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	AL11953250	R 05/07/2019
NAME OF PROVIDER OR SUPPLIER **HOMESTEAD RETIREMENT**	STREET ADDRESS, CITY, STATE, ZIP CODE **1117 MASSACHUSETTS AVENUE** **SAINT CLOUD, FL 34769**	

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0000 - Initial Comments

A revisit to complaint investigation #2019001246 was conducted at Homestead Retirement on . . . and . . . . . Deficiencies were identified at the time of survey.

0008 - Admissions - Health Assessment - 429.26( ) FS; 58A-5.0181(2) FAC

Based on resident record review and interview, the facility failed to ensure the health assessment (AHCA form 1823) was complete and accurate for 1 of 7 residents sampled (#19).

Findings:

Review record for resident #19 revealed undated health assessment with diagnoses which included . He was not noted to be an elopement risk. He was independent with all Activities of Daily Living. The assessment documented he required assistance with medications, but the form was blank for the type of assistance required.

On at 1:30 PM the facility supervisor confirmed the findings.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

DEFICIENCY REMAINED UNCORRECTED

Based on observations and interviews the facility failed to honor the resident's right to be treated with consideration and respect and with due recognition of personal dignity and failed to provide accommodations that were homelike, safe and comfortable.

Findings:

In an interview with resident #4 on at 11:30 AM who said when it rained she felt a drip coming from the pipe above her bed. She told the facility supervisor, who told her she needed to get money from the owner to make the repairs.

Observations of # (first floor) noted a pipe came from the wall to the ceiling above the bed of

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resident #4. The ceiling was discolored/stained.

In an interview on at 11:15 AM with resident # 15 who said she had felt a drip coming from the ceiling when she is in the bed. She told the facility supervisor, who told her they will fix it.

Observations on at 11:25 in (first floor) noted the ceiling tiles above the bed or resident #15 had several stains. The stains were over a resident's bed.

Observations of the second floor bathroom noted there was major leak. The wall by the toilet tank had broken plaster, there were plaster pieces on the floor. The wall to the left of the door was peeling and had dark brown stain, the door was warped and peeled away from door frame (from ceiling leak). This bathroom only had a toilet and a sink. This was also noticed on a visit on and has not been fixed or remedy to ensure the safety of the residents.

In an interview with resident #13 on at 12:45 PM who said he used the "leaky bathroom". Observations in (second floor) noted the window pane was loose, held in place with black tape. The wall behind the air conditioning unit was broken and dirty.

The other second floor bathroom had a shower and a toilet. The shower glass door was covered with a black substance. The inside of shower stall also had the black substance.

These two bathrooms were open for the use of the facility residents.

In an interview with resident #22 on at 1:20 PM there was leak from the ceiling, she put a bucket on the floor to collect the water.

Observations noted the room had a window air conditioning (ac) unit that had plywood and was held with gray tape. The tape was coming off. There was a small hole and the ceiling and was stained.

In an interview with the administrator/owner on at 1:45 PM who said everything will be fixed. He does not have a contract to repair the roof yet but he was working on it. He had someone else coming to give him an estimate and he will repair today. Another estimate was for $100,000 and he felt that was too much money for a roof, he was also working with his insurance.

The Agency representative asked about immediate remedies for the leaky bathroom, the hot water in the kitchen and the leaks in the resident's room. The administrator/owner said that the supervisor could have taken care of that herself, she did not need his permission to relocate the residents to other room

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temporarily. The supervisor said that she moved the bed in 212 and the resident put it . . . . She left the second floor leaky bathroom open in case a resident needed to use a bathroom and the other was occupied. Regarding the water faucet she said, it worked, all the staff need to do was open the . . . water valve when they need . . . water,

Class III

0077 - Staffing Standards - Administrators - 429.176 FS; 429.52( ),58A-5.019(1) FAC

