

AGENCY FOR HEALTH CARE
ADMINISTRATION

PRINTED: 08/28/2013
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11967268	(X3) DATE SURVEY COMPLETED 08/08/2013
NAME OF PROVIDER OR SUPPLIER Lafeta Family Home Care	STREET ADDRESS, CITY, STATE, ZIP CODE 1061 Division Street Jacksonville, FL 32209	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0000 - - Initial Comments
St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0032 - 58a-5.0182(8) Fac - Resident Care - Elopement Standards S-S= D
St - A - 0074 - 58a-5.019(3)(b) - Staffing Standards - Personnel File (bgs) S-S= C
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0079 - 58a-5.019(4) Fac - Staffing Standards - Levels S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D
St - A - ZB15 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses S-S= D

Specific Tag Findings:

0000-Initial Comments

An unannounced complaint investigation, CCR#2013005013, was conducted at Lafeta Family Home Care in Jacksonville, Florida on 08/08/2013. Deficiencies were identified as a result of the survey.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC

Based on resident record review and staff interview, the facility failed to obtain a completed Resident Health Assessment (AHCA Form 1823) for 3 of 3 sampled residents. (Residents #1, #2 and #3)(photos obtained)

The findings include:

A review of the clinical record for Resident #1 revealed that the examiner failed to indicate whether or not the resident required assistance with medication administration.

A review of the clinical record for Resident #2 revealed that the examiner failed to indicate whether or not the resident required assistance with medication administration. The examiner also failed to specify the type of diet the resident was to receive and which type of nursing services or treatments the resident required.

A review of the clinical record for Resident #3 revealed that the examiner failed to indicate whether or not the resident required assistance with medication administration.

An interview on 08/08/2013 at approximately 2:00 PM with Employee A revealed that she was unaware that the documentation was incomplete. She said that she would make the administrator aware of the discrepancies.

Class III

0025-Resident Care - Supervision 58A-5.0182(1) FAC

Based on record review and staff interview, the facility failed to provide personal supervision as appropriate for each resident. The facility failed to provide daily observation by designated staff of the resident's general whereabouts. The facility also failed to contact the resident's health care provider and other appropriate party

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such as the resident's family, guardian, health care surrogate or case manager of a significant change for 1 of 3 sampled residents. (Resident #1)

The findings include:

A review of Resident #1's clinical record on revealed a handwritten note dated and signed by Employee C which indicated that Employee C arrived for work at an unknown time, and upon arrival Employee C noticed that Resident #1 was not on the premises. Employee C went on to write, "I asked (Employee B), the staff that was on duty where was (Resident #1) and he said she got mad because he refuse give her some of his cigarettes to smoke and she walk off and left, so I call the Administer to tell her what happened and she told me to tell (Employee B) to canvass the neighbor hood to look for (Resident #1) but he stayed at the facility with the another residents and I went and look for her but didn't found her anywhere, so I came back and call the Police and they came and put out a missing person report." (photo obtained)

A further review of Resident #1's record revealed no other observation notes written that day by Employee B who was working when Employee C arrived. (photos of observation notes obtained) No documentation was located in Resident #1's clinical record which indicated that Resident #1's responsible party was notified of this occurrence. A review of Resident #1's Resident Health Assessment (AHCA Form 1823) dated revealed that Resident #1 required "close supervision" as stated on page one of the document. (photos obtained)

A review of Employee B's personnel file on revealed that his date of hire was more than one month after this occurrence.

An interview with Employee A on at approximately 12:00 PM revealed that she was unable to offer more information than what was documented in Resident #1's record. When asked what time the 24-hour shifts change over, Employee A said that the shift change was at 2:00 PM.

Class III

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

Based on observation, staff interview and record review, the facility failed to provide a safe and decent living environment, and to respect the religious liberties for 3 of 3 sampled residents. (Residents #1, #2 and #3)(photos obtained)

The findings include:

On at 9:15 AM, a tour of the facility revealed the following: a foul odor throughout the facility, dirt and grime on the floors and walls near the baseboards, a hole in the kitchen floor tile which was approximately three inches deep. It measured approximately two inches in width by five inches in length. Sub-flooring was visible. A small sink in the kitchen was blackened, the kitchen air-conditioning vent was full of black dirt/dust/grime, and the exit door from the kitchen to the back yard had a visible gap at the bottom. The hallway what appeared to be adaptive equipment/assist bars for the commode folded and rusted between the commode and the tub. The grout in the shower/tub had a significant amount of mold and mildew present, the floor of the tub was blackened and the shower curtain was stiff with soap scum and mold/mildew at the bottom edge. The toilet paper holder and the towel rack were covered with dust and grime.

