STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969245	**09/06/2018**
NAME OF PROVIDER OR SUPPLIER **JASMINE RETIREMENT HOME LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **8914 JASMINE BLVD** **PORT RICHEY, FL 34668**	

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

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on record review and interview, the facility failed to maintain the employment status of employees within the employee roster listed in the AHCA background screening clearinghouse (Employee Roster), within 10 business days of initial employment or termination of employment for two (Administrator and Staff A) of five employee records sampled.

Findings included:

A review of employee records showed that the Administrator was hired on and Staff A, a direct care staff member, was hired on . . . with their position terminated on . . . .

A review of the Employee Roster conducted on . . . showed that the Administrator and Staff A were not entered.

The Owner was interviewed on at 12:01 PM concerning the Administrator and Staff A not being entered in to the Employee Roster. The Owner acknowledged that the Administrator and Staff A were not entered.

Unclassified

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0000 - Initial Comments

Assisted Living Facility

A complaint investigation (CCR 2018011379 and 2018012130) was conducted at Jasmine Retirement Home on . Jasmine Retirement Home had deficiencies at the time of the investigation.

(License #13120)

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

Based on observation, interview, and record review the facility failed to ensure that residents' rights for personal dignity and privacy were maintained for two (Resident #3 and Resident #4) of three residents sampled. Additionally, the facility failed to ensure that devices that could be considered physical were prohibited for use for one (Resident #1) of one resident observed.

Findings included:

An interview was conducted with the Owner at 9:53 AM on and they stated that they had received text messages and photos of Resident #3 and Resident #4 that were taken and sent by Staff A. The Owner stated that Staff A explained that they took pictures to show their family members. The Co-Owner was interviewed at 10:26 AM on and indicated that they has also seen the text messages from Staff A. They stated that the slander and obscenity that Staff A used about the residents and photographic images taken made them mad.

A review of facility records showed that Staff A was employed there from until .

Photographic evidence obtained showed an image of Resident #3 in bed with their socks halfway on. The text message showed demeaning and obscene references about Resident #3. Also included in evidence was a text message with a vulgar reference to Resident #4 and a video of them walking around the facility, dressed in a nightshirt.

A tour of the facility was conducted beginning at 9:20 AM on . Resident #1 was observed resting in bed. Resident #1's bed contained two bed rails on the right side of the bed, enclosing the entire side of the bed. The left side of the bed was situated flush up against the wall.

A review of Resident #1's record showed no evidence of a doctor's order for half bed rails.

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

Resident #1 was interviewed at 11:31 AM on . . . . while they were resting in bed. Resident #1 was asked if they could bring the bed rails down and they were not able to respond to the question.

An interview was conducted with the Owner at 12:01 PM on and they stated that Resident #1 was not able to take the bed rails down. The owner stated that there was no doctor's order for a half bed rail and acknowledged that the other side of the bed was up against the wall, creating a physical as the resident was not able to get out of their bed.

Class III