Based on observations, interviews, resident and facility records review the facility administrator failed to oversee the operation and management of the facility to prevent breakdown of facility operation and ensure the facility's ability to:

1. Honor the resident's rights with due recognition of personal dignity and failed to provide accommodations that were homelike, safe and comfortable.
2. Provide and provide and maintain a home-like and decent environment in which to provide safe care for the residents, free from hazards
3. To honor resident's rights for grievances
4. To maintain a grievance log in which to confirm that resolutions were provided
5. To submit electronic adverse reports for # 19, #21 and staff A.
6. To maintain minimum staffing hours and to maintain an accurate staff schedule
7. To maintain time sheets
8. To submit the Emergency Power Plan (EPP) and install monoxide detectors
9. To obtain accurate health assessment report for # 19
10. To maintain an up to date BGS roster
11. To maintain substitutions of menu and to provide therapeutic diets

Findings:

In an interview with resident #4 on . . . . at 11:30 AM who said when it rained she felt a drip coming from the pipe above her bed. She told the facility supervisor, who told her she needed to get money from the owner to make the repairs.

Observations of . . . # . . (first floor) noted pipe came from the wall to the ceiling above the bed of resident #4. The ceiling was discolored/stained.

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In an interview on at 11:15 AM with resident # 15 who said she had felt a drip coming from the ceiling when she is in the bed. She told the facility supervisor, who told her they will fix it.

Observations on at 11:25 in (first floor) noted the ceiling tiles above the bed of resident #15 had several stains. The stains were over a resident's bed.

Observations of the second floor bathroom noted there was major leak. The wall by the toilet tank had broken plaster, there were plaster pieces on the floor. The wall to the left of the door was peeling and had dark brown stains, the door was warped and peeled away from door frame (from ceiling leak). This bathroom only had a toilet and a sink. This was also noticed on a visit on and has not been fixed or remedy to ensure the safety of the residents.

In an interview with resident #13 on at 12:45 PM who said he used the "leaky bathroom". Observations in (second floor) noted the window pane was loose, held in place with black tape. The wall behind the air conditioning unit was broken and dirty.

The other second floor bathroom had a shower and a toilet. The shower glass door was covered with a black substance. The inside of shower stall also had the black substance.

These two bathrooms were open for the use of the facility residents.

In an interview with resident #22 on at 1:20 PM there was leak from the ceiling, she put a bucket on the floor to collect the water.

Observations noted the room had a window air conditioning (ac) unit that had plywood that was held with gray tape. The tape was coming off. There was a small hole and the ceiling and was stained.

In an interview with the administrator/owner on at 1:45 PM who said everything will be fixed. He does not have a contract to repair the roof yet but he was working on it. He had someone else was coming to give him an estimate and he will repair today. Another estimate was for $100,000 and he felt that was too much money for a roof, he was also working with his insurance.

The Agency representative asked about immediate remedies for the leaky bathroom, the hot water in the kitchen and the leaks in the resident's room. The administrator/owner said that the supervisor could have taken care of that herself, she did not need his permission to relocate the residents to other the room temporarily. The supervisor said that she moved the bed in 212 and the resident put it . She left the second floor leaky bathroom open in case a resident needed to use a bathroom and the other

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were occupied. Regarding the water faucet she said, it worked, all the staff need to do was open the water valve when they need water,

2. During the facility entrance the supervisor said the census was 38 residents. Based on a census of 38 residents, the facility needed 335 staff hours weekly. The facility weekly hours were from Monday to Sunday. She said she had tried to hire more staff and still was short hours.

Staff schedule review of the staff schedule for the week of (Monday) to (Sunday revealed 6 staff were scheduled to work. Both schedules were dated , . The schedule indicated , , was a Friday, in reality that date was a Saturday. The schedule indicated a t total of 286 staff hours including the hours of overtime worked by the supervisor. At 11 AM on the supervisor printed another set of schedules and were identical to the previous ones.

