STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943128	R **11/09/2017**
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

A follow-up to complaint investigation #2017009807 was conducted on . St. Mary's Home, license #4860, had deficiencies pertaining to this investigation at the time of the visit.

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

Based on observation and interview, the facility failed to provide for the care and supervision of their 11 residents by not maintaining trained and qualified staff in the facility at all times.

Findings:

Upon arrival at the facility on at 8:40 AM, resident #10 answered the door and instructed the surveyor to go to the administrator's office. No one was in the office. None of the residents knew where the administrator was.

Observation of the staffing in the facility on 11/ at 8:40 AM did not reveal any resident care staff on duty. Staff C was in the kitchen and did not answer or acknowledge questions. Staff D was in the backyard painting the sidewalk trim. Resident #2 identified the people as the parents of the administrator. She looked in the backyard and said the administrator's car was gone, so he must have gone out.

Neither staff C nor D spoke English and did not answer any questions. At 8:45 AM on , resident #2 said staff C cooked their meals and staff D did gardening and painting.

On at 9 AM, resident #5 said she did not know who to call in case of an emergency, "I guess I could call my sister."

The administrator arrived at the facility at 10:10 AM on . He stated he just went grocery shopping and brought in boxes of frozen dinners and put them on the kitchen floor.

Review of the staff schedule for the week of 1-7, 2017 revealed staff C and D were listed on the facility schedule.

On at 12:20 PM, the administrator stated, "My parents [staff C & D] are getting too old and they are not really helping with the residents. My mom [staff C] cooks and my dad [staff D]does the garden. They do not assist with medications or provide care for the residents." The administrator confirmed he understood staff hours meant resident care, and not housekeeping, cooking or gardening. The administrator confirmed that he left the facility without anyone in supervision of the residents.

Class II

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

Based on record review and interview, the facility failed to follow the facility's Elopement policy and procedures and did not have photographs of residents at risk for elopement on record.

Findings:

Tour of the facility on revealed that all residents were present.

Review of the Elopement Policy and Procedure for the facility on found, among other requirements, the facility would obtain a current photograph of each resident at risk for elopement and attach it to their demographic data sheet in the notebook labeled "Resident at Risk for Elopement" at the reception desk. Someone other than the administrator signed the policy on .

In an interview with the administrator on at 11:30 AM, he confirmed he did not have photos of each of the residents at risk for elopement, and did not have a book to contain this information. He confirmed he did not know the policy contained those things. He did not explain why it was not his signature on the policy.

Class III

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

Based on observation, record review and interview, the facility failed to provide staffing for resident care and supervision that met the minimum requirements as required.

Findings:

Observation of the staffing in the facility on 11/ at 8:40 AM did not reveal any resident care staff on duty. Staff C, in the kitchen, did not answer or acknowledge questions. Staff D, in the backyard, painted the sidewalk trim. Residents identified the people as the parents of the administrator. Neither staff answered questions.

Review of the staff schedule for the week of 1-7, 2017 revealed staff C and D were listed on the facility schedule. Staff A, C and D were on the schedule to each work 24 hour shifts on ,

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, . Staff A was scheduled for 24 hours on . Staff C and D were scheduled for the 8 AM-8 PM shift on . Staff A, C and D were listed off on 11/ , and . Staff B was on the schedule to work 24 hour shifts on , , . Staff B was listed off on , , and .

Staff B, C and D did not have eligible Level 2 Background screening results in their files or on the Agency for Health Care Administration's Clearinghouse website.

Staff hours remaining for the facility equaled 96 hours, all from staff A. The facility had 11 residents and required 212 staff hours for resident care.

In an interview with the administrator on at 12:20 PM, he stated, "My parents are getting too old and they are not really helping with the residents. My mom [staff C] cooks and my dad [staff D] does the garden." The administrator confirmed he understood staff hours meant resident care, not housekeeping, cooking or gardening.

Class III

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

Based on review of the Agency for Health Care Administration's (AHCA) 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:

Review of AHCA's BGS website was reviewed for the facility's employee roster. The roster contained only the name of the administrator.

On at 11:30 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 15-day Adverse Incident Report timely through the Agency for Health Care Administration's (AHCA) internet site for 1 of 4 sampled resident (#2).

AGENCY FOR HEALTH CARE ADMINISTRATION

PRINTED: 12/01/2017
FORM APPROVED

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Findings:

Review of the resident #2's record revealed 2 different hand written Day 1 Adverse reports for the elopement of resident #2.

One report was dated and reflected that they noticed resident #2 was missing at 6:30 AM on , and contacted the family after a search of the facility. The report reflected they contacted police at 10 AM to report a missing person.

The other report was dated and reflected resident #2 was noticed to be missing at 6 AM and they contact the resident's sister. The report reflected that the facility contacted police in the late afternoon and the resident's case worker. The report reflected a police investigation was opened on .

In an interview with the administrator on at 10:45 AM, he stated he did not know how to use the computer to send the report, and so he still had not submitted the Day 1 report electronically. He also said he did not know why there were 2 reports for Day 1. He said he did not know about submitting a report for Day 15.

Unclassified