STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968987	**12/20/2017**
NAME OF PROVIDER OR SUPPLIER **ASTORIA ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **319 ELDRIDGE AVE** **ORANGE PARK, FL 32073**	

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

0000 - Initial Comments

Two complaint investigations (CCR #2017011031 and #2017014182,) were conducted on and at Astoria Assisted Living Facility (Lic # 12817). Astoria Assited Living Facility had deficiencies at the time of the investigation.

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation, interview, and record review, the facility failed to ensure a safe living environment, free of hazards for the 57 current residents, with the potential to affect any future residents of the facility.

The findings include:

During a tour of the facility on , 35 were observed to be unoccupied by residents, being empty, used for storage or under renovation. The remaining were currently occupied by the 57 residents at the time of the survey.

At 3:30 pm on , the Administrator stated during an interview that he was aware of a case of within the facility, which was assessed by the Department of Health (DOH). He was tasked with purchasing new shower head filters for the facility. During that time he was not acting as the Administrator; but he was made aware that the facility was supposed to replace the filters.

During an interview with the Health and Wellness Director on at 9:35 am she was asked about the . She stated that she was notified by a representative from DOH that everything was clear from the investigation that was done in . When asked if she had documentation of the notification from DOH saying the facility was cleared, she stated she had no documentation of it.

During an interview with Resident #1 on at 9:40 am, he stated, he had lived here roughly one year. He was not aware of the staff changing out the filter on his shower head. He was not aware of the DOH investigation of in the facility. He was unaware of at the time of the interview.

An interview was conducted with the Administrator on at 9:45 am. He was asked for evidence the facility had complied with DOH regarding the remediation. He stated he looked last night after this surveyor left the facility for any documentation to indicate that the facility had conducted the remediation for the growth of (as outlined by DOH). He could not find any documentation to support the facility. He knew the shower filters were being used, because he ordered them. When

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asked if the facility was documenting the use of the shower filters, he shook his head. He could not find any. When asked if any other efforts were made to remediate, he shrugged his shoulders and stated, "It wasn't done."

A phone interview on at 10:28 am with the epidemiologist from DOH, who the HWD referenced in her interview at 9:35 am. She confirmed that a case of Legionnaires was identified in , 2017 in a resident from this facility. The resident had been treated for , at a local hospital. She stated their department had conducted a complaint investigation at this facility in , 2017 and found that there is one water main coming in from the city of Orange Park. It split in two with one going to the hotel next door, and one going to the Assisted Living Facility (ALF). She stated that based on their assessment, it was unclear whether it was originating from the hotel or ALF. Remediation was recommended, but at the time of this interview, they have not received any proof of remediation from the ALF.

Class II