In an interview with the administrator/owner on at 1 PM, who said how they could be short with all the overtime he had paid. He asked the supervisor to produce the documentation of the hours the staff had worked. The supervisor said that she was unable to print or locate the information from the computer. The administrator /owner looked at some paperwork he had and then said "Let's continue with the list (exit). The facility did not produce time sheets for all staff.

3. Observations on at 11:30 AM of the menu dated for the week of to indicated the menu to be served was hamburger on a , baked fries, lettuce tomato, and pudding and for 's sugar free pudding. The menu was last reviewed by a nutritionist on .

Observations on at 11:30 AM of the lunch to be served noted that rice with vegetables, 3 pieces of Italian sausage, collard green, canned peaches and fruit punch.

The staff who cooked said that cooking was not her usual job duty, but the cook quit on Friday, so the supervisor asked her to cook. She did not prepare the meal on the menu because the food products were not available, so she improvised the menu and tried to feed the resident a healthy meal. The former cook did not buy the groceries for the current week, so 2 staff went out grocery shopping. She did not know she needed to write down the menu substitutions.

Observations on at 11:45 AM of the menu dated for the week of to indicated the menu to be served meatloaf, mashed potatoes, and broccoli, ice cream and for , sugar free ice cream.

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Observations on at 11:45 AM of the lunch to be served noted that it consisted of, 3 meat balls, green beans, peaches and fruit punch. The staff who cooked said that she did not serve broccoli because it was not available and did not make meat loaf because she did not have the meat and there was no ice cream. She said she knew at least of 7 residents and needed to get sugar free cookies, low fat milk and other items.

Resident record review for resident #5 revealed a health assessment report 1823 dated that listed diagnosis of type 2 and 1800 American Association diet was needed.

Resident record review for resident # 7 revealed a health assessment report 1823 dated that indicated diagnosis of type 2 and a diet was needed.

4. Observations on at 10 AM noted the following:
1. First floor bathroom had missing ceiling tiles, light switch was broken, and a piece of the cover was missing.
2. Broken /loose floor time on first floor main hallway near medication room.
3. The paint by the medication room door was peeling.
4. First floor common area/living room ceiling had two large brown stains by ceiling fan. The ceiling on left side of living room/ by wall paper trim had stains and dark spots. The paper and plaster were peeling.
5. (first floor) had a ceiling tiles discolored, water stained and there was a black stain. The stain was over a resident's bed. The resident said, she had felt drips while she was on the bed.
6. # (first floor) had a pipe from the ceiling and the ceiling was discolored/stained. The resident said that when it rained, she could feel water dripping on her bed.
7. had a window air conditioning (ac) unit that was had plywood that was held with gray tape. The tape was coming off. The resident said there was leak from the ceiling. There was a small hole and the ceiling and was stained. The resident said she put a bucket on the floor.
8. A second floor bathroom had a major leak. The wall by toilet tank had broken plaster on floor, there were plaster pieces on the floor. The wall to the left of door was peeled and had dark brown stain, the door was warped and peeled away from door frame (from ceiling leak). This bathroom only had a toilet and sink. A resident said he used it "the leaky bathroom". This was also noticed on a visit on and has not been fixed yet or remedy to ensure the safety of the residents.
9. The other second floor bathroom had a shower and a toilet. The shower glass was covered with a black substance. The inside of shower stall also had the black substance.
10. (second floor) had a loose window pane, held with black tape. The wall being the air conditioning unit was broken.

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11. The hot water faucet in the kitchen did not work, no water came out when handle turned on.

In an interview with the administrator/owner on at 1:45 PM who said everything will be fixed. He does not have a contract to repair the roof yet but he was working on it. He had someone else was coming to give estimate and he will repair today. Another estimate was for $100, 00 and he felt that was too much money for a rook, he was also working with his insurance.

