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

Based on record review and interview the facility failed to ensure that a Level II background screening was completed for one (Staff B) of four employees who worked at the facility and had access to residents and resident living areas.

Findings included:

Review of the AHCA Background Screening Clearinghouse Agency website revealed that Staff B was not listed on the employee roster for the provider. Further review of the revealed that Staff B did not have a Level II background screening.

During interview with Staff B, on at 09:49 a.m., he stated that he does maintenance work at the facility, had removed items from one of the residents' and stated that he did not have a level II background screening.

During an interview conducted with Resident #6 on , he stated that Staff B "fixes things" throughout the facility and had recently fixed a closet in a resident's

interview with the Administrator, on at 06:17p.m., she confirmed that Staff B did not have a level II background screening.

Unclassified

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0000 - Initial Comments

Assisted Living Facility

An unannounced complaint (CCR#2017013097 & CCR#2017014427) survey was conducted in conjunction with a second revisit to a complaint survey on at Mari-Mar Manor 2 (License #10437), an Assisted Living Facility located in Saint Petersburg, Florida. There were deficiencies identified during the survey.

License #10434

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

Based on observation, record review and interview, the facility failed to maintain a general awareness of residents' well-being, maintain written documentation of changes in resident behavior and failed to maintain oversight of resident whereabouts for one resident (Resident #10) and left all of the facility residents unattended.

Findings included:

During an interview with Staff A on at 1:09 PM, Staff A reported that Resident #10 left the building about a week prior to the survey and did not report her whereabouts. Staff A stated she tried to follow Resident #10 for "a long time" and left the other residents alone in the facility while she tried to locate Resident #10. Staff A further stated that she notified the administrator about Resident #10 leaving the facility and the administrator told Staff A not to call the police. Staff A stated the police eventually found Resident #10 and Resident #10 was hospitalized under a .

During an interview with the Administrator on at 1:20 PM, the Administrator stated that "the residents are allowed out" and the facility did not notify the police when Resident #10 left the facility.

Class III

0026 - Resident Care - Social & Leisure Activities - 58A-5.0182(2) FAC

Based on observation and interview, the facility failed to provide an ongoing activity program with a

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minimum of twelve hours per week as required.

Findings included:

A focused Resident interview conducted on at 10:40am with Resident #4 revealed that, the Facility does not provide any activities. Resident #4 stated, "They don't provide any activities."

A focused Resident interview conducted on at 12:45pm with Resident #7 revealed that, the Facility does not provide any activities. Resident #7 stated, "They don't provide anything; we do our own thing."

A focused Resident interview conducted on at 05:40pm with Resident #8 revealed that, the Facility does not provide any activities. Resident #7 stated, "They do not provide any activities for us."

A review of the posted Activity Calendar on indicated a provision for activities in excess of the minimum of 12 hours per week requirement. The activities scheduled for indicated exercise to be from 10:00am - 11:00am and dominoes from 03:00pm - 04:00pm. However, no activities were observed during survey on .

During an interview on at 05:00pm, the Administrator acknowledged that the Facility does not offer activities. The Administrator stated, "The Residents do their own thing. They never showed up to anything so we stopped doing them."

Class III

0027 - Resident Care - Arrangement for Health Care - 58A-5.0182(3) FAC

Based on observation, interview, and record review, the facility failed to provide assistance in reminding one Resident (#4) of one sampled Resident about a scheduled appointment for medical services.

Findings Included:

An observation on at 10:40am of Resident #4's neck noted intact staples open to air, dry and intact with some dried around most of the staples with no signs of from recent surgery.

An interview conducted on at 10:40am discovered that Resident #4 did not know when staple removal appointment was and stated, "I'm not sure. I think it's Friday."

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A record review conducted on revealed a notation on the Agency for Health Care Administration Health Assessment Form 1823 indicating "staple removal on ".

An interview conducted on at 11:00am discovered the Administrator did not know when Resident #4's staple removal appointment was for or where and stated, "I'm not sure." The Administrator phoned the health care provider's office at 11:05am and found that the staple removal appointment had been scheduled on at 09:30am.

