STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969022	09/19/2018
NAME OF PROVIDER OR SUPPLIER ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2250 S SEMORAN BLVD ORLANDO, FL 32822	

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

0000 - Initial Comments

A complaint investigation #2018008916 was conducted on and . In addition to complaint investigation 2018008768 and a second revisit to complaint investigation # 2018001731. Assisted Living Facility, license #12850 had deficiencies at the time of the visit.

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on record review, observation, and interview, the facility did not ensure 1 of 10 sampled residents (#10) met the minimum admission criteria upon admission to the facility and admitted a resident who needed 24 hour nursing supervision and was needed total care with bathing and eating.

Findings:

On at 9:15 AM the administrator said 8 residents were accepted from another facility because that facility closed.

On at 11:30 AM the Director of Nursing said that resident #10 needed a lot of care, to go look at her.

On at 11:55 AM caregiver G and private caregiver both said resident #10, fed herself, pivoted during transfers and needed total care with bathing, dressing, and toileting.

Observations of the resident on at 12 PM noted she sat in a wheelchair with private caregiver nearby. She was unable to engage in conversation and was .

Resident record review for resident #10 revealed an admission date of . The health assessment report listed Parkinson's , , , lower extremity , , poor judgement and risk. According to the assessment she needed assistance with all activities of daily living and was appropriate for assisted living. A facility note dated indicated resident arrived with private caregiver. Resident was , and with poor judgment.

In an interview with the administrator on at 1:45PM who said the resident's Power of Attorney was coming to the facility Thursday and may want to move her. She will tell her that the resident is total care and not eligible for standard assisted living.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969022	09/19/2018
NAME OF PROVIDER OR SUPPLIER **ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **2250 S SEMORAN BLVD ORLANDO, FL 32822**	

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

Based on observations, interviews and records reviewed the facility failed to honor the resident's rights to be treated with consideration and respect and with due recognition of personal dignity and did not answer calls bell timely for 2 of 6 sample residents (2 and 4) and did not give appropriate discharge notice to 1 of 6 sampled residents (3).

Findings:

1. Resident #2's call bell report revealed that on a push on his call bell occurred at 8:10 p.m. and was responded to at 9:38 p.m., a wait time of 88 minutes.

On four pushes occurred at 6:27 p.m. and were responded to at 8:13 p.m., a wait time of 106 minutes.

On a push occurred at 4:58 p.m. and was responded to at 6:24 p.m., a wait time of 85 minutes.

On at 5:50 p.m. seventeen pushes occurred at 5:50 p.m. and were responded to at 7:19 p.m., a wait time of 88 minutes.

In addition, a facility incident report for resident #2 and dated , indicated that at 8:22 a.m. he was observed sitting on the floor by his bed. He said he tripped over his feet and there were no apparent injuries. His call bell report revealed that on thirteen pushes occurred at 8:01 a.m. and were responded to at 8:33 a.m., a wait time of 32 minutes.

On at 8:45 a.m. resident #2 said there were multiple times he had to wait an excessive amount of time for staff to respond to his call bell.

On at 1 p.m. the director of nursing confirmed the findings and said whenever resident #2 rang his call bell he left before the staff could respond. Resident #2's record did not contain facility documentation to indicate the facility addressed this at any time with the resident.

Resident #2's record contained a facility note, dated , that indicated the director of nursing received a call from a staff member that during rounds the resident was observed on the floor in his , his recliner. He was very weak. 911 was called but he refused to go to the hospital. The staff told the resident that if he continued to be weak and unable to stand they would call the police.

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ASSISTED LIVING FACILITY	2250 S SEMORAN BLVD ORLANDO, FL 32822

SUMMARY STATEMENT OF DEFICIENCIES
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On . . . . . at 11 a.m. the director of nursing said that when resident #2 refused to go to the hospital on the staff told him they would call the police to scare him.

2. Resident # 3 was admitted and discharged . Health assessment report 1823 dated . . . . listed diagnoses of . . . . . , ... , high . . . . , ... , and . . . . The resident is under hospice care. Had no behaviors, was independent with eating; supervision was needed with . . . . . ; assistance was needed with ambulation, bathing, dressing, toileting and transferring and medications. Was on a regular diet. She was admitted to hospice on . The resident contract was dated . . . . . .

Facility note dated . . . . . indicated met with daughter and son in law regarding alternate placement.

Facility note dated . . . . AM as documented by staff on Saturday . . . . . daughter came in at 9 AM packed up resident's clothes and moved her furniture in the process of transferring resident from bed to chair the resident . . Daughter called 911 and resident transfer, moved resident out at 9:50 AM.

E mail send 6/4 dated 6/6 indicated a meeting was held on . . and it was explained that the resident exceeded ALF residency criteria because of a pattern of behavior. "Consider this notice from the time of discussion thru . . . . , is 45 days".

The administrator stated on . . . . . at 1:50PM that they family were informed in the conversation in the meeting, in essence that was the purpose of the meeting. They were told.

3. Observations on . . . . . at 1:55PM found resident #4 on the floor on her knees. She was in her . . . Her call bell was not nearby. The Agency representative rang the call bell, 2 staff came in and checked on the resident and assisted her back to chair. She said the reason she gets up by herself is because they don't answer the call bell or you wait too long, especially in the morning and early evening. She does not want to urinate on clothes and furniture.

Health assessment report 1823 dated . . . . listed Parkinson's, ... leg pain, spinal . . . . . , and . She was discharged from hospice .

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SUMMARY STATEMENT OF DEFICIENCIES
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Facility notes indicated that on:
resident used pendant, was lying on left side in front of (BR) - stated lost balance walking to BR
yelled for help, resident was non- complainant using pendant, was sitting on floor front of BR
9AM resident tripped on at 3AM coming from BR, redness to right elbow noted - call log 2 min wait
at 9:30 AM stated she tripped and landed on the floor and got self-up- no call log
12 PM observed sitting on floor in front of recliner , walker in front of her, forgot to use pendant
7/7 4 PM sitting on recliner , stated she lowered self to floor with her right knee in the BR - redness to right knee- call log 2 min
8AM she slipped to floor no injuries noted
9/2 10:30 AM was kneeling on the floor next to bed. Stated was sitting on bed and slid on the floor
9/5 10AM Resident was on left knee she did not .

Call bell log review revealed dated to the following excessive response times
6/4 from 7:29 AM to 8:58 AM from =89 minutes
6/4 from 4:29 PM to 7:06 PM from = 156 minutes
6/5 from 8:14AM to 9:18 AM = 64 minutes
6/6 from 8:02 AM to 9:29AM = 87 minutes
6/6 from 9:07 PM to 9:34 PM = 27 minutes
from 9:42 PM to 9:59 PM from = 17 minutes
from 7:48 AM to 10:08AM from =139 minutes

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

Based on observations, record reviews and interviews, the facility failed to ensure that 2 of 4 sampled staff (F and L) received the required in-service training.

Findings:

On at 10:40 am caregiver F was observed in the facility. She said her work schedule was from 9

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a.m. until 9 p.m. and she began to provide resident care on .

Review of a facility staffing schedule revealed caregiver L was scheduled to work on from 8:30 p.m. until 9 a.m.

Both caregiver F's and caregiver L's personnel record contained a hire date of .

Both caregiver F's and caregiver L's personnel record did not contain documentation to indicate they received at least 2 hours of preservice orientation prior to interacting with residents that covered resident rights and the facility's license type and services offered by the facility, as required.

On at 3:20 p.m. the administrator confirmed the findings and was unable to provide additional documentation.

Class III