The Agency representative asked about immediate remedies for the leaky bathroom, the hot water in the kitchen and the leaks in the resident's room. The administrator/owner said that the supervisor could have taken care of that herself, she did not need his permission to relocate the residents to other room temporarily. The supervisor said that she moved the bed in 212 and the resident put it . She left the second floor leaky bathroom open in case a resident needed to use a bathroom and the other were occupied. Regarding the water faucet she said, it worked, all the staff need to do was open the water valve when they need water,

4. The facility supervisor said on at 9:30 AM that she did not keep a grievance log, she thought she did not need one. She added that when a resident presented a grievance she resolved at the time, but did not keep a written record. She provided a folder with a couple of blank grievance client logs.

In an interview with resident #4 on at 11:30 AM who said when it rained she felt a drip coming from the pipe above her bed. She told the facility supervisor, who told her she needed to get money from the owner to make the repairs.

Observations of # (first floor) noted pipe came from the wall to the ceiling above the bed of resident #4. The ceiling was discolored/stained.

In an interview on at 11:15 AM with resident # 15 who said she had felt a drip coming from the ceiling when she is in the bed. She told the facility supervisor, who told her they will fix it.

Observations on at 11:25 in (first floor) noted the ceiling tiles above the bed or resident #15 had several stains. The stains were over a resident's bed.

Observations of the second floor bathroom noted there was major leak. The wall by toilet tank had broken plaster, there were plaster pieces on the floor. The wall to the left of door was peeled and had dark brown stain, the door was warped and peeled away from door frame (from ceiling leak). This bathroom only had a toilet and sink. This was also noticed on a visit on and has not been fixed yet or remedy to ensure the safety of the residents.

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In an interview with resident #13 on . . . . . at 12:45 PM who said he used the "leaky bathroom". Observations in (second floor) noted the window pane was loose, held in place with black tape. The wall being the air conditioning unit was broken and dirty. The supervisor said they would fix the window.

In an interview with resident #22 on at 1:20 PM there was leak from the ceiling, she put a bucket on the floor to collect the water.
Observations noted the room had a window air conditioning (ac) unit that was had plywood that was held with gray tape. The tape was coming off. There was a small hole and the ceiling and was stained.

In an interview with the administrator/owner on . . . . . at 1:45 PM who said everything will be fixed. He does not have a contract to repair the roof yet but he was working on it. He had someone else was coming to give estimate and he will repair today. Another estimate was for $100, 00 and he felt that was too much money for a rook, he was also working with his insurance.

The Agency representative asked about immediate remedies for the leaky bathroom, the hot water in the kitchen and the leaks in the resident's room. The administrator/owner said that the supervisor could have taken care of that herself, she did not need his permission to relocate the residents to other room temporarily. The supervisor said that she moved the bed in 212 and the resident put it . . . . She left the second floor leaky bathroom open in case a resident needed to use a bathroom and the other were occupied.

4. In an interview with the facility supervisor on . . . . . at 9:30 AM, who said staff F quit and last worked on .

Review of the Agency's BGS roster on 50/6/19 at 9:55 AM revealed that staff F was listed as current employee.

In an interview with the supervisor on . . . . . at 10 AM who said she had updated the BGS roster and could not understand why the names keep showing up as current employees. She proceeded to show the BGS roster on the Agency's website and staff F was still listed as a current employee.

5. Incident report, not dated, indicated the supervisor came to the facility to meet with staff A to collect money from him, staff A became verbally toward the supervisor. The police came to investigate the altercation. Staff A was told to stay away from the facility.
The supervisor said on at 11 AM that staff A quit on after the police was called to

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report a theft of $300.00 from her purse. She called the police. He had $300.00 in his pocket. She did not file an adverse report.

6. Police report dated indicated they responded to the facility on because a report of battery between a female and male resident. The report dated indicated that after an investigation the case was closed unfounded.

The supervisor said on at 1: 30 PM hat she did not file adverse report for the above events because after caring for 38 residents; she did not have time.