Class III

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

Based on observation, interview, and record review, that facility failed to:
(1) Provide a 45-day notice of residency termination, and failed to maintain resident's belonging indoor and secure for one resident (#9) who was discharged by the facility following an incident that involved theft and law enforcement;

(2) Ensure that residents were provided with a safe environment in which resident are treated in a dignified manner, free of bed bug infestation and free of resident on resident violence. Specifically, five of ten sampled residents (#2, #8, #3, #7 and #9) indicated that staff yells at them; and three of ten sampled residents (#2, #6, and #8) indicated that the Administrator failed to respond when they expressed their desire to leave, and told residents not to talk about their grievances to Agency staff at the facility. Three residents were involved in incidents with one another that caused injury with no follow-up or documentation by the facility. Residents also reported an ongoing problem with bedbugs.

(3) compensate residents in accordance with the minimum state and federal wage laws for two (Resident #3 and Resident #9) of two residents who were not paid at federal and state wage requirements for assisting with facility tasks that included cooking, cleaned and common areas, stripping and waxing common areas, and pouring concrete for the facility's outdoor patio.

Findings included:

On at 09:15 a.m., bags of personal clothing and belongings, including electronics, were observed outside of the facility in the grass. Items, including electronics were wet from the morning condensation.

During interview with the Administrator, on at 09:40 a.m., the Administrator confirmed that

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the items belonged to Resident #9, and stated that the resident was aware that his items were removed from his left outside overnight.
During interview with the Administrator, on at 09:16a.m, she identified Resident #9 as a former resident who "took off for 3 days, and signed that he will be staying with his (family)," after an incident that involved theft of a facility generator by the resident and involvement of law enforcement.

During interview with Staff B on at 09:49a.m., he stated that he does maintenance work at the facility and that he took all of Resident #9's belongings outside to clean the . He confirmed that the items were left outside overnight and no one was watching Resident #9's items. He confirmed that Resident #9's items were wet from condensation. He stated, "We sent him away after he stole the generator." He confirmed that Resident #9 did not know that the items were removed from his .

During interview with Staff A, on at 10:37 a.m., she stated that Resident #9 was "kicked out" of the facility for stealing.

Review of the hand written residency termination notice provided by the Administrator, revealed that tthe notice, addressed to Resident #9 was a 30-day notice and not a 45-day notice. Further review revealed that a signature, identified by the facility as Resident #9's signature, was on a document indicating that Resident #9 would be absent from the facility for the weekend.

During telephonic interview with Resident #9, on at 03:00p.m., he indicated that the facility kicked him out without providing a 45-day notice. He stated that he did not tell them that he was staying with his family and did not write or sign any document.

During interview with the Administrator, on at 04:11 p.m., she confirmed that it was a 30-day notice and not a 45-day notice. The Administrator stated that Resident #9 asked her for another chance, and confirmed that she gave him another chance and that was why he did not sign the 30-day notice. Administrator confirmed that she did not provide Resident #9 with another notice prior to telling him to leave the facility.

2. During interview with Resident #6, on at 09:55 a.m., he stated that the facility staff told him not to "say anything" to Agency staff during survey. He stated that he informed the Administrator that he wanted to leave the facility but the Administrator has not responded to his request.

During interview with Resident #2, on at 10:08 a.m., he stated that the Administrator threatened to remove him from the facility, and told him not to say anything about being yelled at by Staff

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A and the Administrator, or about an ongoing bedbug issue that the facility was experiencing. He stated, "I have been trying to get out of here. I have told them I wanted to leave here many times. They have not done anything. They have not helped me find another place. I am supposed to have a social worker. They never gave me the social worker's number."

Resident #2 also reported during the same interview that the facility is infested with bedbugs. Resident #2 stated that the only time the facility took any sort of action was after the last survey. Since then, the facility will spray "occasionally" but "it doesn't help."

During interview with Resident #8, on at 10:51 a.m., he stated that the Administrator told him not to say anything about any negative concerns during a survey by the Agency. He stated that he expressed his desire to leave the facility many times, but the facility will not help him or provide him with the phone number for his case manager. He stated that Staff A retaliated at residents by shouting at the residents, providing food late and giving medications late.

