STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967903	**05/01/2018**
NAME OF PROVIDER OR SUPPLIER **ALL SENIORS ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **2706 PIONEER ROAD** **ORLANDO, FL 32808**	

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

0000 - Initial Comments

A Biennial Relicensure survey with Limited Mental Health (LMH) and Limited Nursing Service (LNS) was conducted on and . All Seniors Assisted Living, License #11853, had deficiencies at the time of the survey.

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

Based on observations, record reviews, and interviews, the facility failed to provide adequate supervision to a resident who eloped from the facility (#9).

Findings:

Observations made on at 9:45 a.m. revealed resident #9 repeatedly told caregiver C that he had to go to the Social Security office.

On at 11:17 a.m., the man who was doing lawn care at the facility knocked on the front door and informed caregiver C that resident #9 left the facility and walked toward a busy 6 lane roadway. Caregiver E drove a vehicle to see if resident #9 could be located. Caregiver C said the resident exited the facility by way of a side gate that had been unlocked for the lawn company. Caregiver C said the lawn man was always told to make sure none of the residents got out.

On at 11:28 a.m., Caregiver E was unable to locate the resident so caregiver C called 911 to assist in the search.

On at 11:39 a.m., an Orange County Sheriff's officer arrived to the facility and said the resident was located at a bus stop a half of a mile from the facility. He further stated the resident's intentions were to go to the Social Security office. The resident was returned to the facility by a Sheriff's deputy.

Resident #9's record contained a facility note, dated on , that indicated the resident was missing from the facility and police were contacted. The resident was found by the police walking towards the facility on the busy 6 lane roadway. The resident had gone to a grocery store to buy snacks and said he would not leave the facility again without notifying someone where he was going.

The facility's inadequate supervision of resident #9 directly threatened the resident's physical safety.

Class II

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

Based on record review and interview, the facility failed to honor the rights of 2 of 2 sampled residents and restricted visiting hours (#4 & 9).

Findings:

Review of the resident bill of rights in the contract for residents #4 and #9 revealed the residents were allowed to have visitors until 8 p.m. However, at a minimum, the facility was required to allow visitors until 9 p.m.

On at 3 p.m., the administrator confirmed the findings.

Class III

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

Based on observation, record review, and interview, the facility failed to make a daily effort to determine that a resident who was at risk for elopement had identification on their person that included their name and the facility's name, address, and telephone number and failed to conduct a minimum of two resident elopement prevention and response drills per year (#4).

Findings:

1. Resident #4's most recent health assessment form 1823, dated on , indicated the resident was at risk for elopement.

Observations made of resident #4 on at 1:30 p.m. revealed the resident did not have identification (ID) on her person. The administrator confirmed and said resident #4 removed her ID bracelet and it was in resident #4's . A search of the resident's caregiver C did not produce an ID bracelet.

2. Review of the facility's documented elopement drills on at 1:45 p.m. revealed the facility conducted drills on , , and . On at 1:53 p.m. the administrator confirmed a minimum of two resident elopement prevention and response drills were not conducted per year, as required.

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Class III

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

Based on observations, record review, and interview, the facility failed to ensure the Medication Observation Record (MOR) was updated immediately after giving medications to a resident who required assistance with self-administered medications (#1).

Findings:

Observations made during a medication pass for resident #1 on at 8:45 a.m. revealed unlicensed caregiver C signed the MOR after each time that she poured the medication into a cup and not immediately after she gave resident #1 his medications, as required.

On at 10:38 a.m., caregiver C confirmed the findings.

Class

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

Based on personnel record review and interview, the facility failed to ensure that 2 of 4 sampled staff received the required in-service training within 30 days of hire (B & D).

Findings:

Caregiver B's personnel record revealed a hire date of . Caregiver D's personnel record revealed a hire date of . Neither personnel record contained documented evidence to indicate caregivers B and D received in-service training that covered the facility's emergency procedures including chain-of-command and staff roles relating to emergency evacuation.

On at 2:45 p.m., caregiver C confirmed the findings.

Class III

0082 - Training - / - 58A-5.0191(3) FAC

Based on personnel record reviews and interview, the facility failed to ensure 1 of 4 sampled staff completed a one-time education course on ( ) and Acquired

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Deficiency ( ) within 30 days of employment (B).

Findings:

Caregiver B's personnel record revealed a hire date of but did not contain documented evidence to indicate caregiver B completed a one-time education course on and , as required.

On at 2:45 p.m., caregiver C confirmed the findings.

Class III

0083 - Training - First Aid and - 58A-5.0191(4) FAC

Based on review of the facility staffing schedule, personnel record reviews, and interview, the facility failed to ensure a staff member who held a current valid ( ) and First Aid card was in the facility at all times (B).

Findings:

Caregiver B's personnel record did not contain documented evidence to indicate she held a current and First Aid card.

Review of the facility's staffing schedule revealed caregiver B was scheduled to work alone in the facility on from 4 p.m. to 5 p.m.