7. Review record for resident #19 revealed undated health assessment with diagnoses which included . He was not noted to be an elopement risk. He was independent with all Activities of Daily Living. The assessment documented he required assistance with medications, but the form was blank for the type of assistance required. On at 1:30 PM the facility supervisor confirmed the finding.

8. Review of the facility incident log book reveal an incident report dated for resident #19 who was discovered by a caregiver to be missing from the facility on at 4:00AM. The note documented another caregiver last saw him at 10:50PM the night before. The police non-emergency number was called at 4AM. The note further documented the resident returned to the facility on his own at 5:40AM and told the caregiver he asleep at a gas station. Review of the facility communication book found an entry for from the 11pm-7am shift which noted "(#19) not here. Did B/C (bed check). Everyone else is here. 34 residents." An undated and untimed update appeared in a different handwriting below the 11pm-7am note which stated "UPDATE: (#19) is home at 7AM. 35 residents." Review of the health assessment for resident #19 revealed diagnoses which included . He was not noted to be an elopement risk. He was independent with all Activities of Daily Living. Further review revealed there was no adverse incident report submitted to AHCA for this incident in which police were

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involved.

Review of the facility incident log book reveal an incident report dated for resident #21 who was discovered by a caregiver to be missing from the facility on . The police non-emergency number was called for assistance. The note did not document if or when the resident returned to the facility. Review of the facility communication book found an entry for , but resident #21 was not noted to be missing on the entry. Also noted in the resident file was a copy of a 45-day notice of discharge provided to the resident's case manager on and another notice on . Review of the facility admission-discharge log found the resident was admitted to the facility on , but there was not discharge date noted on the log. Further review revealed there was no adverse incident report submitted to AHCA for this incident in which police were involved.

On at 1:30 PM the facility supervisor stated she did not know she had to send in adverse reports for these incidents.

9. Request to review the approval letter for the facility's Emergency Power Plan (EPP) revealed they have not yet received approval. The plan submitted to the county was provided for review and was incomplete and contained outdated information. Request concerning installation of monoxide detectors found 3 monitors were purchased, but not installed. The monitors were seen in their original packaging in the in the facility office.

On at 12:05PM, the facility supervisor stated she submitted the EPP plan to the county on but still did not receive approval. She stated the local fire marshal told them to purchase 2 monoxide detectors, and confirmed they have not yet installed them.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on staff schedule review and interview the facility failed which is licensed for 40 residents failed to maintain time sheets of all staff.

Findings:

During the facility entrance the supervisor said the census was 38 residents. Based on a census of 38 residents, the facility needed 335 staff hours weekly. The facility weekly hours were from Monday to Sunday. She said she had tried to hire more staff and still was short hours.

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Staff schedule review of the staff schedule for the week of (Monday) to (Sunday revealed 6 staff were scheduled to work. Both schedules were dated . The schedule indicated , was a Friday, in reality that date was a Saturday. The schedule indicated a t total of 286 staff hours including the hours of overtime worked by the supervisor. At 11 AM on the supervisor printed another set of schedules and were identical to the previous ones.

In an interview with the administrator/owner on at 1 PM, who said how they could be short with all the overtime he had paid. He asked the supervisor to produce the documentation of the hours the staff had worked. The supervisor said that she was unable to print or locate the information from the computer. The administrator /owner looked at some paperwork he had and then said "Let's continue with the list (exit).

The facility did not produce time sheets for all staff.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

DEFICIENCY REMAINED UNCORRECTED

Based on staff schedule review and interview the facility failed to maintain the minimum staff hours per week and failed to maintain a written work schedule that reflected its 24-hour staffing pattern for a given time period.

Findings:

During the facility entrance the supervisor said the census was 38 residents. Based on a census of 38 residents, the facility needed 335 staff hours weekly. The facility weekly hours were from Monday to Sunday. She said she had tried to hire more staff and still was short hours.

