form in each employee's file.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

August , 2016

Administrator
Bethel Health INC dba Good Hope of Pinellas
7575 65th Way
Pinellas Park FL 33781

Dear Administrator:

This letter reports the findings of a complaint survey conducted 12- , 2016, 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 directed below:

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

A0025 – Resident Care – Supervision - Class II – Your facility failed to provide the level of supervision required to meet the needs of the residents.
A0030 – Resident Care – Rights & Facility Procedures. Class II-Your facility failed to provide a safe living environment, free from and neglect.
A0032 – Resident Care – Elopement Standards. Class II – Your facility failed to provide elopement drills and follow its own elopement policy.
A0052 – Medication – Assistance with Self-Admin. Class III – Your facility failed to assist with self-administration of medication as required under 429.256 FS.
A0054 – Medication – Records. Class III – Your facility failed to maintain accurate Medication Observation Records (MORs).
A0077 – Staffing Standards – Administrators. Class II – Your facility failed to have a trained administrator providing required oversight over residents and resident care.
A0078 – Staffing Standards – Staff. Class II – Your facility failed to have staff trained to perform their duties.
A0163 – Records – Resident, Penalties for Alteration. Class II – Your facility produced fraudulent training certificates which did not accurately reflect the training received by staff.
Z815 – Background Screening; Prohibited Offenses. Unclassified
Z816 – Background Screening; Compliance Attestation. Unclassified
A0079 – Staffing Standards – Levels. Class III

Good Hope of Pinellas
[illegible], 2016

A0026 – Resident Care – Social & Leisure Activities. Class III
A0084 – Training – Assis Self-Admin Meds & Med Mgmt. Class III
A0093 – Food Service – Dietary Standards. Class III
A0165 – Risk Mgmt & QA; Adverse Incident Report. Class III

The facility must comply with the following:

1) Your facility must develop a written policy on steps to take related to oversight of residents, especially in regards to [illegible], sudden illness or injury of a resident. This policy must include:

a) Directions on notifying the resident's primary care physician and family.
b) Directions on which staff person in charge should be notified, and which staff person is responsible for follow-up.
c) Specific instructions on how residents will be assessed post- [illegible]

All facility employees must be trained on the facility's above procedures and must be able to demonstrate an understanding of the procedures. Documentation of training on this policy, including sign-in sheets and/or certificates must be maintained in the facility and available for review by the Agency upon request. This must be completed by **, 2016.**

2) Your facility must review the current elopement policy and ensure it contains the following components:

a) The process of assessing residents as an elopement risk;
b) Required notifications during and after a resident elopement and the timeframe for completing notifications;
c) The process for ensuring all staff on all shifts participates in elopement drills at a minimum of once every 90 days.

All facility employees must be trained on the facility's above procedures and must be able to demonstrate an understanding of the procedures. Documentation of training on this policy, including sign-in sheets and/or certificates must be maintained in the facility and available for review by the Agency upon request. This must be completed by **, 2016.**

3) All facility staff must have complete staff records available in the facility. The staff records must contain the following:

a) Complete job applications and references;
b) Documentation of a Level II background screen and a signed attestation;
c) Documentation of freedom from communicable including

[illegible]

d) Completion of all required in-service trainings. The training must be provided by someone who has completed CORE training and successfully passed the CORE examination. Documentation of the training must include the training content and curriculum, sign-in sheets, any post-test results and accurate training certificates. This must be completed by **, 2016.**

***There shall be no staff working with residents or handling resident monies or having access to resident living areas without a Level II background screen. This must be completed immediately.** **

4) All facility staff must obtain a minimum of 2 hours of training on Resident Rights and Recognizing and Reporting , Neglect and 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 for the Administrator and all employees of the facility. 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.**

5) The facility must have an accurate staffing schedule which accurately reflects its staffing pattern. The facility staffing must be sufficient and include the trained staff necessary to meet the needs of all the facility residents. The staffing must have qualified staff to provide assistance with self-administration to residents who require it, staff trained to prepare meals listed on the facility's menu approved by the registered dietician and at least one person in the facility at all times with current certification in First Aid and (...). This must be completed by **, 2016.**

6) All staff providing assistance with self-administration of medication to residents must complete an updated 4-hour training from a Registered Nurse or licensed Pharmacist on assistance with self-administration of medication. This must be completed by , **2016.**

7) The facility must contract with a pharmacist to conduct an audit of the facility's medication carts and medication practices and follow all recommendations. All audit reports and recommendations shall be submitted to the Agency's local field office for review and must also be maintained at the facility and available immediately for the Agency's review upon request. This must be completed by **, 2016.**

8) The facility must be overseen by an Administrator who has completed a CORE training course from a trainer approved and recognized by the Department of Elder Affairs, has successfully passed the CORE examination and is in compliance with all continuing education requirements. **This must be completed by , 2016.**

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to

Good Hope of Pinellas
August 2, 2016

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) 552-1955.

Sincerely,

Paul F. Brown
FOR Health Facility Evaluator Supervisor

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