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NAME OF PROVIDER OR SUPPLIER Lafeta Family Home Care	STREET ADDRESS, CITY, STATE, ZIP CODE 1081 Division Street Jacksonville, FL 32209	
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A review of the records for Residents #1, #2 and #3 revealed the same form in each record explaining that this assisted living facility (ALF) was a Baptist facility, and that this facility respected every religion except "Athens".

On at approximately 1:00 PM, an interview with Employee A supported the fact that this ALF did not respect Atheism which is how Employee A clarified the form to the surveyor when the surveyor showed Employee #1 the form and requested an explanation of what "Athens" meant.

Class III

0032-Resident Care - Elopement Standards 58A-5.0182(8) FAC

Based on resident record review and staff interview, the facility failed to maintain photo identification of residents who were at risk for elopement for 2 of 3 sampled residents. (Residents #1 and #2)(photos of facility's signed and dated elopement policy and procedure obtained for each resident) The facility also failed to produce documentation of required biannual elopement drills which could potentially affect all residents within the facility.

The findings include:

A review of the resident clinical records on revealed that each resident had an elopement policy and procedure in their record. The policy and procedure specifically said, "I the undersigned consumer do hereby understand the policy concerning elopement, and I do understand that I must have a current up-to-date photograph in my file for this purpose." Resident #3 had a Florida identification card with his photograph on it taped to the inside of his record, however, there were no photographs in either Resident #1's or Resident #2's records.

There was no documentation provided which showed evidence of biannual completion of elopement drills by the facility staff.

An interview on at approximately 12:00 PM with Employee A revealed that she was aware that photographs were needed in the residents' charts, however, she did not produce any during the time the surveyor was in the facility. When asked about biannual elopement drills, Employee A was unaware that they were required.

Class III

0074-Staffing Standards - Personnel File (BGS) 58A-5.019(3)(b)

Based on interview and record review, the facility failed to ensure that documentation of the results of employee background screening was maintained in the employee's personnel file for 1 of 3 employees.(Employee B)

The findings include:

On a complaint survey was conducted. Upon entrance to the Assisted Living Facility (ALF), a male staff member (Employee B) answered the door and reported that there were four residents currently residing in the facility. The staff member identified himself as a "caregiver" and was observed moving about throughout the facility, interacting with the residents, and sitting at the desk in the front the facility using the telephone.

A review of the employee personnel records revealed an application for Employee B with a hire date of

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There was no documentation of Employee B having had a background screening performed. There was no letter of eligibility in his file.

On at approximately 1:00 PM, an interview with Employee A revealed that Employee B was not employed at the facility, though he had previously been employed there. Employee A clarified that Employee B was the son of the Owner/Administrator who was not present. Employee A could not explain why Employee B had no evidence of background screening in his personnel file.

Unclassified

0076-Staffing Standards - Staff 58A-5.019(2) FAC

Based on staff interview and record review, the facility failed to ensure adequately trained, qualified staff to meet the needs of all facility residents. The facility failed to ensure that 1 of 3 facility employees had a statement from a health care provider confirming that the employee had no signs or symptoms of a communicable (Employee B). The facility also failed to ensure that freedom from was documented on an annual basis for 1 of 3 sampled employees. (Employee A)

The findings include:

On at 9:00 AM during an unannounced visit, there was one employee on duty (Employee B) who referred to himself as a "caregiver". Upon the surveyor's arrival at the facility, Employee B answered the door explaining that the administrator was not present. He said that he was unable to access any resident or employee files, and he asked that the surveyor wait until he could reach someone who had access to the files to come to the facility. Employee B said that he was "helping out" until the staff member arrived.

A review of the employee personnel records revealed an application for Employee B with a hire date of

There was no documentation of freedom from communicable disease for Employee B in his file. Employee A's personnel file revealed that her most current documentation of freedom from was dated , confirming that she was five months overdue for this examination.