Staff schedule review of the staff schedule for the week of (Monday) to (Sunday revealed 6 staff were scheduled to work. Both schedules were dated . The schedule indicated , was a Friday, in reality that date was a Saturday. The schedule indicated a t total of 286 staff hours including the hours of overtime worked by the supervisor. At 11 AM on the supervisor printed another set of schedules and were identical to the previous ones.

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In an interview with the administrator/owner on . . . . . at 1 PM, who said how they could be short with all the overtime he had paid. He asked the supervisor to produce the documentation of the hours the staff had worked. The supervisor said that she was unable to print or locate the information from the computer. The administrator /owner looked at some paperwork he had and then said "Let's continue with the list (exit).

The facility did not produce an accurate written work schedule that reflected its 24- hour staffing pattern for a given time period and hours worked.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observations, facility records review and interviews the facility failed to ensure: 1. Regular and therapeutic menus as served, with substitutions noted before or when the meal was served, and kept on file in the facility for 6 months. 2. Therapeutic diets were prepared and served as ordered by the health care provider, 3. Regular and therapeutic menus to be used by the facility were reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian.

Findings:

Observations on at 11:30 AM of the menu dated for the week of to indicated the menu to be served was hamburger on a . . , baked fries, lettuce tomato, and pudding and for . . . . . 's sugar free pudding. The menu was last reviewed by a nutritionist on .

Observations on at 11:30 AM of the lunch to be served noted that rice with vegetables, 3 pieces of Italian sausage, collard green, canned peaches and fruit punch.
The staff who cooked said that cooking was not her usual job duty, but the cook quit on Friday, so the supervisor asked her to cook. She did not prepare the meal on the menu because the food products were not available, so she improvised the menu and tried to feed the resident a health meal. The former cook did not buy the groceries for the current week, so 2 staff went out grocery shopping. She did not know she needed to write down the menu substitutions.

Observations on at 11:45 AM of the menu dated for the week of to indicated the menu to be served meatloaf, mashed potatoes, and broccoli, ice cream and for . . . . . , sugar free ice

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cream.

Observations on at 11:45 AM of the lunch to be served noted that it consisted of, 3 meat balls, green beans, peaches and fruit punch. The staff who cooked said that she did not serve broccoli because it was not available and did not make meat loaf because she did not have the meat and there was no ice cream. She said she knew at least of 7 residents and needed to get sugar free cookies, low fat milk and other items.

Resident record review for resident #5 revealed a health assessment report 1823 dated that listed diagnosis of type 2 and 1800 American Association diet was needed.

Resident record review for resident # 7 revealed a health assessment report 1823 dated that indicated diagnosis of type 2 and a diet was needed.

Class III

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

DEFICIENCY REMIANED UNCORRECTED

Based on observations and interview, the facility failed to provide and maintain a home-like and decent environment in which to provide safe care for the residents.

Findings:

Observations on at 10 AM noted the following:

1. First floor bathroom had missing ceiling tiles, light switch was broken, and a piece of the cover was missing.
2. Broken /loose floor time on first floor main hallway near medication room.
3. The paint by the medication room door was peeling.
4. First floor common area/living room ceiling had two large brown stains by ceiling fan. The ceiling on left side of living room/ by wall paper trim had stains and dark spots. The paper and plaster were peeling.
5. (first floor) had a ceiling tiles discolored, water stained and there was a black stain. The stain was over a resident's bed. The resident said, she had felt drips while she was on the bed.

