STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969073	**08/28/2017**
NAME OF PROVIDER OR SUPPLIER **THE RANCH ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **4919 LORRAINE RD** **BRADENTON, FL 34211**	

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

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

Based on record review and interview the facility failed to maintain an updated employee roster in the Agency background-screening clearinghouse for one (Housekeeping staff) of five employees at the facility.

Findings included:

During interview with the housekeeping staff, on at 02:41 p.m., she stated that she worked at the facility since , and that she cleans areas in the facility to include residents' .

Review of the AHCA Background Screening Clearinghouse Agency website revealed that the housekeeping staff was not listed on the employee roster for the provider.

During interview with the Administrator, on at 03:09 p.m., she confirmed that the housekeeping staff was an employee. The Administrator confirmed that the housekeeping staff was not listed in the employee roster for the facility.

Unclassified

Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on record review and interview the facility failed to ensure one (Housekeeping Staff) of five employee who has access to residents' personal property and living areas had a level II background screening.

Findings included:

During interview with the housekeeping staff, on at 02:41 p.m., she stated that she worked at the facility since , and that she cleans areas in the facility to include residents' .

Review of the AHCA Background Screening Clearinghouse Agency website revealed that the housekeeping staff was not listed on the employee roster for the provider. Further review of the AHCA

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969073	**08/28/2017**
NAME OF PROVIDER OR SUPPLIER **THE RANCH ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **4919 LORRAINE RD** **BRADENTON, FL 34211**	

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

Background Screening Clearinghouse Agency website revealed that the Housekeeping staff required a new screening.

During interview with the Administrator, on . . . . . at 03:09 p.m., she confirmed that the house keeping staff is an employee that cleans residents' . She stated that the facility did not do the fingerprints for the housekeeping staff.

. . . . . at 04:24 p.m., the Administrator confirmed that there were no employee record for the Housekeeping staff. The Administrator was shown the level II background status, on the AHCA Background Screening Clearinghouse Agency website, for the housekeeping staff, and she confirmed that a new background screening was required.

Unclassified

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c) FS

Based on record review and interview the facility failed to maintain a signed Attestation of Compliance in the employee record for two of (Activities Director and Housekeeping Staff) five facility employees.

Findings included:

Record review conducted on , revealed there were no documentation of Attestation of Compliance with Background Screening Requirements for the housekeeping staff and the Activities Director.

On at 04:24 p.m., the Administrator confirmed that there were no employee record for the Activities Director or the Housekeeping staff.

Unclassified

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969073	**08/28/2017**
NAME OF PROVIDER OR SUPPLIER **THE RANCH ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **4919 LORRAINE RD** **BRADENTON, FL 34211**	

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

0000 - Initial Comments

Assited Living Facility

Two unannounced complaint surveys, (CCR# 2017006902 and CCR# 2017007028), were conducted on , at The Ranch ALF, (License # 12936), an Assisted Living Facility, located in Bradenton, Florida. There were deficiencies identified at the time of the visit.

Please note the statement of deficiencies was administratively amended on .

(License # 12936)

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, interview and record review, the facility failed to ensure that residents medical records were maintained in a manner that protected residents' protected health information for four (#1, #5, #6, and #8) of five residents selected for record review, and that residents were treated in a dignified manner. Specifically, residents were provided with drinking containers (sports bottles and condiment containers) without consideration of their personal dignity; the residents were locked out of their during the day to keep them from napping, and locked in their to prevent access to common areas and to control behavior. The facility also failed to keep the residents free of by using lap belts and lap trays.

Findings included:

While conducting a facility tour on , orange folders were observed on a hallway shelf, outside of kitchen/office area. Further review revealed that folders contained home health records, with protected health information, for residents #1, #5, #6, and #8. Continued facility tour revealed that the lock on the door that separated main lounging area from of six residents, was positioned on the opposite side of residents' . The door was also equipped with a metal latch that locked the door from the top edge of the door (image taken #1).

During interview with the Administrator, on at approximately 07:30 a.m., she confirmed that

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969073	**08/28/2017**
NAME OF PROVIDER OR SUPPLIER **THE RANCH ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **4919 LORRAINE RD BRADENTON, FL 34211**	

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

the folders contained resident medical records and documentation by home health company (images taken #2). Administrator stated that she keeps the residents' home health records. The Administrator acknowledged that residents and anyone in lounging area would be able to access the records.

During meal observation, on at 08:00 a.m., and throughout the survey, residents were observed drinking out of blue sports bottles and white condiment containers (image taken #3).

During a family interview for Resident #7, on at 9:45 AM, the family member interviewed stated that the facility rewards Resident #7 with more privileges based on behavior. Resident #7 receives more outside time by complying with the expectations at the facility. He stated that Resident #7 was not allowed to take a nap in her the day, and stated, "According to her and based on my experience when I get here, no she does not have access to any time she chooses."
During interview with the housekeeping staff, on at 02:41 p.m., she stated that she has been locked in that section of the building by residents and was unable to open the door until the Administrator's husband opened the door for her.

