| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11968565 | 10/11/2017 |
| NAME OF PROVIDER OR SUPPLIER<br>**EXTENDING LOVABLE LIVING ASSISTANCE, LLC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**14514 STORY FORD RD**<br>**ORLANDO, FL 32832** | |

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

**0000 - Initial Comments**

A re-licensure survey was conducted on . Extending Lovable Living Assistance, LLA Assisted Living Facility, license #12433, had deficiencies at the time of the visit.

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

Based on observation, record review and interview, the facility failed to document observations of changes in behavior or health status or notification of health care providers or family for changes in behaviors or health status for 2 of 2 sampled residents. (#3 & #4).

Findings:

1. Resident #3 was admitted on . Her Health Assessment, dated , indicated a diagnosis of , , and , . She was assessed to be independent with all Activities of Daily Living.

In an interview with resident #3 on at 8:50 AM, she stated her clothes were in the garage.

When asked about the lack of personal storage in the resident #3, the administrator opened the closet to show that a storage unit and shelving had been moved into the closet and that the clothing and belongings for resident #3 and #2 were kept in the closet in the shared with resident #2. The administrator stated that resident #3 had been going through her clothing, taking things, emptying the contents and damaging some items belonging to the resident and her . The administrator went on to explain that resident #3 repeatedly went into the dug at her with her fingers and pulled out feces, putting it in the sink and shower drains and in the trash. She explained that Staff #B had to snake out the drains in the more than one occasion due to the behaviors of resident #3. The administrator stated they try to be present when the resident goes into the . The administrator stated she had spoken to the resident's physician and the ARNP and they had examined the damage the resident had self-inflicted to her body and were working to heal her skin and prevent future occurrences. The administrator stated that she believed that resident #3 needed more help and supervision than she could provide in her facility and had given the family a notice of discharge.

Review of the record for resident #3 revealed no documentation or notes about the resident's behaviors or and instances of notification to the health care provider or the family about these behaviors. There was no documentation indicating what actions the facility staff had taken to discourage, prevent or change the behaviors of resident #3. There were no notes or orders from the healthcare provider about

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an examinations, test results or changes in medications.

In an interview with the administrator on at 2:00 PM, she stated she believed she had done everything that was needed for the resident, but confirmed she had not written notes or documented any of resident #3's behaviors or if anyone had been notified.

2. Observations during the facility tour of resident #4's a a bed, a portable commode and a TV on a rolling stand. The entire floor was covered in plastic.

In an attempt to interview resident #4 on at 9:05 AM, he smiled but did not answer any questions. He was observed walking on his own.

Review of resident #4's record revealed he was admitted on . His health assessment, dated , documented a diagnosis of , communication , major , and history of . His assessment also indicated he was independent with all Activities of Daily Living (ADLs).

According to the administrator on at 11:00 AM, resident #4 was not independent with all ADLs and had a problem remembering when and where to urinate. He would forget to remove his pants when he sat on the commode. The administrator explained they covered the hardwood floors in resident #4s protect the floors and make it easier to clean up after accidents.

Review of the record for resident #4 revealed no documentation or notes about the resident's behaviors or and instances of notification to the health care provider or the family about these behaviors. There was no documentation indicating what actions the facility staff had taken to discourage , prevent or change the behaviors of resident #4. There were no notes or orders from the healthcare provider about an examinations, test results or changes in medications.

In an interview with the administrator on at 2:00 PM, who confirmed she did not document any of this in resident #4s record and did not document if she had notified the provider or family.

Class III

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

Based on resident record review and interview, the facility failed to provide a written 45-day notice of discharge, as required by regulation 428.29 (1) (k) F.S., for 1 of 2 sampled residents (#3).

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SUMMARY STATEMENT OF DEFICIENCIES
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Findings:

During a tour of the facility, the administrator stated resident #3 would be leaving soon. She said she had given the family a 45-day notice of discharge.

Record review for resident #3 did not reveal any notes or documentation of a notice of discharge.

In an interview with the administrator on at 1:00 PM, she stated that on she had sent a text to the son of resident #3, the power of attorney for the resident, notifying him that she was giving him 45 days' notice to relocate the resident. She confirmed she did not have this in writing.

Class III

**0078 - Staffing Standards - Staff - 58A-5.019(2) FAC**

Based on personnel record review and interview the facility failed to obtain an annual statement from the health care provider for 1 of 2 sampled Staff (#B) documenting freedom from communicable . . . . . and ( ).

Findings:

Personnel record review for Staff B (caregiver, hired ), revealed no documentation to confirm freedom from communicable . . . . . or .

On . . . at 1:40 PM, the administrator confirmed that the documentation was not in the records.

Class III

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

Based on personnel record review and interview, the facility failed to ensure that 1 of 2 sampled staff who provide direct care (#B) received the required in-service training within 30 days of employment.

Findings:

Personnel record review for caregiver Staff #B, hired , revealed there was no documentation to confirm he had completed the required in-services covering: 1) providing assistance with the activities of daily living, or 2) the facility's elopement response policies and procedures.

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On . . . at 1:45 PM, the manager confirmed the finding.

Class III

**0162 - Records - Resident - 58A-5.024(3) FAC**

Based on resident record review and interview, the facility failed to maintain a copy of the documentation of a resident's Power of Attorney (POA) on file for 2 of 2 sampled residents (#3 & #4).

Findings:

1. Record review for resident #3 revealed the son signed the contract and consents. Further review revealed no documentation of the appointment of a Power of Attorney in the record.

2. Record review for resident #4 revealed the daughter signed the contract and consents. Further review revealed no documentation of the appointment of a Power of Attorney in the record.

In an interview with the administrator on , who confirmed she had did not have copies of the POA for resident #3 and #4.

Class III

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

Based on 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 2 of 2 sampled staff employees (A, B)

Findings:

Review of the Agency's Background Screening website for 2 sampled staff revealed that no roster had been created for the facility.

In an interview with the administrator on at 2:30 PM, who confirmed the findings.

Unclassified