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6. . . # (first floor) had a pipe from the ceiling and the ceiling was discolored/stained. The resident said that when it rained, she could feel water dripping on her bed.
7. had a window air conditioning (ac) unit that was had plywood that was held with gray tape. The tape was coming off. The resident said there was leak from the ceiling. There was a small hole and the ceiling and was stained. The resident said she put a bucket on the floor.
8. A second floor bathroom had a major leak. The wall by toilet tank had broken plaster on floor, there were plaster pieces on the floor. The wall to the left of door was peeled and had dark brown stain, the door was warped and peeled away from door frame (from ceiling leak). This bathroom only had a toilet and sink. A resident said he used it "the leaky bathroom". This was also noticed on a visit on and has not been fixed yet or remedy to ensure the safety of the residents.
9. The other second floor bathroom had a shower and a toilet. The shower glass was covered with a black substance. The inside of shower stall also had the black substance.
10. (second floor) had a loose window pane, held with black tape. The wall being the air conditioning unit was broken.
11. The hot water faucet in the kitchen did not work, no water came out when handle turned on.

In an interview with the administrator/owner on at 1:45 PM who said everything will be fixed. He does not have a contract to repair the roof, but he was working on it. He had someone else was coming to give estimate and he will repair today. Another estimate was for $100,000 and he felt that was too much money for a rook, he was also working with his insurance.

The Agency representative asked about immediate remedies for the leaky bathroom, the hot water in the kitchen and the leaks in the resident's room. The administrator/owner said that the supervisor could have taken care of that herself, she did not need his permission to relocate the residents to other room temporarily. The supervisor said that she moved the bed in 212 and the resident put it . She left the second floor leaky bathroom open in case a resident needed to use a bathroom and the other were occupied. Regarding the water faucet she said, it worked, all the staff need to do was open the . . . water valve when they need . . . water,

Class III

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

Based on interviews and facility records review the facility failed to ensure it had a working grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 58A-5.0182, F.A.C.

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Findings:

The facility supervisor said on [redacted] at 9:30 AM that she did not keep a grievance log, she thought she did not need one. She added that when a resident presented a grievance she resolved at the time, but did not keep a written record. She provided a folder with a couple of blank grievance client logs.

In an interview with resident #4 on [redacted] at 11:30 AM who said when it rained she felt a drip coming from the pipe above her bed. She told the facility supervisor, who told her she needed to get money from the owner to make the repairs.

Observations of [redacted] # [redacted] (first floor) noted pipe came from the wall to the ceiling above the bed of resident #4. The ceiling was discolored/stained.

In an interview on [redacted] at 11:15 AM with resident # 15 who said she had felt a drip coming from the ceiling when she is in the bed. She told the facility supervisor, who told her they will fix it.

Observations on [redacted] at 11:25 in [redacted] (first floor) noted the ceiling tiles above the bed or resident #15 had several stains. The stains were over a resident's bed.

Observations of the second floor bathroom noted there was major leak. The wall by toilet tank had broken plaster, there were plaster pieces on the floor. The wall to the left of the door was peeled and had dark brown stain, the door was warped and peeled away from door frame (from ceiling leak). This bathroom only had a toilet and sink. This was also noticed on a visit on [redacted] and has not been fixed or remedy to ensure the safety of the residents.

In an interview with resident #13 on [redacted] at 12:45 PM who said he used the "leaky bathroom". Observations in [redacted] (second floor) noted the window pane was loose, held in place with black tape. The wall behind the air conditioning unit was broken and dirty. The supervisor said they would fix the window.

In an interview with resident #22 on [redacted] at 1:20 PM there was leak from the ceiling, she put a bucket on the floor to collect the water.

Observations noted the room had a window air conditioning (ac) unit that was had plywood that was held with gray tape. The tape was coming off. There was a small hole and the ceiling and was stained.

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In an interview with the administrator/owner on at 1:45 PM who said everything will be fixed. He does not have a contract to repair the roof, but he was working on it. He had someone else was coming to give estimate and he will repair today. Another estimate was for $100,000 and he felt that was too much money for a rook, he was also working with his insurance.

The Agency representative asked about immediate remedies for the leaky bathroom, the hot water in the kitchen and the leaks in the resident's room. The administrator/owner said that the supervisor could have taken care of that herself, she did not need his permission to relocate the residents to other room temporarily. The supervisor said that she moved the bed in 212 and the resident put it . She left the second floor leaky bathroom open in case a resident needed to use a bathroom and the other were occupied.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Revisit conducted. Deficiency A-200 remained uncorrected.