During an interview with Resident #7, on at 09:56 a.m., she stated that the Administrator and her husband lock the hallway door that prevents residents from accessing the rest of the building. Residents are locked in their or not given dinner as punishment by the owners for non-compliant behaviors. Resident #7 stated that she hated the sports bottles provided by the facility and, described the bottles as "nasty." Resident #7 stated that she has voiced her dismay to the Administrator and her husband.

During interview with Resident #1, on at 10:50 a.m., she stated, "They lock us in there all the time. When we don't do what were supposed to do and every night. We don't walk out of the , it's locked, we have no phones, we're just stuck there." Resident #1 expressed that she did not like the bottles provided by the facility for drinking.
During interview with the Administrator, on at 01:01 p.m., she confirmed that residents are given sport bottles and white condiment bottles for daily usage.

On at 02:01 p.m., the Administrator stated that she uses lap trays for residents that use wheelchairs.

During interview with the Activities Director, on at 03:30 p.m., she stated that she has witnessed the Administrator and her husband lock Resident #4 in her calling another resident name, and has witnessed Resident #4 being locked in her , by the Administrator, on multiple other occasions. The administrator locks the residents' and does not allow the resident to go back in

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969073	08/28/2017
NAME OF PROVIDER OR SUPPLIER **THE RANCH ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **4919 LORRAINE RD** **BRADENTON, FL 34211**	

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

their , and she has witnessed the Administrator deny residents' request to go to their retrieve personal belonging (sweater).

During interview with the Administrator, on at 03:30 p.m., she confirmed there have been occurrences, four times in the past two months, in which residents lock each other in the back hallway and she confirmed that the housekeeping staff have been locked in the hallway by the residents in the past. The Administrator stated, "I put Resident #4 in her she was screaming, and I lock the door so Resident #2 does not get in there. Resident #4 is on the inside and wants me to lock the door. We are protecting both parties. It's not a punishment."

An interview with a third party nurse, who provided medical services for residents at the facility, on at 04:22 p.m., revealed that the nurse has witnessed the Administrator and her husband locking residents in their and in the back hallway. The nurse also witnessed residents tied on a wheelchair with towels, in addition to a lap tray secured on the wheelchair that prevented the resident from getting out of the wheelchair. The nurse also stated that the residents' doors are locked during the day because the Administrator did not want them to sleep during the day and be up night.

Class II

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation and interview, the facility failed to provide assistance with self-administered medications in accordance with procedures described in Section 429.256, F.S. The facility failed to ensure that the Administrator, who was observed administering oral dosages of medication for three (#2, #4 and #6) of five resident was licensed to administer medications.

Findings included:

On between 8:44 AM and 8:51 AM, a medication observation was conducted for Residents #2, #4, and #6. The Administrator was observed administering medication with a spoon to Resident's #2, #4, and #6. They popped the pills onto a spoon and asked the resident, "do you want to do it or do you want me to?" The Administrator put the spoon into the resident's mouth, administering the medications to the resident's.

During interview with the Administrator, on at 1:57 PM, she confirmed that she administered the

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969073	**08/28/2017**
NAME OF PROVIDER OR SUPPLIER **THE RANCH ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **4919 LORRAINE RD BRADENTON, FL 34211**	

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

medication for Residents #2, #4 and #6 and that she was not licensed to administer medications. The Administrator stated, "I did not know it was considered medication administration. You heard me, I asked them first if they wanted to do it or me to help them. From now on, I will let them do it."

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on record and interview, the facility failed to maintain personnel records which contain employment application with references for two (Activities Director and Housekeeping Staff) of five facility employees.

Findings included:

During interview with the housekeeping staff, on at 02:41 p.m., she stated that she worked at the facility since , and that she cleans areas in the facility to include residents' .

During interview with the Activities Director, on at 03:30 p.m., she stated that she worked at the facility since Memorial Day of 2017.
Review of employee schedule revealed that the Activities Director has been on the schedule since .

No records were found for the Activities Director and the housekeeping staff during employee record review.

During interview with the Administrator, on at 03:09 p.m., she confirmed that the Activities Director and the housekeeping staff are employees.

at 04:24 p.m., after an extensive search though the facility records, the Administrator confirmed that there were no employee record for the Activities Director or the Housekeeping staff.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969073	**08/28/2017**
NAME OF PROVIDER OR SUPPLIER **THE RANCH ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **4919 LORRAINE RD** **BRADENTON, FL 34211**	

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

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 report an adverse incident to the Agency (elopement of Resident #7, which placed the resident at risk of harm.)

Findings included:

During family interview for Resident #7, on , the family member stated that Resident #7 wandered from the facility
Record review for Resident #7 revealed no documentation of resident elopement.

During interview with the Administrator, on at 12:08 p.m., she stated that that Resident #7 did elope by going out of her window on . Local law enforcement was called and that facility was informed that they had Resident #7. Administrator stated that she forgot to report the elopement to the Agency. Administrator confirmed there was no adverse incident report documented for Resident #7's elopement.

Class III