STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968835	R 08/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEWOOD ESTATES ASSISTED LIVING FACILITY	**4055 PINEWOOD RD MELBOURNE, FL 32934**

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

0000 - Initial Comments

An unannounced Monitoring revisit was conducted related to Complaint Investigation #2017003680, regarding unlicensed activity at Pinewood Estates Assisted Living Facility, License #12678, on 8/01/17, 8/10/17, 8/11/17 and 8/15/17. Deficient practice was found at the time of the monitoring revisit.

0190 - Administrative Enforcement - 58A-5.033(1-2) & (3)(b) FAC; 429.075(6)

Recited

Based on record reviews, observation and interviews, the facility failed to cooperate with the Agency for Health Care Adminstration (AHCA) during survey activity. The facility failed to allow AHCA to conduct private interviews with 1 of 5 sampled residents (#3). The facility failed to provide information related to its employees that had direct access and provided care and serviced to the Residents. AHCA was denied access to employee background screening, Do Not Resuscitate Order (DNRO) training, medication compliance, and staff qualifications and training including emergency procedures and reporting abuse, neglect and exploitation for employees working at the facility, which directly threaten the safety and welfare of 5 of 5 residents currently residing at the facility.

Findings:

On 8/10/17 at 9:15 AM, Staff A was being interviewed when Staff E interrupted the interview and stated she is the legal representative of the Administrator's law firm. Staff E stated the administrator works in Miami and works at the facility. Staff E stated that she was his legal representative. When Staff E was asked if she worked at the facility, she would not answer. Staff E stated Staff A is the manager. The surveyor asked Staff E if she had documentation in writing that placed Staff A as manager. Staff E reported they did not have to do that since the administrator works at the facility.

On 8/10/17 at 9:50 AM, Staff E was asked the correct spelling of her name. Staff E walked out of the interview.

On 8/10/17 at 2:00 PM, in an interview with Staff E regarding the background screening status for Staff F, Staff E stated he is only the maintenance man and does not need to be screened. Staff F had been observed driving the residents to an activity and was in the care of the residents on 8/10/17.

On 8/10/17 at 11:40 AM, in an interview with Staff A, Staff E interrupted Staff A. Staff A was requested to provide the medication observation records (MORs) for review. Staff E removed the notebook from the medication cart and stated she would give us what we need to see and stated, "Why do you think you

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can look at everything?" While Staff E was pulling MORs from the notebook, a second notebook was on the medication cart. Staff E stated that was not something the Agency for Health Care Administration (AHCA) needed to see, grabbed the notebook from the surveyor, and left the room.

On 8/10/17 in an attempt to review employee records, the facility was asked a second time to provide access to employee files. Staff E stated she had provided all of the employee records necessary. On 8/10/17 at 10:00 AM, Staff E stated the AHCA representative would not be allowed to review the employee files because they are legal office records. No files were provided for review.

On 8/10/17 at 1:41 PM, Staff E was requested to provide the missing resident record for Resident #1. Staff E stated all files were given.

On 8/10/17 at 3:00 PM, in an attempted interview with Resident #3, Staff E stopped the AHCA representative from talking with Resident #3.

On 8/10/17 at 3:15 PM, during the exit interview, Staff E was asked about her name and if her name was noted as Staff E or Staff H. Staff E demanded the AHCA representatives leave the property. At the time of the exit conference, the facility failed to provide the following items: Employee files, MORs notebook, August 2017 MORs for Resident #4, Resident #1's file, and Date of birth for Staff E and Staff F.

On 8/15/17, in an interview at 3:59 PM with a local home health nurse, the nurse stated the facility failed to cooperate with her visits. The nurse stated that Staff E required all of her treatment shots to the residents be provided in the rest room of the facility. The nurse stated Staff E required a staff member to observe what care she was providing to the resident.

Class II

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

Recited

Based on record reviews and interviews, the facility failed to ensure all employees, 2 of 5 (E & F), had completed a Level II background screening. The facility failed to ensure all employees, 2 of 5 (E & F), were listed on the background screening roster.

Findings:

On 8/10/17, a record review of the facility work schedule was completed. The work schedule

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documented work hours for Staff A, B, C, E, F and G. The work schedule documented the dates from 8/1/17 to 8/12/17.

On 8/10/17, a review of the Agency for Health Care Adminstration's (AHCA) background screening website revealed that the facility only listed Staff A, B, C and G on their roster. The web site did not have a listing for Staff E or F.

On 8/10/17 at 9:09 AM, the AHCA representative requested copies of all employee records.

On 8/10/17 at 9:51 AM, the AHCA representative attempted to interview Staff F and was informed by Staff A that Staff F had transported Resident #1 and Resident #3 to an outside activity.

On 8/10/17 at 1:10 PM, Staff E stated she is not required to provide employee files. Staff E stated she needed to provide only the missing items. The files were requested again so missing items and obtain dates of birth could be reviewed. Staff E did not provide copies of the employee records and documents required to confirm dates of birth.

On 8/10/17 at 2:00 PM, Residents #1 and #3 had returned to the facility. Staff E denied Staff F worked with the residents.

On 8/10/17 at 3:15 PM, in an exit interview with Staff E and Staff A, Staff E advised that the AHCA representatives would need to leave her property.

On 8/10/17, the AHCA background screening web site was not able to determine if Staff E and Staff F have completed background screens without their dates of birth or other identifying information.

Unclassified