STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910149	**09/17/2018**
NAME OF PROVIDER OR SUPPLIER **AMER HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **1918 BARRINGTON DRIVE, W.** **CLEARWATER, FL 33763**	

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

0000 - Initial Comments

Assisted Living Facility

A Biennial licensure survey with Limited Nursing Services (LNS) was conducted on .

The Amer Home, Assisted Living Facility /License #6644, had deficiencies at the time of this visit.

0009 - Admissions - Admission Package - 58A-5.0181(3) FAC; 400.0078(2)

Based on records review and interview, the facility failed to ensure that facility resident's contracts included all the required information for 2 of 2 residents' records reviewed (#5 and #6).

Findings included:

A review of the records the facility had on file for Resident #5 was conducted on . The record showed that the resident was admitted to the facility on . The resident's contract, dated , did not include a monthly rate that the facility charged to the resident. The contract did not include the required provision regarding a 45-day notice of discharge, nor did the contract include a provision for a 30-day notice of a rate increase.

A review of the records the facility had on file for Resident #6 was conducted on . The record showed that the resident was admitted to the facility on . The resident's contract, dated , did not include a monthly rate that the facility charged to the resident. The contract did not include the required provision regarding a 45-day notice of discharge, nor did the contract include a provision for a 30-day notice of a rate increase.

In an interview with the Assistant Administrator and Staff B at 1:00pm on , they could not find any further documentation in either Resident #5's record or Resident #6's record that stated what the monthly rate charged to the residents was. The Assistant Administrator stated it could have been $3,000.00 a month, but could not be sure. Both the Assistant Administrator and Staff A stated that there was no further contract documentation for either resident that included the provisions for the 45-day notice or discharge or a 30-day notice of a rate increase.

Class III

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

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	AL11910149	**09/17/2018**
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

Based on observations, records review and interviews, the facility failed to determine the appropriateness for admission and continued residency for 1 of 6 residents observed (#5).

Findings included:

A review of Resident #5's record was conducted on . The record review revealed that Resident #5 was admitted to the facility on . The latest (and only) resident health assessment (AHCA form 1823) or (1823) in the resident's record was dated . The 1823 indicated that the resident was wheel-chair bound and a risk.
At 10:45am on , Staff A stated that Resident #5 required a , mechanism with a cloth sling (Hoyer lift) to enable the facility staff to transfer the resident from the wheelchair to bed or a shower chair. Transferring the resident required at least 2 staff people to safely operate the Hoyer lift. Staff A was a live-in employee and stated that there were times when Staff A was the only staff person in the facility, especially overnight.

At 12:30pm, on , the resident's Hoyer lift was observed on the back patio of the facility, covered with a water proof tarp. Staff A confirmed that the Hoyer lift on the patio belonged to Resident #5.

Resident #5 was observed sitting in a high backed electronic wheel chair for the entirety of the day on , from 9:00am until 4:45pm, and on the seat of the wheel chair, a cloth sling for the Hoyer lift was visible, underneath the resident. At 2:00pm on , Resident #5 was observed receiving assistance from staff to push the button on the electronic wheel chair to move the chair forward and backward and to get from one another.

At 3:00pm, on , the Assistant Administrator was interviewed regarding Resident #5's physical functional capabilities. The Assistant Administrator stated that Resident #5 came into the facility with a Hoyer lift (on) and required at least 2 people to safely assist the resident from the wheel chair to and from the bed, a shower chair and the toilet. The resident required more than just supervision and/or assistance with most activities of daily living. The resident required and extensive amount of assistance in the areas of ambulation, bathing, toileting and transferring, because of the need for the Hoyer lift to move the resident. The facility schedule for the month of , 2018 was reviewed and showed that every week, Monday through Friday, Staff A and the Assistant Administrator were the only 2 employees on the schedule. The Assistant Administrator stated the neither the Administrator, nor the Assistant Administrator lived in the facility, thereby confirming that Staff A, who did live in the there, was the only staff person in the facility at times, primarily overnight.

Class III

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

0081 - Training - Staff In-Service - 58A-5.0191(2-3) FAC

Based on records review and interview, the facility failed to provide, or arrange for, in-service training to facility staff who provide direct care to residents within 30 days of employment and control training prior to providing personal care to residents for 1 of 3 staff records reviewed (Staff B).

Findings included:

An employee records review was conducted on . The review revealed that Staff B had begun employment with the facility on and was written on the care staff schedule for the month of , 2018 to be working on the weekends throughout the month. An interview with Staff A revealed that Staff B was hired to work weekends and was in the facility every Saturday and Sunday since employed on .

Staff B's training record did not include 1 hour of control training that was due to be given prior to the staff member providing any personal care to residents. Staff B's record also did not contain any evidence of training as follows: 1 hour of elopement response training, 1 hours of incident reporting, 1 hour of resident rights, 1 hours of recognizing and reporting , neglect and , and 1 hour of nutrition and safe food handling. Staff B began employment with the facility on and the required in-service training classes were due to be given by .

In an interview with the Assistant Administrator at 11:30am on , the Assistant Administrator could not explain why Staff B did not have evidence of the required in-service training in the record, the training probably was not completed.

Class III