Based on observations and interviews the facility failed to: 1 Obtain approval for the facility emergency power plan (EPP) from the County Office of Emergency Management in a timely fashion, and 2) Install Monoxide monitors as required.

Findings:

Request to review the approval letter for the facility's EPP revealed they have not yet received approval. The plan submitted to the county was provided for review and was incomplete and contained outdated information.

Request concerning installation of CO monitors found 3 monitors were purchased, but not installed. The monitors were seen in their original packaging in the in the facility office.

On at 12:05 PM, the facility supervisor stated she submitted the plan to the county on but still did not receive approval. She stated the local fire Marshall told them to purchase 2 CO monitors, and confirmed they have not yet installed them.

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Class III

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

DEFICIENCY REMAINED UNCORRECTED

Based on record review and interview the facility failed to maintain the employment status of all employees within the BGS clearinghouse.

Findings:

In an interview with the facility supervisor on at 9:30 AM, who said staff F quit and last worked on .

Review of the Agency's BGS roster on 50/6/19 at 9:55 AM revealed that staff F was listed as current employee.

In an interview with the supervisor on at 10 AM who said she had updated the BGS roster and could not understand why the names keep showing up as current employees. She proceeded to show the BGS roster on the Agency's website and staff F was still listed as a current employee.

Unclassified

Z821 - Reporting Requirements; Electronic Submission - 59A-35.110 FAC

DEFICIENCY REMAINED UNCORRECTED

Based on resident and facility records review and interview, the facility failed to file adverse incident reports for events reported to law enforcement for investigation.

Findings

1. Incident report, not dated, indicated the supervisor came to the facility to meet with staff A to collect money from him, staff A became verbally toward the supervisor. The police came to investigate the altercation. Staff A was told to stay away from the facility.

The supervisor said on at 11 AM that staff A quit on after the police was called to

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report a theft of $300.00 from her purse. She called the police. He had $300.00 in his pocket. She did not file an adverse report.

2. Police report dated indicated they responded to the facility on because a report of battery between a female and male resident. The report dated indicated that after an investigation the case was closed unfounded.

The supervisor said on at 1: 30 PM hat she did not file adverse report for the above events because after caring for 38 residents; she did not have time.

3. Review of the facility incident log book reveal an incident report dated for resident #19 who was discovered by a caregiver to be missing from the facility on at 4:00AM. The note documented another caregiver last saw him at 10:50PM the night before. The police non-emergency number was called at 4AM. The note further documented the resident returned to the facility on his own at 5:40AM and told the caregiver he asleep at a gas station.

Review of the facility communication book found an entry for from the 11pm-7am shift which noted "(#19) not here. Did B/C (bed check). Everyone else is here. 34 residents." An undated and untimed update appeared in a different handwriting below the 11pm-7am note which stated "UPDATE: (#19) is home at 7AM. 35 residents." Review of the health assessment for resident #19 revealed diagnoses which included . He was not noted to be an elopement risk. He was independent with all Activities of Daily Living. Further review revealed there was no adverse incident report submitted to AHCA for this incident in which police were involved.

4. Review of the facility incident log book reveal an incident report dated for resident #21 who was discovered by a caregiver to be missing from the facility on . The police non-emergency number was called for assistance. The note did not document if or when the resident returned to the facility. Review of the facility communication book found an entry for , but resident #21 was not noted to be missing on the entry. Also noted in the resident file was a copy of a 45-day notice of discharge provided to the resident's case manager on and another notice on . Review of the facility admission-discharge log found the resident was admitted to the facility on , but there was not discharge date noted on the log. Further review revealed there was no adverse incident report submitted to AHCA for this incident in which police were involved.

On /19 at 1:30 PM the facility supervisor stated she did not know she had to send in adverse reports for these incidents.

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