STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966607	**05/29/2018**
NAME OF PROVIDER OR SUPPLIER **HERON HOUSE OF LARGO**	STREET ADDRESS, CITY, STATE, ZIP CODE **2050 EAST BAY DRIVE** **LARGO, FL 33771**	

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

Based on record review and interview, the background screening results for one of five staff sampled (J) was not available in their file.

Findings include:

An employee file review during the investigation found no Level 2 background screening report in the record of Staff J (hired). Although an online screening request was made, and an "eligible" outcome was found, no hardcopy had been placed in the staff member's file.

Interview with the director of administration at 2:30pm provided no clarification.

UNCLASSIFIED

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0000 - Initial Comments

Assisted Living Facility

A complaint investigation (CCR 2018002063, 2018004475, and 2018006105) was conducted at Heron House of Largo on in conjunction with a revisit to complaint CCR 2018001643. Heron House of Largo had deficiencies at the time of the investigation.

(License #10811)

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and interview, the Facility failed to obtain an interdisciplinary care plan that included all aspects of care and services provided by Hospice, and those care and services provided by the Facility for one hospice Resident (#23) of one sampled hospice resident. The facility also failed to get updated documentation of a face-to-face health assessment (AHCA form 1823) when the resident experienced a significant change (admission to Hospice.)

Findings Included:

A record review for Resident #23, conducted on , revealed that Resident #23's record did not include an Interdisciplinary Care Plan ( ) specifying all care and services provided by Hospice and those care and services provided by the Facility and agreed upon by hospice, the facility, and Resident #23 (or Responsible Party). The Administrator and Hospice signed Resident #23's on the day of survey. The Hospice nurse signed the using first name only and no last name provided. According to Resident #23's Agency for Health Care Administration Form 1823 (AHCA 1823) dated , services required not identified on the provided, included (but not limited to) , transfers, unsteady gait/ambulation, , brace to left upper extremity, and care. The Facility did not obtain a new AHCA 1823 when Resident #23 had a decline in condition necessitating Hospice services. There was no indication on Resident #23's AHCA 1823 that Resident #23 required Hospice nursing services.

During an interview with the Administrator, conducted on at 05:30pm, the Administrator acknowledged and confirmed that Hospice signed and faxed the on the day of survey. The Administrator confirmed that the did not include all aspects of care and services that Hospice and the Facility provided to Resident #23. The Administrator confirmed that the Facility did not obtain a new AHCA 1823 when Resident #23's condition declined necessitating admission to Hospice services.

Class III

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

Based on observation, interview, and record review, the facility failed to provide personal supervision as appropriate to the needs for three Residents (#21, #4, and #24) of three sampled residents, including providing the level of oversight to safely meet the needs of the residents in preventing elopement and providing a safe living environment.

Findings included:

A resident record review for Resident #21 conducted on , revealed that Resident #21 eloped from the facility's locked memory care unit on . Staff opened the locked memory care door and let Resident #21 off the unit unattended. Resident #21 exited the facility at that time. Resident #21 was found by local law enforcement at a former residence and law enforcement returned Resident #21 back to the facility.

A record review for Resident #24 conducted on , revealed that Resident #24 eloped from the facility on . Resident #24 resides in the facility's locked memory care unit. Staff escorted Resident #24 off the memory care unit to participate in an activity. Staff left Resident #24 unattended. Resident #24 exited the facility. Resident #24 was found 0.3 miles away from the facility by staff and returned to the facility locked memory care unit. In addition, the record review revealed that Resident #24's record contained seven documented aggressive behaviors from through including a and combative behaviors toward other residents.

An observation of Resident #4's on at 3:15 PM, revealed that the facility failed to supervise the resident's ability to store medication safely in their own . A pile of medication was observed on Resident #4's floor. Resident #4's observed as very cluttered and dirty with an odor of cat in . An aging banana peel (black in color) was on Resident #4's table. Dried was observed on the floor next to the pile of medication and sharps container. observed in Resident #4's refrigerator did not contain a label stating the resident's name, directions for use, or the physician information. An interview was conducted with the Director of Resident Care during this observation and they acknowledged all of these issues in Resident #4's .

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During an interview with the Director of Resident Care, conducted on at 11:35am, they stated that memory care residents are physically checked every two hours. During a later interview at 04:30pm on , the Director of Resident Care confirmed that facility staff opened the locked memory care door and let Resident #21 leave the unit unattended on . The Director of Resident Care stated that when staff take residents off the memory care unit, they have one-to-one (Staff-to-Resident) assistance.

