STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943128	08/28/2017
NAME OF PROVIDER OR SUPPLIER **ST MARY'S HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **718 W. WINTER PARK STREET** **ORLANDO, FL 32804**	

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

0000 - Initial Comments

Complaint Investigation #2017009807 was conducted on , , and . St. Mary's Home, License #4860 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 notify a licensed physician for 1 of 4 sampled resident of significant changes with status (#2), and failed to maintain a general awareness of resident whereabouts. This resulted in an elopement from the facility (#2).

Findings:

Resident #2's record review did not reveal any documentation that a licensed physician was notified on when the resident refused physician ordered , , medications on and . Resident #2 required assistance with self-administration of medications. Resident #2 from facility on and was until , without medications and without the facility knowing the resident's for a total of nine days (#2).

Resident #2's 1823 AHCA Form Health Assessment, dated , documented that resident #2 required assistance with self-administration of medications.

The administrator did not report resident #2 fron to the local Law Enforcement agency until , five days after the resdien from the .

On at 10 AM, the administrator stated that the residents have a right to refuse their medications but was not aware that he must notify the licensed physician immediately. The administrator confirmed the findings.

Class II

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on record review and interview, the facility failed to follow and respond to the facility's Elopement policy and procedures with conducting an immediate search of the facility and premises for 1 of 4 sampled residents (#2), and failed to conduct required elopement drills twice each year and document written elopement drills completed.

Findings:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943128	08/28/2017
NAME OF PROVIDER OR SUPPLIER **ST MARY'S HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **718 W. WINTER PARK STREET** **ORLANDO, FL 32804**	

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

The facility's Elopement policies and procedures directs the facility to conduct an immediate and prompt search of the resident's all the residents' , common area spaces, storage areas, , linen closets, locked areas, courtyards, and surrounding outdoor areas within 20-30 minutes. After this time has passed and the facility still does not know the missing residents whereabouts, staff must notify police, family representative, and attending physician. Furthermore, documentation must be written in residents' medical record of the attempted search efforts.

On at 8 AM, resident #2 eloped from the facility and was not reported missing to the local Law Enforcement Agency until on .

Resident #2's Medication Observation Record (MORs), dated and revealed that the resident refused , , , medications, which is a significant change in the resident's behavior.

Resident#2's record review did not reveal any documentation of the elopement incident and search efforts that occurred and did not document that police, family representative, and the physician were notified immediately.

Resident #2's record review did not reveal any documentation that a licensed physician was not notified on , when the resident refused her , , , medications, a significant change in the resident's behavior on and . Resident #2 required assistance with self-administration of medications. Resident #2 eloped from facility on and was missing until , none days without medications and without the facility knowing the resident's whereabouts.

Resident #2's 1823 AHCA Form Health Assessment, dated , reflected that resident #2 needed assistance with self-administration of medications.

The administrator did not report resident #2 missing from facility to the local Law Enforcement agency until , and did not report to the regulatory licensing agency for this assisted living facility, the Agency for Health Care Adminstration (AHCA), until .

The facility's last Elopement Drill conducted and documented was at 5 PM, which indicated the facility was not in compliance with the Elopement Drill regulations which requires drills to be conducted twice a year.

On at 11 AM, the administrator confirmed the findings of the resident's elopement and the facility's failure to follow their own elopement policy and procedures.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943128	**08/28/2017**
NAME OF PROVIDER OR SUPPLIER **ST MARY'S HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **718 W. WINTER PARK STREET** **ORLANDO, FL 32804**	

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

Class II

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

Based on observation and interview, the facility failed to maintain a current written work schedule that reflects the 24-hour staffing pattern for given time period.

Findings:

Observation on at 9 AM, the staff schedule for 2017 was not available for review. Additionally there was no schedule available for review for 2017 and 2017. The only staff schedule available for review was 2017.

On at 11 AM, an interview with the Administrator who confirmed the above findings.

Class III

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

Based on the Background Screening Clearinghouse (BGS) website and interview, the facility failed to register and maintain all employees on the employee roster within 10 business days from employment date and/or termination date.

Findings:

On at 8:30 AM, the BGS website was reviewed for the facility's employee roster, and did not reveal any employees listed on the employee roster.

On at 11 AM, the administrator confirmed the finding.

Unclassified

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

Based on observation and interview, the facility failed to report and submit an electronic 1-day and 15-day Adverse Incident Report timely through the Agency for Health Care Administration's (AHCA) internet site for 1 of 4 sampled resident (#2).

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943128	**08/28/2017**
NAME OF PROVIDER OR SUPPLIER **ST MARY'S HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **718 W. WINTER PARK STREET** **ORLANDO, FL 32804**	

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

Findings:

On at 9 AM, a hand-written 1-day Adverse Incident Report, dated , was reviewed. The administrator stated he faxed this written 1-day Adverse Incident Report to AHCA. The administrator was informed that all Adverse Incident Reports are to be submitted electronically.

Furthermore, the hand-written 1-day Adverse Incident Report was not faxed to AHCA on time. It was faxed on , four days after resident #2 eloped from the facility on .

On at 11 AM, the administrator stated he was not aware that Adverse Incident Reports are to be submitted electronically.

Unclassified