During interview with Resident #3, on at 11:22 a.m., he stated that Staff A and the Administrator yell at the residents.

During interview with the Administrator, on at 11:35 a.m., she stated that she documents resident complaints in resident records. Per the Administrator, only Resident #8 stated that he wanted to leave about a month ago. She confirmed that there was no documentation of Resident 8's request to leave in his record. The Administrator confirmed that Resident #8's request to leave was in writing and kept in his chart at one time, but the Administrator removed it when the resident rescinded his request to leave.

During interview with Resident #7, on at 03:40 p.m., she stated that Staff A and the Administrator yell at the residents.

During interview with Resident #2, on at 03:40 p.m., he reported recent incidents in which he was hit by other residents that included Resident #10, and Resident #5, who hit him with a wooden walking stick and slammed his head on the dining . Resident #2 was observed to have a on his left cheek, under his left eye.

During interview with Staff A, on at 03:45 p.m., she stated that she did not witness the hit but noticed the on Resident #2's face, and the she was informed about the incident by Resident #2. Staff A did not remember if law enforcement or paramedics were called.

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During interview with Resident #5 on at 03:56p.m., he confirmed that he hit Resident #2 in the face with a cane during one altercation, and slammed Resident #2's head on the dining during another. Resident #5 stated that he told the Administrator about it.

Record review for Resident #2 and Resident #5 revealed no documentation of the physical altercation for both residents, no follow-up with family or the health care providers for either resident or any assessment and treatment for the on Resident #5's left cheek.

During an interview with the Administrator, on at 04:11 p.m., she stated she did not report the incident or injuries to Resident #2's health care provider or to the familes for either Resident #2 nor Resident #5. She stated she did not remember if she reported either incident and said she did not think Staff A notified her about both incidents because Staff A didn't remember. In a continued interview, the Administrator stated no investigation was done because she was not told about the incident by Staff A.

3. During interview with Resident #6, on at 09:55 a.m., he stated that Resident #9 worked at the facility and performed tasks that included washing dishes, cooking for the residents, yard work, cleaning and helped with pouring the concrete for the facility's outside patio.

During interview with Resident #8 on at 10:51a.m., he stated that Resident #9, who poured the concrete, worked at the facility and performed tasks that included general handyman tasks and work on toilets.

During interview with Resident #8 on at 3:00 p.m. he stated that he worked at the facility and was paid "thirty or forty dollars, under the table", every Friday. He stated that he did not complete an application. He stated that he helped with the residents, cooked, cleaned , stripped and waxed the floor from the dining area to the back door, and helped Staff B with the concrete patio outside.

During interview with Resident #7 on at 03:22 p.m., she stated that Resident #9 worked for the owners; he worked on the concrete outside, he waxed the floor inside and sometimes cooked for the residents.

During interview with Resident #1 on at 03:22 p.m., she stated that she has seen Resident #9 working at the facility which included cleaning , cooking for the residents, working on the concrete patio and waxing the facility floor.

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During interview with Staff A, on at 03:27p.m., she stated that Resident #9 worked at the facility. He waxed the floor, swept and mopped common areas and kitchen once or twice a week, and cooked for the residents. She stated that the Administrator paid him, but was not sure of the amount.

During interview with Resident #3 on at 03:04 p.m., he stated that he cleaned three , once or twice a week, and he was given fifteen dollars a week when done. He stated that Resident #9 and Staff B worked on the concrete patio outside.

During interview with Resident #2, on at 03:40 p.m., he stated that Resident #9 stripped and waxed the floor, cooked for residents, cleaned the kitchen and .

During interview with the Administrator, on at 04:11p.m., she stated that Resident #9 cleaned the floor, cooked for the residents, and assisted Staff B with carrying materials for concrete patio outside. She stated that when he was doing that, he got probably dollars per week, for cigarettes. She stated that Resident #9 helped strip and wax the floors and the total amount paid was $300 in cash. The Administrator stated that Resident #3 cleaned in other residents' , and she would give him money for cigarettes. She stated that she gave him $5 dollars per day for couple of resident cleaned.