On at 3 p.m., the administrator confirmed caregiver B worked alone during that time and caregiver C confirmed the lack of a valid and First Aid card.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on personnel record reviews and interview, the facility failed to ensure that an unlicensed caregiver who provided assistance with the resident's medications, received the annual 2 hours of continuing education on providing assistance with self-administered medications and safe medication practices in an assisted living facility (B).

Findings:

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On at 9:40 a.m., unlicensed caregiver B said she assisted the facility's residents with self-administered medications.

Caregiver B's personnel record contain a 2-hour certificate of completion, dated on , on providing assistance with self-administered medications but did not contain a 2-hour certificate of completion for 2018.

On at 2:45 p.m., caregiver C confirmed the findings.

Class III

0086 - Training - ADRD - 58A-5.0191(9) FAC

Based on observations, personnel record reviews, and interview, the facility failed to ensure 3 of 3 direct care staff received 's and Related (ADRD) level 1 training within three months of employment and level 2 training within nine months of employment (B, C & D).

Findings:

Review of personnel records on revealed caregiver B was hired on , caregiver C was hired on , and caregiver D was hired on .

Observations made on at 3:30 p.m. revealed caregiver C had to punch a code into a key , by the front door to allow the surveyors to exit.

During a phone interview with the administrator on at 12:15 p.m., she said all of the facility's exits were secured. A request was made for the administrator to send an email to the surveyor by at 10 a.m. that included documented evidence that caregivers B, C, and D received ADRD levels 1 and 2 trainings.

On , an email was received from the administrator. The email contained an attachment of training certificates for caregivers B, C, and D, all of which were dated on , on "level one, four hour training." However, the certificates did not contain the curriculum approval number and the training provider's approval number to indicate the training and provider were approved by the Department of Elder Affairs. The email did not contain documentation to indicate caregivers B, C, and D received ADRD level 2 training.

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Class III

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

Based on observations and interviews, the facility failed to provide and maintain a home-like and decent environment in which to provide a safe living environment for 3 of 6 sampled resident (2, & & 8).

Findings:

Observations during an interview with a resident in revealed the mini blinds were missing a large amount slats, anyone passing by could see inside of the the openings. In and 8, the mini blinds were missing slats.

On at 3:30 PM, the administrator confirmed the findings.

Class III

0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS

Based on record reviews and interview, the facility failed to ensure the documentation in 2 of 2 sampled residency contracts was accurate (#4 & 9).

Findings:

Resident #4's residency contract was signed and dated on . Resident #9's residency contract was signed and dated on .

Both contracts read, "If at least 45 days written termination notice is given, a refund will be made within 45 days of termination. If less than 45 days notice is given, the resident will be charged for 45 days from the date the notice is received and a refund will be made within 45 days of discharge."

Facility residents were only required to provide 30 days notice of termination. Therefore, the information in the contracts was inaccurate.

On at 2:45 p.m., the administrator confirmed the findings.

Class

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L241 - LMH - Records - 429.075(3-4); 58A-5.029(2) FAC

Based on record review and interview, the facility did not maintain an up-to-date admission and discharge log identifying all Limited Mental Health (LMH) residents, did not obtain an appropriate placement health assessment provided by the resident's mental health care provider, and a completed Alternate Care Certification for [redacted] form, CF-ES Form 1006 and community living support plan and [redacted] agreement for 1 of 1 sampled Limited Mental Health residents (#9).

Findings:

Review of the admission and discharge log revealed there were no residents identified as LMH residents.

On [redacted] at 10:30 AM, the administrator said 3 residents received [redacted] and also received Social Security due to a mental [redacted]. She said she was not aware that they were to be identified as LMH residents.

Resident #9's record identified her as an LMH resident, but there was no a appropriate placement health assessment provided by the resident's mental health care provider, a completed Alternate Care Certification for [redacted] form, CF-ES Form 1006, community living support plan annually, and [redacted] agreement available for review.

On [redacted] at 2 PM, the administrator confirmed the findings.

Class III

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(8) FAC

Based on personnel record reviews and interview, the facility failed to ensure 3 of 4 staff received a minimum of 3 hours of continuing education in Limited Mental Health biennially (B, C & D).

Findings:

Review of the facility's posted license on [redacted] revealed the facility held a Limited Mental Health (LMH) specialty license.

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Caregiver B's personnel record revealed a hire date of . Caregiver C's personnel record revealed a hire date of . Caregiver D's personnel record revealed a hire date of .

All of the records contained documentation to indicate caregivers B, C, and D received only 2 hours of continuing education in LMH on .

On at 2:45 p.m., the administrator confirmed the findings and said she thought the continuing education requirement was for only 2 hours.

Class III

Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC

Based on personnel record reviews, review of the agency's background screening website, and interview, the facility failed to maintain the current results of a background screening in the personnel record for 1 of 4 staff who was in a role that required a background screening (D).

Findings:

Caregiver D's personnel record revealed a hire date of , and an eligible background screening dated . A new screening was required in 2016.

Review of the agency's background screening website on at 2 PM revealed staff D had an eligible screening dated but this screening was not in the personnel record as required.

On at 2:30 PM, staff C confirmed the finding.

Unclassified