| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11967056** | **04/21/2017** |
| NAME OF PROVIDER OR SUPPLIER<br>**KARE ASSISTED LIVING, LLC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**2715 UINTAH AVENUE**<br>**ORLANDO, FL 32805** | |

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

**L241 - LMH - Records - 429.075(3-4); 58A-5.029(2) FAC**

Based on record review and interview the facility failed to ensure 1 of 2 sampled resident records reviewed had all required information (#1).

Findings:

A review of the facility license#11143 revealed it provided limited mental health services (LMH). A review of the facility admission and discharge logs revealed a census of 16 residents who received LMH services.

Resident #1 was admitted on . Review of resident #1's record did not include a community living support plan and , agreement with mental health care services provider. In addition, there was no affirmative statement on the Alternate Care Certification for , , ( ) form, CF-ES 1006, 2005.

On at 11:00 AM, the assistant administrator stated the resident's family member had taken both forms on and had not returned them to the facility.

Class III

**Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC**

Based on record review and interview the facility failed to ensure the background screening (BGS) results were in personnel files for 1 of 2 sampled staff reviewed (C).

Findings:

Staff C's personnel record review revealed no results of BGS in the file. Staff C was hired on .

A review of the Agency for Health Care Administration, BGS website was conducted on . It revealed Staff C's eligibility result was dated .

On at 6:00 PM, the assistant administrator (Staff B) confirmed Staff C's BGS result was not on file.

Class

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SUMMARY STATEMENT OF DEFICIENCIES
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**Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS**

Based on record review and interview the facility failed to maintain its employment status within the Background Screening (BGS) Clearinghouse under the Agency for Health Care Administration (AHCA) website. Initial employment status and any changes in status must be reported within 10 business days.

Findings:

A review of the facility employee roster under the BGS Clearinghouse website was conducted on . None of the facility employees was listed under its employee roster.

A review of the facility staffing schedule for the month of , 2017 revealed 5 employees, including the administrator.

On at 6:00 PM, the assistant administrator confirmed that she had not maintained the employee roster. She said she was not aware of the requirements.

Unclassified.

**0000 - Initial Comments**

A Change of Ownership (CHOW) survey with Limited Mental Health services (LMH) was conducted on - . Kare Assisted Living, LLC had deficiencies found at the time of the visit.

**0081 - Training - Staff In-Service - 58A-5.0191(2) FAC**

Based on observation, record review and interview the facility failed to ensure 2 of 2 sampled staff received the required in-service training within 30 days of employment (B and C).

Findings:

Observation made on and revealed Staff B and Staff C provided direct care to residents.

Personnel record review revealed Staff B was hired in . There was no evidence she had received in-service training that covered the following subjects:

1. Reporting major incidents,
2. Facility emergency procedures including chain-of-command and staff roles relating to emergency

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SUMMARY STATEMENT OF DEFICIENCIES
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evacuation,
3. Facility resident elopement response policies and procedures,

Staff C was hired on . There was no evidence showing she had received in-service training that covered the following subjects:

1. Reporting major incidents,
2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.

On at 7:00 PM Staff B, who also was an assistant administrator, confirmed she was unable to provide certifications for the above required in-service training.

Class III

**0082 - Training - / - 58A-5.0191(3) FAC**

Based on observation, record review and interview the facility failed to ensure 1 of 2 sampled staff (C) received a one-time education course on ( ) and ( ).

Findings:

Observation made on and revealed Staff C provided direct care to residents.

A review of personnel records revealed Staff C who was hired had no evidence that within 30 days of employment Staff C had received a one-time education course on ( ) and ( ).
On at 7:00 PM Staff B/assistant administrator, stated she was unable to provide a certificate that Staff C had / training.

Class III

**0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC**

Based on observation, record review and interview the facility failed to ensure an unlicensed person (Staff B) had obtained a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility (ALF).

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Findings:

On at 2:30 PM Staff B provided assistance with self-administered medication to Resident#9 in the medication storage .

A review of Staff B's personnel record review revealed that she had not obtained a minimum of 2 hours of continuing education on providing assistance with self-administered medications and safe medication practices in an ALF. The only medication training found on her file was 4-hour training dated . Staff B was hired on .

On at 6:00 PM Staff B stated she could not locate her current certification for the training.

Class III

**0090 - Training - - 58A-5.0191(11) FAC**

Based on record review and interview the facility failed to ensure 1 of 2 sampled staff (C) received at least one hour of training in the facility's policy and procedures regarding ( ).

Findings:

A review of personnel record revealed staff C date of hire had no evidence that within 30 days of employment she had received at least one hour of training in the facility's policy and procedures regarding ( ).
On at 7:00 p.m. Staff B/assistant administrator, stated she was unable to provide a certificate that Staff C had received training.

Class III

**0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC**

Based on observation, record review and interview the facility failed to follow its menus and to note substitutions before or when the meal was served.

Findings:

A review of the facility menus posted for revealed lunch menus were 1 cup vegetable soup, 3 ounces (oz.) chicken sandwich, 1 cup tossed salad, vanilla custard and juice/lemonade.

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SUMMARY STATEMENT OF DEFICIENCIES
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Lunch observation conducted on at 12:00 noon showed the following menus were served: corn beef and buns, vegetable soup, a bag of vegetable chips, and juice.

On at 12:05 PM, Staff B (assistant administrator) confirmed that Staff C (who cooked the meal) did not follow the menus because some residents had requested to have corn beef today. She also stated she was not aware that the substitutions were not posted.

Class III

**0160 - Records - Facility - 58A-5.024(1) FAC**

Based on record review and interview, the facility failed to ensure the administrator's personnel record was available for review.

Findings:

On a review of the facility information was conducted via FloridaHealthFinder.gov website. It revealed Staff A was the administrator of the facility. The facility license#11143, effective , expires .

On and the assistant administrator (Staff B) who assisted with the survey stated she could not access Staff A's personnel record. Staff A was out of the country due toa family emergency.

Class III

**0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC**

Based on interview and record review, the facility failed to submit an incident report to the Agency for Health Care Administration (AHCA) when Resident#1 had wandered from the facility and law enforcement was called to search for the resident.

Findings:

According to Staff B and C's interviews conducted on , Resident #1 had wandered from the facility on . The facility had called the police to search for the resident. The resident was brought back to the facility on the same day.

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Interview on at 5:00 PM, with the assistant administrator (Staff B) revealed that on at about 10:30 AM she had called the police after she realized resident#1 was not on the premises. It was about 30 minutes after she could not find resident #1 in the facility. She stated the police brought the resident back about 4 hours later. The resident was found on Orange Avenue. The resident did not have any injuries. She said the resident was admitted to the facility in 2016. She was not aware of any history of resident elopement. She stated a 45-day discharge notice was given to the resident's family member who was looking for a more suitable place for the resident.

A review of resident #1's health assessment (AHCA 1823), dated revealed the resident was diagnosed with mood and sleep status was noted as alert and oriented. Special precautions noted as 'None.' There was no evidence showing the resident was at risk for elopement.

On at 5:00 PM when asked whether she had submitted an Adverse Incident report to the agency (AHCA), she said she had forgotten to do so.

Class III