STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964891	**07/02/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEURORESTORATIVE FLORIDA (WHITNEY ACRES)	**2769 WHITNEY ROAD CLEARWATER, FL 33760**

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

0000 - Initial Comments

Assisted Living Facility

On , 2018 a complaint survey (CCR#2018006117) was conducted at Neurorestorative Florida (Whitney Acres.) Deficiencies were identified during the visit.

(license #9425)

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

Based on record review and interview the facility failed to determine the appropriateness of admission for 4 (#3, #6, #7, #10) residents currently residing In the facility. Specifically, the residents require use of called Crisis Prevention Intervention (CPI) to manage their behavior .
In addition, the facility admitted a resident (Resident #3) who required one-to-one supervision to manage their behavior.

Findings included:

During a review of the facility records on , they revealed the facility trains their staff and utilizes the Crisis Prevention Intervention (CPI) training. This training teaches staff to safely restrain a resident.

During an interview with the Administrator on , at approximately 6:00 PM, the Administrator stated their staff are in fact trained to use CPI on residents. They stated the facility has always utilized CPI. They stated the staff have used CPI on Residents #3, #6, #7 and # 10.

During interviews with Residents #8, #9, #6 on between 8:30 AM and 6:00 PM, they stated the staff have used CPI on them.
During an interview with Resident #6 on at 10:34 AM, Resident #6 confirmed staff "hold you down on the ground until you are calm."

During an interview with Staff L on at 4:21 PM, Staff L stated that the training on restraining residents was for when residents acted out violently and would "get to breaking windows."

During a review of the record for Resident #3 on , an incident report dated indicated that Resident #3's supervision level was moved to one-to-one.

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Class III

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

Based on employee record review and interview, the facility failed to ensure staff received required staff in-service training within 30 days of employment, for staff who provide direct care to residents for 9 (Staff A, Staff B, Staff C, Staff D, Staff E, Staff F, Staff H, Staff J, and Staff I) of 10 employee records reviewed.

Findings Included:

1. Focused closed employee record review revealed Staff A with a date of hire did not have proof of resident elopement response policies and procedures training or resident rights in an assisted living facility training.

2. Focused closed employee record review revealed Staff B with a date of hire did not have proof of resident elopement response policies and procedures training, or resident rights in an assisted living facility training.

3. Focused closed employee record review revealed Staff C with a date of hire did not have proof of resident rights in an assisted living facility training, resident elopement response policies and procedures training, or recognizing and reporting resident , neglect, and .

4. Focused closed employee record review revealed Staff D with a date of hire did not have proof of resident rights in an assisted living facility training, recognizing and reporting resident , neglect, and or resident elopement response policies and procedures training.

5. Focused closed employee record review revealed Staff E with a date of hire did not have proof of resident rights in an assisted living facility training, resident elopement response policies and procedures training or recognizing and reporting resident , neglect, and .

6. Focused closed employee record review revealed Staff F with a date of hire did not have proof of recognizing and reporting resident , neglect, and or resident rights in an assisted living facility training, resident elopement response policies and procedures training.

7. Focused employee record review revealed Staff H with a date of hire did not have proof of resident elopement response policies and procedures training.

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SUMMARY STATEMENT OF DEFICIENCIES
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8. Focused employee record review revealed Staff I with a date of hire did not have proof of resident rights in an assisted living facility training, recognizing and reporting resident , neglect, and , or resident elopement response policies and procedures training.

9. Focused employee record review revealed Staff J with a date of hire did not have proof of recognizing and reporting resident , neglect, and , or resident rights in an assisted living facility training, resident elopement response policies and procedures training.

10. An interview on at 4pm was conducted with the Human Resources Coordinator. The Human Resources Coordinator reviewed the facility's tracking and documentation system for trainings and confirmed there is no documentation in the employee records that state they have had resident rights training, elopement response training, or recognizing and reporting resident , neglect, and , .

Class III