STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953250	06/02/2017
NAME OF PROVIDER OR SUPPLIER **HOMESTEAD RETIREMENT**	STREET ADDRESS, CITY, STATE, ZIP CODE **1117 MASSACHUSETTS AVENUE** **SAINT CLOUD, FL 34769**	

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

0000 - Initial Comments

A 6 month Survey was conducted on and . Homestead Retirement Home, license #245 had deficiencies at the time of the visit.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review and interview the facility failed to provide care and services appropriate to the needs of 2 of 4 sampled residents and did not notify the healthcare provider of unplanned weight loss or multiple medication dosages missed and did not notify responsible party of significant changes, hospitalizations or when the resident was missing from the facility for resident #12 and did not contact responsible party when resident #13 was missing from the facility.

Findings:

1. An updated health assessment report 1823 dated for resident #12 indicated diagnoses of , , and . He was independent with his activities of daily living and needed assistance with self-administration of medications. The health assessment dated indicated a weight of 183 pounds (lbs.).

Resident record review for resident #12 revealed a weight of 177 lbs. on . On , his weight was 168 lbs. and on , he was 144 lbs. The record review revealed no evidence the healthcare provider was notified and made aware of the resident's weight lost. There was no evidence the healthcare provider had placed the resident on a therapeutic diet to encourage weight loss.

In an interview with the caregiver on at 12 PM who stated the doctor was aware of the weight loss and had noted the weight loss in his progress notes, but he did not have them now.

In an interview with the supervisor on at 12 PM who said the resident went out a lot and ate outside.

An opportunity was given to obtain the progress notes and submit by electronic mail (e-mail) to the office by by end of business day; an e-mail was not received.

Continued review revealed the Medication Observation Record (MOR) dated , 2017 indicated the resident missed his medications because he was not in the facility during the medication pass.

The MOR listed , 10 milligrams (mg) tale one-half tablet twice a day, , 1 mg twice a

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day, 5 mg twice a day all scheduled @ 8 AM & 8 PM.
1 mg 3 times daily; 0.5 mg 3 times daily; 1 mg 3 times daily
scheduled @ 8 AM, 4 PM & 8 PM. The back page of the MOR indicated the resident did not take his medications because on:
5/2 @ 4 PM all evening meds (medications) - not in facility
5/4 @ 4 PM all evening meds- not in facility
@ 8 PM all bedtime meds not in facility
@ 8 PM all bedtime meds not in facility- not here at staff called said she saw him walking to a nearby fast food restaurant with another resident , will call emergency if not back in 6 hours- came in at 12:52 PM
@ 4 PM all evening meds not in facility
@4 PM all evening meds not in facility

Continued review revealed there were no healthcare provider's orders that mandated the resident to take these medications at those specific times. There was no evidence the facility made the resident's healthcare provider aware of the resident's pattern of going out and not be present during the medication passes to possibly make arrangements for him to take them when he return to the facility or before he went out to ensure that therapeutic levels were reached and maintained.

Incident reports reviewed revealed the resident left the facility and did not return when expected. The events were reported to law enforcement but there was no evidence the family/ responsible party or case manager were notified
11 PM called non- emergency to report resident missing
10:45 PM non-emergency called to report missing

There was no evidence to confirm the family/responsible party or case manager were notified when the resident became aggressive and was .
12:14 AM - non emergency police and calmed him down
10:30 PM called non- emergency - resident was very aggressive - was -
- 7 PM Police were called - resident was very aggressive
8:50 PM Resident in street yelling, ripping clothes off, told him would call emergency transport, he calmed down took meds.

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2. Review of the closed record for resident #13 revealed he was admitted to the facility on and discharged on . A Health Assessment dated documented a diagnosis of chronic , , . He required assistance with self-administration of medications and was independent with all ADLs.

Review of the incident reports and staff shift notes from 2016 through , 2017 revealed 3 distinct times when resident #13's location was unknown and no responsible party was notified:

- whereabouts unknown at evening medication time. Police called. "Searched the whole town." Listed as a missing person. No adverse report filed. Shift notes said, "Everyone is here and fine." In an

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interview with Staff F on at 10:30 AM, she gave all 3 of the following answers regarding this incident: "he was found in the hospital" "he came back that night," and "the police found him on the streets." There was no documentation that his physician, family, POA or any responsible party was notified the resident was missing on .

- whereabouts unknown. Last seen at 9pm. Police called 3am and took information. Resident returned at 5:50AM and said he was working at Walmart. There was no documentation that his physician, family, POA or any responsible party was notified the resident was missing on 11/ .

- whereabouts unknown from prior to the start of the 3pm shift on until 3:45am. Shift notes documented, "Police were notified by 2nd shift. At 3:45am called police non-emergency number for (resident #13). (Staff C) said to call again by 3-4am (police said). As talking with police, (resident #13) walks in." There was no documentation that his physician, family, POA or any responsible party was notified the resident was missing on .

In an interview with Staff F on at 10:45 AM, she confirmed that the notes do not document that anyone was called. She explained they try to remember to call the POA whenever possible.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on staff schedule review and interview the facility failed to meet the needs of the residents and maintain an accurate written work schedules that met the minimum staff hours per week as required by 58A-5.019(2) F.A.C.

Findings:

The facility had a capacity of 40 residents. On the date of the visit, there were 39 residents in the facility. The staffing requirement for a facility with 36-45 resident is 335 staff hours per week.

The staff schedule provided by Staff F was reviewed for the weeks of - and - . The schedules documented that each week there was a total of 280 hours scheduled for staffing. The administrator was listed on the schedule as working in the facility from 9am-5pm Monday through Friday. The administrator was not present in the facility at any time during the visit on and .