Class II

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on interview and record review, the facility failed to ensure that Medical Observation Records (MORs) were updated each time a medication (med) was offered and were accurate, and free from omissions and errors for five Residents (#1, #2, #4, #5 and #6) of five sampled Residents.

Findings Included:

A MOR review conducted on revealed that Resident #1's med 50mg tablet was orderd to take one tablet three times every day as needed. There was no documentation on the MOR that Resident #1 received this medication. At 01:30pm, the Assistant Administrator stated that it is seldom that Resident #1 takes the for pain. Resident #1 stated on at 1:55 PM that he does take the three times a day for heel pain due to a .

A MOR review conducted on revealed that Resident #2 (admitted) meds ordered included , , 5 mg tablet twice daily and , 5mg tablet twice daily. On , Resident #2 had a new order for 30mg tablet three times daily. Resident #2, who needs

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assistance with self-administration of meds did not have a MOR for 2017.

A MOR review conducted on revealed that Resident #2's 2017 MORs (See Photographic Evidence4) found that prescribed 5mg tablet and 5mg tablet had not been documented as given through . Also 2017 MORs revealed that Resident #2 had a new order for 30mg which the Pharmacy filled on . Resident #2's MOR showed documentation that the was given on @08:00am - 02:00pm - 08:00pm and on @08:00am - 02:00pm - 08:00pm.

An interview with Resident #2 on at 12:35 revealed that Resident #2 does not receive meds as prescribed. Resident #2 stated that, "I get one pill every day."

A med cart audit conducted on revealed that Resident #2 had two unopened medication packs. One med pack was for prescribed 5mg filled on . The other med pack was for prescribed 30mg filled . No med pack for prescribed found.

A phone interview was conducted on at 10:45am with the Pharmacy Intern, who stated that the Pharmacy never sent meds for Resident #2 because the facility did not provide the insurance information after several requests. Pharmacy Intern stated that the Facility provided that information this morning ( ) and the Pharmacy would be sending the meds for Resident #2 today.

A MOR review conducted on revealed that Resident #4 (admitted) who needs assistance with self-administration of meds did not have a MOR for 2017 to be up-dated each time the Facility offers a med. At 10:40 am Resident #4 stated that, "I'm not on any medications." Four med packages (B1, , 81mg, and 40mg) for Resident #4 were found in the med cart unopened and filled on .

A MOR review conducted on revealed that Resident #5 had a new order on for 250mg "take two tablets today and one tablet every day for four days." The Pharmacy filled the on . The med was signed as given on , , and and there were no signatures indicating Resident #5 received the on and . A med cart audit on revealed that there continues to be four tablets of that were not distributed to Resident #5 (See Photographic Evidence3).

A MOR review conducted on revealed that Resident #6 had the following meds not documented as given on at 08:00am: , 0.5mg, 250mg, and 300mg. The prescribed Polyethylene Powder due at 08:00am every

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morning had no documentation that this med was given to Resident #6 from through .

In an interview conducted on at 12:39pm, the Assistant Administrator confirmed and acknowledged the MOR documentation errors and lack of MORs but was unable to provide further documentation or explanation. In regards to Resident #4's missing MOR the Assistant Administrator stated that, "I know, I made a hand written one for him." No document was presented for review during the survey.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on interview and record review, the facility failed to follow prescription medication orders and obtain newly ordered medications in a timely manner for four Residents (#2, #5, #6, and #8) of five sampled Residents who need assistance with self-administration of medications (meds).

Findings Included:

A med cart audit conducted on revealed that Resident #2 had two unopened med packs. One med pack was for prescribed 5mg filled on . The other med pack was for prescribed 30mg filled . No med pack for prescribed was found (See Photographic Evidence4).

An interview with Resident #2 on at 12:35 revealed that Resident #2 does not receive meds as prescribes. Resident #2 stated that, "I get one pill every day."

In a phone interview conducted on at 10:45am, the Pharmacy Intern stated that the Pharmacy never sent meds for Resident #2 because the facility did not provide the insurance information after several requests. The Pharmacy Intern stated that the Facility provided that information this morning ( ) and the pharmacy would be sending the meds for Resident #2 today.