A review of training records conducted on showed that Staff K (hired in , 2018) and Staff L (hired in , 2017), showed no proof of requited training in 's and related . Staff K and Staff L both worked in the facility's memory care unit.

Class III

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

Based on record review and interview, four of five staff sampled (H; I; J; K) had either not obtained a communicable statement from a health care provider (physician; physician's assistant; ARNP) based on an examination no earlier than 6 months prior to submission of this statement or a current ( ) evaluation.

Findings include:

A personnel file review during the survey indicated that Staff H, I, J, and K, (hired , , , and , respectively) did not have statements from a health care provider attesting to their freedom from communicable . Further review of these files revealed that Staff H, I, and K had no evaluations as well. Interview with the Director of Administration at 1pm on , and the administrator at 2:30pm the same day provided no explanation for this oversight.

Class III

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

Based on record review and interview, three of five staff sampled (I; J; L) had not received several mandatory trainings within 30 days of employment.

Findings include:

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A personnel file review during the investigations indicated that there was no documentation verifying that Staff I (hired), Staff J (hired), and Staff L (hired) had received the following training:
a) providing assistance with activities of daily living (ADLs) and resident behavior/needs; b) elopement response training; c) emergency preparedness and evacuation training; d) incident reporting; e) recognizing/reporting , neglect and , ; and e) safe food handling. Further review of the files found that neither Staff I nor L had received control nor resident rights training. Interview with the Director of Administration at 1:40pm on provided no clarification for this discrepancy.

Class III

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

Based on record review and interview, two of two staff (K; L) dedicated to the facility's Memory Care unit had not received the initial 4 hours training pertaining to 's/ residents required within 3 months of employment.

Findings include:

A personnel record review during the investigation found that neither Staff K (hired) nor Staff L (hired), who are both assigned to work in the memory care unit, had any documentation verifying they had received the mandatory 4 hours initial training regarding 's and Related . Interview with the director of administration at 1:15pm on provided no clarification for this discrepancy.

Class III

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

Based on record review and interview, the facility had not implemented official training certificates containing required elements to include trainer's signature and credentials, duration and date of training and training content, with respect to one of five staff sampled (L).

Findings include:

A review of personnel records during the investigation revealed that Staff K, hired , had a "check-off list" regarding about 6-7 different training-related areas. This listing had been signed and

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dated, but no detailed agenda or other additional information contained on a certificate was evident. Further review of the file found no formal training certificates with the exception of the employee's First Aid and , , ( ) certification.

Interview with the director of administration at 2pm on revealed that "they were under the impression that a check-off list was acceptable."

Class III

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

Based on observation and interview, the facility failed to maintain a safe and decent living environment that was free of potential hazards.

Findings include:

At 10:45am on , the following was observed during facility tour:
a) three (3) locations in front of the facility where wiring had been left on the ground/grass approximately 8-10 feet apart from each other. The first was larger, and had been covered by a large plastic pail. The other two were covered by bricks (photographic evidence obtained). At 11:15am, interview with the maintenance director revealed that the first location that had been covered by the pail is where one of their lamp posts had recently stood, while the other two apparently were already there on the grass when the new owners took over.

At 1:04 PM on , Resident #4 was interviewed in their . The resident pointed out dried on the carpeting near the bed. The resident stated that it had been there for weeks and was told that they would have to hire someone to clean up their .

At 3:15 PM on , Agency staff observed Resident #4's the Director of Resident Care. Dried was observed near the resident's bed, medication packages scattered over the floor near a sharps container, a dried out, blackened banana peel, a strong smell of cat , and overall dirty conditions of the . (photographic evidence obtained). The Director of Resident Care acknowledged the issues within the resident's .

At 3:30 PM on , the Director of Resident Care knocked on Resident #3's door and entered with the Agency staff. In the middle of the floor, located a few feet from the resident's bed, was a large pile of

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newspapers, boxes, and other personal items in a mound (photographic evidence obtained). The Director of Resident Care was interviewed at 3:37 PM on . . . . . and acknowledged that the resident's a fire hazard.

A review of an inspection report from the local fire agency dated showed that emergency lights were not working and required repair (photographic evidence obtained). The Maintenance Director was interviewed via phone at 4:41 PM on concerning the status of the emergency lights. The Maintenance Director stated that the emergency lights located in the . . . the pool table had not yet been repaired (photographic evidence obtained).

Class III