STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968942	**09/06/2017**
NAME OF PROVIDER OR SUPPLIER **THE FOUNTAINS OF HOPE**	STREET ADDRESS, CITY, STATE, ZIP CODE **2250 JESUS WAY** **SARASOTA, FL 34240**	

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

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

Based on a review of 4 employees of a total of 10 on the employee clearinghouse roster, and interview with administrative staff, the facility failed to ensure their roster was up to date within 10 days of an employee leaving employment of the facility for staff G, H, I, and J.

The findings included:

According to the clearinghouse roster, staff G was hired on , Staff H was hired on , staff I was hired on , and J was hired on . All of these staff were direct care employees. Further review of the roster revealed all of these staff remained as active employees. They were compared to the active employee list provided by the facility and found not to be on the active list.

On at 11:10 a.m., the Administrator said she was unaware this roster had to be kept up. She provided the following information: staff G left employment on . Staff H never started working for the facility but remained on the roster. Staff I left employment on and staff J left on .

Unclassified

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c) FS

Based on a review of 3 personnel files, and interview with administrative staff, the facility failed to ensure staff C had another background screening run when there was a lapse in service of 90 or more.

The findings included:

Staff C was hired on . The employee's background screening was dated . No new background screening was done on this employee. The employee's work history showed there was a 90 day lapse in employment of a qualifying entity.

On at 11:23 a.m., the director of assisted living agreed there was a 90 day lapse in employment for this staff member.

Unclassified

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E210 - ECC - Training - 58A-5.0191(7) FAC

Based on a review of 3 direct care staff, and interview with administrative staff, the facility to ensure the extended congregate care training was of the required length and content for 3 (Staff A, B, and C) of the 3 staff reviewed.

The findings included:

Staff A was hired on as a certified nurse assistant. Staff B was hired on as a nurse (licensed practical nurse, LPN). Staff C was hired on as a med aide. In each file was a document listed as extended congregate care-employee training manual consisting of 4 pages of information about extended congregate care (ECC). On the final page was a place for the employee to sign and date the pages. There was no evidence about how the training was done and whether the time for the training met the requirement of 2 hours.

On at 11:23 a.m., the director of assisted living said the training also included a test and an opportunity to go over the answers and ask questions. She admitted none of their training show the length of time the training entailed.

Class III

0000 - Initial Comments

An unannounced relicensure and extended congregate care (ECC) survey was conducted from through at The Fountains of Hope, an assisted living facility (license #12784) in Sarasota, Florida.

The following is description of the deficiencies.

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

Based on a review of 3 of 3 personnel files and interviews with administrative staff, the facility failed to ensure staff A, B, and C had all of the required training for the length of time mandated.

The findings included:

1. Staff A, B, and C are all direct care staff of the facility. They were hired as follows: staff A on , staff B on , and staff C on . In each of the files was a certificate listing the training provided along with the date of the class. There was no documentation on the form listing the length of the training provided. On the back of the certificate was a description of the course, a video,

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and the length of time for the video. For example on the back of the control certificate it had a 23 minute video about " control." There was also a section labeled special supplies, and the last area was course outline. There was no documentation listing the length of the training, an allotment for questions or any interaction with an instructor. In none of the 3 files for staff A, B, and C was there any evidence for the certificates showing the education met the required length. This included all of the training for food safety, and neglect, and did not include , , resident rights, incident reporting, emergency procedures, and control. There was no documentation about elopement procedures in the files for staff A,B, and C.

On at 11:23 a.m., the director of the assisted living agreed none of their certifications contained the length of time the training was. The staff also does a test, and have an opportunity to ask questions. She agreed this was not a part of the course description of any of the training.

Class III

0082 - Training - / - 58A-5.0191(3) FAC

Based on a review of 3 direct care staff personnel files, and interview with administrative staff, the facility failed to ensure the training in and was for the mandated times for staff A, B, and C.

The findings included:

Staff A was hired on , Staff B was hired on and staff C was hired on . In each of the files was a certificate dated on the dates of hire for each staff member. This course included a video on Borne : , , , and staff precautions which lasted 23 minutes. There was no evidence the course lasted the mandated time of training.

On at 11:23 a.m., the director of assisted living agreed the certificate did not show the length of time for the training. She said the course also included a test and a discussion of the questions. She agreed the certification does not show either of these parts of the training.

Class III

0087 - Training - Prov & Curriculum Appr - 58A-5.0194 FAC

Based on a review of 3 personnel files, and interview with administrative staff, the facility failed to ensure the required training was performed for staff A, B, and C.

The findings included:

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This facility includes as a part of their facility a Memory care unit. Staff A was hired on 11/ , staff B was hired on , and staff C was hired on . Staff A had documentation of some type of training, but it did not include the date or the length of the training. Staff B and C had no documentation of any of the required 's training.

On at 11:23 a.m., the director of assisted living said that all of the staff were taking a course on that was broken down into modules. She agreed the modules did not contain the length of the course and she could not provide documentation for all of the staff attending this course.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on a review of 2 of 3 personnel files, and interview with administrative staff, the facility failed to ensure there was training provided for for staff B and C.

The findings included:

A review of the employee files for staff B hired on , and staff C hired on revealed there was no evidence of training present in the files.

On at 11:23 a.m. the director of assisted living facility agreed this training was not present.

Class III

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

Based on observation and interview, the facility failed to ensure a safe living environment was maintained as evidenced by unlocked ovens and cupboards containing materials within easy reach to residents in the memory care units.

The findings included:

1. Observation of Memory Unit B on at approximately 10:15 a.m., found Certified Nursing Assistant (CNA) Staff K assisting 3 residents during activities. Next to the activity area was a small kitchen. The oven door to the kitchen was unlocked and able to be turned on. A large coffee urn, close to the edge of the counter, was observed. Staff K indicated the coffee was from breakfast and had not been returned to the kitchen. Inside one of the bottom of the cupboards was a bottle of

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cleaner labeled, "DO NOT DRINK" and a container of disposable surface wipes was observed next to the bottle of the .

2. On at 10:38 a.m., a tour of the Memory Unit A was conducted. This unit also had a small kitchen and the oven was not locked. The oven was able to be turned on without difficulty. Two bottles of neutral cleaner, a spray bottle of Oasis 146 multiquat sanitizer, and a spray bottle of odor eliminator were observed resting on the bottom of the cupboards under the counter in the kitchen. residents were observed wheeling themselves around the unit and had easy access to the oven and .

3. In an interview on at 10:55 a.m., the Housekeeping Supervisor, Director of Plant Operations, and Executive Director (ED) were not aware the ovens and cupboards in both of the memory care units were unlocked. They said the ovens and cupboards should be locked at all times due to the of the residents in the memory care units. They said the coffee urns should've been removed immediately after breakfast. The ED said she would put a plan in place to ensure the ovens and cupboards would remain locked when not in use.

Class III