A Medication Observation Record (MOR) review conducted on revealed that Resident #5 had a new order on for 250mg take two tablets today and one tablet every day for four days. The Pharmacy filled the on . The med was signed as given on , and and there were no signatures indicating Resident #5 received the on and . A med cart audit revealed that there continues to be four tablets of for Resident #5 (See Photographic Evidence3).

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A MOR review conducted on revealed that Resident #6's prescribed med 50mg tablet "take three tablets by mouth three times every day" was changed to once a day at bedtime on the MOR. Resident #6's record did not contain an order for this change in frequency. Resident #6's prescribed med 300mg capsule take two capsules twice every day was changed to two capsules in the morning and one cap in the evening. Resident #6's record did not contain an order for this change in frequency (See Photographic Evidence5).

A med cart audit conducted on discovered a med pack for Resident #8 of prescribed 500mg capsule take one capsule by mouth three times every day for 10 days (equivalent to 30 capsules). The Pharmacy filled 30 capsules of for Resident #8 on . There were seven capsules remaining in the med pack for Resident #8 (See Photographic Evidence2).

During an interview conducted on at 12:39pm the Assistant Administrator confirmed and acknowledged the unopened/unused and medications for Resident #2. At 05:45pm, the Administrator and Assistant Administrator were unable to provide documentation, med orders, or explanations for Resident #5 not receiving as prescribed; documentation or orders to change Resident #6's and times; and, documentation or explanations for Resident #8 not receiving as prescribed.

Class III

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

Based on record review and interview, the facility failed to meet the minimum staff hours per week for four consecutive months (to) reviewed for staffing hours reviewed for a facility census of nine or ten residents. In addition, the facility failed to maintain an accurate staffing schedule, reflecting the current staffing in the facility.

Findings included:

Review of facility schedule for the months of , , , , and indicated that Staff C worked 64 hours per week and the Assistant Administrator worked 72 hours per week.

During an interview with the Administrator and the Assistant Administrator on at 05:56p.m., the Assistant Administrator stated that she returned to the United States from the Philippines on at night. The Administrator confirmed that the Assistant Administrator was listed on the direct

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staff schedule for the past four months, although she was in the Philippines.

During telephonic interview with Staff C, on at 07:35p.m., she stated that she had not worked at the facility for about one year.

During interview with the Administrator, on at 08:35 a.m., the Administrator confirmed that Staff C has not worked any on the days indicated on the schedule since of 2017.

Review of the facility schedule and the direct care staffing hours, excluding the non-employee (Staff C), and the Assistant Administrator revealed that the facility had the Administrator scheduled for 52 hours per week; and Staff A, who lived in the facility scheduled for 40 hours per week. Collectively the Administrator and Staff A were scheduled for a total of 92 hour per week. The required hours for a census of nine or ten residents is 212 hours.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation, interview, and record review the facility failed to document the lunch meal substitution before or when the lunch meal was served and failed to keep a substitution log for 6 months.

Findings Included:

A lunch meal observation conducted on at 12:30pm revealeded that the meal consisted of chicken and dumplings, sandwich, banana, and milk. The posted menu indicated that the meal should be chicken tenders, Au Gratin potatoes, carrots, chocolate pudding (no concentrated sweet: unsweet pudding), white bread, and tea/water.

A staff interview conducted with Staff A on at 12:32 revealed that Staff A does not follow the posted menu every day. Staff A stated that the menu was not followed for breakfast on nor followed on .

A review of the substitution logon on revealed no entry for or . The last substitution entry made was 2017.

During a staff interview conducted on at 04:40pm with the Assistant Administrator, the Assistant Administrator confirmed and acknowledged that the substitutions for and were not documented.

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Class III

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

Based on interview and record review, the facility failed to ensure that the facility maintained medication (med) orders within Resident records for five (#1, #2, #4, #6, and #8) of five sampled Residents.

Findings Included:

A med cart audit and MOR review conducted on for Resident #1 revealed a discrepancy with the prescribed 25mg tablets. Both the med label on and Medication Observation Record (MOR) read 25mg tablet take half tablet twice a day. The last order found in Resident #1's record is for 25mg tablet take one tab twice a day. Resident #1 needs assistance with self-administration of meds.