On at approximately 1:00 PM, an interview with Employee A revealed that Employee B was not employed at the facility, though he had previously been employed there. Employee A clarified that Employee B was the son of the Owner/Administrator who was not present. She could not explain why there was no background screening in Employee B's file. When asked about the status of her own statement of freedom from, Employee A stated that she intended to see her physician for the examination the following day.

Class III

0079-Staffing Standards - Levels 58A-5.019(4) FAC

Based on record review and staff interview, the facility failed to maintain a written work schedule which reflected its 24-hour staffing pattern for a given time period. (photos obtained)

The findings include:

A review of the employee work schedule revealed that it was developed to cover a 30-day period of time. It was

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set up in a grid format with the dates written sequentially across the top of the form. On the left-hand column of the form two employee names were written. Under any given date at the top, there was an "X" marked beside one of the two employee names. No times or shifts were indicated on the form.

An interview with Employee A on at approximately 2:15 PM revealed that each of the employees listed on the work schedule completed a 24-hour shift for each date that had an "X" marked beside their name.

Class III

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

Based on observation the facility failed to provide a clean, comfortable and safe living environment for 3 of 3 sampled residents. (Residents #1,#2 and #3)(photos obtained)

The findings include:

On at 9:15 AM, a tour of the facility revealed the following: a foul odor throughout the facility, dirt and grime on the floors and walls near the baseboards, a hole in the kitchen floor tile which was approximately three inches deep. It measured approximately two inches in width by five inches in length. Sub-flooring was visible. A small sink in the kitchen was blackened, the kitchen air-conditioning vent was full of black dirt/dust/grime, and the exit door from the kitchen to the back yard had a visible gap at the bottom. The hallway what appeared to be adaptive equipment/assist bars for the commode folded and rusted between the commode and the tub. The grout in the shower/tub had a significant amount of mold and mildew present, the floor of the tub was blackened and the shower curtain was stiff with soap scum and mold/mildew at the bottom edge. The toilet paper holder and the towel rack were covered with dust and grime.

Class III

0165-Risk Mgmt & QA; Adverse Incident Report 429.23 FS; 58A-5.0241 FAC

Based on resident record review and staff interview, the facility failed to provide within one business day after the occurrence of an adverse incident by electronic mail, facsimile, or United States mail, a preliminary report to the Agency for Health Care Administration for 1 of 1 sampled residents. (Resident #1)(photos obtained)

The findings include:

A review of Resident #1's clinical record revealed a resident elopement which was reported to law enforcement on Documentation of the incident in the resident's record was dated The date noted on the Assisted Living Facility Initial Adverse Incident Report (1-Day Form) as completed by the facility staff was two business days later. The date noted on the facsimile indicated that the report was sent via fax on at 1:46 PM.

An interview with Employee A on at approximately 12:00 PM revealed that she was unaware of the regulation related to submission of the incident report. Employee A said, " Well, we just get nervous about it. We don't really know what to do. " Employee A stated that this was the first time that she was aware of that the facility had submitted this report.

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Class III

Z815-Background Screening; Prohibited Offenses 408.809, 435.02(2), 435.06

Based on observation, interview and record review, the facility failed to ensure that 1 of 3 employees was background screened and found eligible prior to providing direct resident care. (Employee B)

The findings include:

On a complaint survey was conducted. Upon entrance to the Assisted Living Facility (ALF), a male staff member (Employee B) answered the door and reported that there were four residents currently residing in the facility. The staff member identified himself as a "caregiver" and was observed moving about throughout the facility, interacting with the residents, and sitting at the desk in the front the facility using the telephone.

A review of the employee personnel records revealed an application for Employee B with a hire date of There was no documentation of Employee B having had a background screening performed. There was no letter of eligibility in his file.

On at approximately 1:00 PM, an interview with Employee A revealed that Employee B was not employed at the facility, though he had previously been employed there. Employee A clarified that Employee B was the son of the Owner/Administrator who was not present.

Unclassified



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Lafeta Family Home Care
1061 Division Street
Jacksonville, FL 32209

Re: CCR #2013005013

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on 2013 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after 2013 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call this office at

Sincerely,

Keisha Woods, MPH
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

LW/KW/sm
Enclosure

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