STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953416	**12/12/2018**
NAME OF PROVIDER OR SUPPLIER **MAGNOLIA MANOR INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **926 S. MYRTLE AVENUE** **CLEARWATER, FL 34616**	

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

0000 - Initial Comments

Assisted Living Facility

A complaint investigation (CCR 2018014470) was conducted at Magnolia Manor, Inc. on . Magnolia Manor, Inc. had deficiencies at the time of the investigation.

(License #8539)

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, interview, and record review, the facility failed to provide personal supervision as required for each resident and maintain a general awareness of the resident's whereabouts for one (Resident #1) of three resident records sampled.

Findings included:

A review of resident records showed that Resident #1 had eloped from the facility on (photographic evidence obtained).

A review of the local hospital's Admission Report, dated , indicated that Resident #1 was found on the street on , was unable to identify themselves, where they came from, or their current residence. The local hospital was eventually able to identify Resident #1 as a resident of this Facility.

A review of Resident #1's record showed a form entitled Elopement Risk Assessment dated that indicated a scoring that Resident #1 was an elopement risk (photographic evidence obtained).

A phone interview was conducted with the power of attorney (POA) for Resident #1 on at 2:23 PM and they confirmed that Resident #1 had eloped from the facility on . They also stated that Resident #1 had eloped from the facility in . The POA stated that the resident was brought to a local hospital on after they eloped. They stated that the hospital was able to identify Resident #1 as they had recognized them from the elopement in . The POA also stated that they learned about Resident #1's elopement from another State Agency on the morning of . The POA stated that The Administrator left a voicemail message for them on that did not inform that Resident #1 had eloped from the facility.

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An interview was conducted with the Administrator on at 11:30 AM. The Administrator stated that it was their policy and procedures for residents to sign out before leaving the facility and Resident #1 did not sign out on . The Administrator also stated that the staff was unaware that Resident #1 had left the facility until the hospital phoned to ask questions about the resident. The Administrator was interviewed again at 3:45 PM and they stated that Resident #1 had also eloped prior to . The Administrator acknowledged that there was no proof on file that Resident #1's POA or doctor were notified.

Four door alarms in the facility were observed and tested on . The purpose of the door alarms was to assist staff and alert them if any residents were leaving the facility. A test of the four alarms showed that two of them were not operating, as they did not have batteries in their casing.

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(I)

Based on record review and interview, the facility failed to follow its elopement policies and procedures for residents assessed at risk for elopement or provide the resident with identification on their persons that included their name and facility's name for one (Resident #1) of one resident sampled.

Findings included:

A review of incident reports conducted on showed that Resident #1 had eloped from the facility in (photographic evidence obtained). The incident report showed the intervention "door alarms" to prevent future elopements.

A phone interview was conducted with the power of attorney (POA) for Resident #1 on at 2:23 PM and they confirmed that Resident #1 had eloped from the facility on and also stated that Resident #1 had eloped in . The POA stated that the resident was brought to a local hospital on after they eloped. They stated that the hospital was able to identify Resident #1 as they had recognized them from the elopement in .

A review of the local hospital's Admission Report dated indicated that Resident #1 was found on the street on , was unable to identify themselves, where they came from, or their current residence. The local hospital was eventually able to identify Resident #1 as a resident of this Facility.

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A review of Resident #1's record showed a form entitled Elopement Risk Assessment dated . . . . that indicated a scoring that Resident #1 was an elopement risk (photographic evidence obtained).

A review of the facility's Elopement Policy directed that resident's assessment shall be revised to reflect elopement and a plan for prevention all be put in place. There was no new Elopement Risk Assessment in Resident #1's record following their elopement on . . . . . . The intervention noted on the incident report showed "door alarms".

Four door alarms in the facility were observed and tested on . A test of the four alarms showed that two of them were not operating, as they did not have batteries in their casing.

Class III

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

Based on interview and record review of staff records, the facility failed to ensure 2 of 3 sampled staff (Staff D and Staff F) had documentation indicating they had completed required in-service training within 30 days of hire related to resident rights, reporting adverse incidents, the facility's emergency procedure, recognizing and reporting resident . . . . . , neglect and . , ... , providing assistance with activities of daily living and training in the facility's policies and procedures related to elopement.

Findings Included:

During a record review on at 2:00pm of the employee records for Staff D and Staff F, the records did not have any documentation that they attended training within 30-days of hire for the subjects noted above. The records for Staff D and Staff F did not contain any training certificates.

During an interview conducted with the administrator on . . at 4:00pm the administrator stated the training documents were at his attorney's office.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record review and interview, the facility failed to maintain an accurate, up-to date admission and discharge log indicating the actual date of discharge for one (Resident #1) of three records sampled.

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Findings included:

A review of the admission and discharge log on showed that Resident #1 was discharged from the facility on (photographic evidence obtained). A further review of Resident #1's record showed indication that Resident #1 was actually discharged from the facility on .

The Administrator was interviewed at 3:39 PM for clarification on when Resident #1 was discharged. The Administrator acknowledged that the admission and discharge log was inaccurate.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on record review and interview, the facility failed to ensure 2 of 3 (D, F) employee records reviewed included all required documentation, to include trainings, health statements and verification of a level II background screening.

Findings Included:

A review of staff records on at 11:00 am, revealed 2 of 3 (Staff D, Staff F) records were not complete. The only items found in the records were the employee application and blank forms. The administrator reviewed the file for staff D at 11:30 am and confirmed that the file was not complete. The file did not contain training, medical information and other required documents.

The record for staff F was reviewed by the administratorat 11:35 am, he confirmed that the file was missing training, medical information and other required documents. The administrator stated that the information was with the facility's attorney.

Class III

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

Based on record review and interview, the facility failed to file an adverse incident report for a resident that eloped from the facility and was at risk of harm for one (Resident #1) of one resident sampled.

Findings included:

An interview was conducted with the Administrator at 11:30 AM on to find out about details of

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Resident #1's elopement on . The administrator stated that Resident #1 left the facility and did not sign out. The Administrator stated that the resident was found on the street, the police were called, and the resident was transported to the hospital. The Administrator stated that it was their policy and procedure for residents to sign out before leaving the facility and Resident #1 did not sign out. The Administrator also stated that the staff was unaware that Resident #1 had left the facility until the hospital phoned to ask questions about the resident.

A review of the local hospital Admission Form for the hospital to which Resident #1 was taken, dated at 3:25 PM, stated that Resident #1 came to the emergency department via emergency medical services after around the streets. The resident was unable to identify who they were or where they came from. Resident #1 was eventually identified as a resident of this Facility.

Documentation of Resident #1's elopement was discovered earlier on . The Administrator was interviewed at 10:54 AM on and asked if they had filed adverse incident reports concerning Resident #1's elopement and they stated that they had not.

Class III

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

Based on, interview and record review the facility failed to list 3 of 3 sampled Staff (Staff C, Staff E, and Staff F) on the Background Screening Clearinghouse website within 10 days of initial employment.

Findings Included:

During an interview with staff C, it was revealed she works Monday, Wednesday and Fridays from 3:00 PM until 11:00pm The employee was called into work on the day of survey. The employee was not on the employee roster or listed on the Clearinghouse website.

Record review for Staff D revealed the employee's hire date was . A review of the Clearinghouse website revealed Staff D was not listed.

Record review for Staff E revealed a hire date of . . . . and was not listed in the Clearinghouse website.
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On 012/12/2018 at 1:30 PM an interview was conducted with the Administrator. The Administrator stated that he thought all the employees were listed on the employee roster/Clearinghouse webiste.

Unclassified