A MOR review conducted on revealed that Resident #2 did not have a MOR record for 2017. Resident #2 needs assistance with self-administration of meds. The Assistant Administrator brought Resident #2's 2017 MORs during survey at approximately 01:00pm. Resident #2's MORs reflected dates that he received his meds and signed by the Assistant Administrator for dates that she was out of the country.

A MOR review conducted on revealed that Resident #4 did not have a MOR record for 2017. Resident #4 needs assistance with self-administration of meds.

A MOR review conducted on revealed that Resident #6's prescribed med 50mg tablet take three tablets by mouth three times every day was changed to once a day at bedtime on the MOR. Resident #6's record did not contain an order for this change in frequency. Resident #6's prescribed med 300mg capsule take two capsules twice every day was changed to two caps in the morning and one cap in the evening. Resident's record did not contain an order for this change in frequency. Resident #6 needs assistance with self-administration of meds

A record review conducted on revealed that Resident #8's record did not contain a list of medications. Resident #8 needs assistance with self-administration of meds.

During an interview on at 05:45pm, the Administrator and Assistant Administrator were unable to: produce orders for med changes for Resident #1 and Resident #6; produce a med list for Resident #8; and, provide a 2017 MOR for Resident #4. The Assistant Administrator

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	AL11966202	**12/20/2017**
NAME OF PROVIDER OR SUPPLIER **MARI-MAR MANOR 2**	STREET ADDRESS, CITY, STATE, ZIP CODE **493 8th AVENUE NORTH SAINT PETERSBURG, FL 33709**	

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

confirmed that she was out of the country on the dates that she signed meds as given on Resident #2's MORs.

Class III

0163 - Records - Resident, Penalties for Alteration - 429.49 FS

Based on record review and interview, that facility altered, or falsified documentation in attempt to cover failure to meet minimum requirements. Specifically, (1) the Assistant Administrator documented that she provided medications to one resident (#2) during dates that the Administrator was out of the country; (2) The Administrator created a false direct care staffing schedule that included one person (Staff C) who did not work at the facility, and the Assistant Administrator who was out of the country; (3) The Administrator provided a communicable and assessment for Staff C, who confirmed that she did not complete it, and; (4) The Administrator provided a signed absentee letter for Resident #9, who indicated that he never signed the letter.

Findings included:

1. On at 09:16a.m., the Assistant Administrator stated she returned on from a three or four month trip out of the country.
Review of the Medication Observation Report (MOR) for Resident #2 revealed that the Assistant Administrator documented that the medication was given to Resident #2 from to .

During an interview with the Assistant Administrator on at 12:23p.m., she stated that she was physically in the facility and she was the one that passed the medication and documented in the MOR from to .

During interview with Staff A on 12:32p.m., she stated that the Assistant Administrator has not assisted with medications for the month of or for several months before, as she was out of the country. Staff A reviewed the MOR for Resident #2 and stated that the medication was not there and needed to be refilled, but she documented that it was given to the resident. She confirmed that she did not document the MOR from (night) to the current date and that those dates did not have any initials. She stated that the Assistant Administrator's signature was not on the MOR for Resident #2 prior to the day of survey. Staff A confirmed that the Administrator did not or was not present during med pass from , 2017 to , 2017.

During interview with the Assistant Administrator on at 05:56p.m., the Assistant Administrator stated that she returned to the United states on at nighttime. When asked about the MOR with

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her initials on the dates that she was out of the country, she confirmed that she wrote her initials during the survey on .

2. Review of the facility schedule for the months of , , , , , and indicated that Staff C worked 64 hours per week; and the Assistant Administrator worked 72 hours per week.

During interview with Staff A, on at 10:37a.m., she stated that she works and lives at the facility. Staff A reviewed the facility schedule and was not able to recall Staff C working. Staff A stated that Staff C did not work at the facility and the Assistant Administrator has been out of the country for months.