The facility did not meet the requirement for staff hours. For the weeks reviewed, they were short by 55 hours each week. Staff F was advised that the administrator's hours were not counted in the total for

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staffing since he was not present or available to be at the facility.

Staff A was documented as being off on , but was working in the facility from 7am-3pm on that date.

In an interview on at 1:00 PM with Staff F, she said, "I know we need 335 hours every week. We are a little short staffed." Regarding Staff A working on a day marked as off on the schedule, Staff F stated she had made a change but did not mark it on the schedule.

Class III

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

Based on personnel record review and interview the facility failed to ensure certificates for training contained all the required information for 1 of 5 sampled staff (B).

Findings:

Personnel record review for staff B revealed she was hired on . The review revealed a certificate that indicated she received an in-service training regarding / on , however the certificate did not indicate the duration of the in-service training, training program agenda. the number of hours of the training program, the training provider's name, the date of the training, the signature of the trainer and credentials/professional license number, if applicable, and the location of the training program;

In an interview on at 12:30 PM with the supervisor who said, she gave the staff a video to watch, and post-test. She did not know the certificate was incomplete.

Class III

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(8) FAC

Based on personnel record review and interview the facility failed to ensure 1 of 5 staff (B) completed Limited Mental Health (LMH) training within 6 months of hire.

Findings:

Personnel record review for staff B (caregiver), revealed a hired date of . The review revealed no evidence she attended the required 6 hour training regarding working with individuals with mental health diagnoses.

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In an interview on at 12 PM with the supervisor who said the training was overlooked.

Class III

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on the Agency Clearinghouse Website Review and Interview, the facility failed to register and maintain the employment status of employees within the Agency's Background Screening Clearinghouse for 5 of 5 sampled staff.

Findings:

Review of the Agency Clearinghouse Roster on at 11:45 AM revealed the 2 two employees.

During an interview with the supervisor on duty on at 12:00 PM, she confirmed that only 2 names were on the roster and stated that neither of them worked in the facility at this time. She confirmed none of the current staff was listed on the roster.

Unclassified

Z821 - Reporting Requirements; Electronic Submission - 59A-35.110 FAC

Based on resident record review, incident report review and interview, the facility failed to file adverse incident reports required pursuant to Sections 429.23(3) and (4), F.S. and Rule 58A-5.0241, F.A.C for multiple incidents involving 3 of 4 sampled residents. (#12, #13, #14).

Findings:

The adverse incident log was requested on at 9:45 AM. Per Staff F, "Thankfully, there have been no adverse reports needed since the new owners took over."

Review of the incident reports and staff shift notes from 2016 through , 2017 revealed 4 distinct times when resident #13's location was unknown and police were called:

- whereabouts unknown at evening medication time. Non-emergency police number called. Police "searched the whole town." Listed as a missing person. Shift notes said, "Everyone is here and fine." In an interview with Staff F on at 10:30 AM, she gave all 3 of the following answers: "he was found in the hospital" "he came back that night," and "the police found him on the streets." There was no

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documentation that his physician, family, POA or any responsible party was notified of his absence on . There were no notes that indicated when he returned to the facility. No adverse report filed.

- shift notes from the 11pm-7am shift document "3-11 shift said Philip gone since 9pm. Will call non-emergency at 3am if he hasn't returned." Then, "3am (Resident #13) still not here. Called non-emergency, wrote incident report. (Resident #13) returns home 5:50AM, , said he was working at Walmart." A copy of the police officer's card was attached to the incident report.

, shift notes from the 11pm-7am shift document "(Resident #13) is not here. (A staff member) said that (Resident #13) was not here when he came to work at 3pm. He checked for him up until 10 pm and still not here. When I came, the police were here and (a staff member) was filling out an incident report. If he comes home- call non-emergency to let police know he's home. (signed by staff D)"

, All shifts wrote (Resident #13) still out
. All shifts wrote "(Resident #13) still out. Not in facility."
, 3-11 & 11-7 wrote "(Resident #13) still not in facility."
, 7-3- (Resident #13) at hospital

There were no notes documenting how they found him at the hospital and what had happened to him requiring hospital admission. He remained in the hospital until , when he returned to the facility during the 7am-3pm shift. No adverse report was filed.

- whereabouts unknown from prior to 3pm shift until 3:45am. Shift notes documented, "Police were notified by 2nd shift. At 3:45am called police non-emergency number for (resident #13). (Staff C) said to call again by 3-4am (police said). As talking with police, (resident #13) walks in." There was no documentation that his physician, family, POA or any responsible party was notified of his absence on . No adverse report was filed.

An updated health assessment report 1823 dated for resident # 12 indicated diagnoses of , , and .

Incident reports review revealed the following:

@ 10:45 PM non-emergency called to report resident missing. The report indicated the resident was not in the facility for his 8 PM medications. She waited 6 hours since he was last seen to call non-emergency. He returned at 11 PM.

@ 11 PM called non-emergency to report resident missing after last seen at 8:30 PM. The staff

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indicated she waited the required 6 hours and then called non- emergency to report resident #12 missing. The person on the telephone told her the police had seen two males by a store nearby. When the police went to check again, the females were gone. The police told her to call if he returned.

Resident #14 had a health assessment report dated that listed diagnosis of ,

Incident report dated at 10:30 AM indicated the resident argued with another resident, almost to a fistfight. The police was called. When the police arrived, they had calmed down and all was well.

In an interview on at 12 PM with the supervisor who said she was somewhat with the adverse report, as she was unsure when an adverse was needed or not and had submitted any report.

Unclassified