During interview with the Administrator and the Assistant Administrator on at 05:56p.m., the Assistant Administrator stated that she returned to the United States on at nighttime. The Administrator confirmed that the Assistant Administrator was listed on the direct staff schedule for the past four months, although she was out of the country. The Administrator stated that Staff C was an employee at the facility.

During telephonic interview with Staff C, on at 07:35p.m., she stated that she had not worked at the facility for about one year.

During interview with the Administrator, on at 08:35 a.m., the Administrator confirmed that Staff C only worked at the facility for a couple of hours, cooking in . She confirmed that Staff C has not worked any on the days indicated on the schedule since of 2017. The Administrator stated that was aware that she lied to surveyor about the schedule and staffing, and that she did it to be in compliance for the Agency when they are at the facility during survey.

3. Record review for Staff C revealed documentation that indicated completion of a communicable and ( ) examination on by a health care provider.

During telephonic interview with Staff C, on at 09:25 a.m., she stated she completed her communicable statement on . She confirmed that she did not complete her and communicable examination dated . She did not know who the health care provider was when the name was provided and she did not know why the facility would have that document since Staff C had not worked at the facility for the past year.

During interview with the Administrator, on at 09:28 a.m., the Administrator stated that she

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did not know if the health care provider had actually seen Staff C when he completed the form dated , and stated, "He knows her, maybe he just wrote it." The Administrator could not remember how she received the examination dated .

During interview with the health care provider on at 1:56 p.m., he stated that the assessment for the Administrator and Staff C was completed six month prior, and he compiled the letters on . He stated that the Administrator and Staff C came to his house and he conducted a medical screening based on a physical assessment. He confirmed that he did not perform any exam. The health care provider stated, "I was just doing a personal favor. Based on what they told me, it was their employees. I didn't check her I.D.; I just went off introductions. I don't recall verifying who she was, I just went off what they said."

4. During interview with the Administrator, on at 09:16a.m, she identified Resident #9 as a former resident who "took off for 3 days, and signed out that he will be staying with his (family member)," after an incident that involved theft by the resident and involvement of law enforcement.

During telephonic interview with Resident #9, on at 03:00p.m. he indicated that the facility kicked him out without providing a 45- day notice. He stated that he did not tell them that he was staying with his family member and did not write or sign any document.

Review of Resident #9's signature on the Facility's "Policy and Procedure of Grievance and Complaint", signed by Resident #9, in the presence of Agency staff during a prior survey, revealed that the signatures did not match the signature on the alleged note from Resident #9 that indicated that he is staying at his family member's for several days.

On at 05:43 p.m. Resident #9 arrived back at the facilty to pick up his belongings. He was shown an image of the letter and he stated that it was not his signature, and that the facility had kicked him out without providing a 45-day notice.

Class III

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 complete an Adverse Incident Report with the Agency following an elopement for one resident (#10) that placed the resident at risk of harm and resulted in a hospitalization under a .

Findings included:

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During interview with Staff A on at 01:09 p.m., she indicated that Resident #10 hit her and left the facility one week prior on . She stated that she called the Administrator who told Staff A not to call the police.

Record review of the facility notes for Resident #10, dated , indicated that Resident #10 left the facility without permission from staff, and that Resident #10 was picked up by paramedics at 10:00 p.m. away from the facility, and taken to the hospital.

During interview with the Administrator and Assistant Administrator on at 01:19 p.m., the Assistant Administrator stated that Resident #10 was to a hospital after she left the facility and was found, sleeping on the bench, by law enforcement. The Administrator confirmed that Staff A called and informed her, but law enforcement was not notified by the facility, and that it was Resident #10's family that notified that facility that the resident was taken to the hospital. Both the Administrator and the Assistant Administrator confirmed that the elopement was not reported to the Agency.

Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on observation and interview, the facility failed to submit a Certified Emergency Management Plan (CEMP) for approval to the local emergency management agency.

Findings Included:

During an observation conducted on at 09:30am, the facility had a posted CEMP that had expired .

An interview conducted on at 2:18pm revealed the Facility had not submitted the CEMP to the County's Emergency Management Agency. The Administrator stated that, "no we have not submitted it yet".

Class III