Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964808	A. BUILDING: _____ B. WING _____	09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH COTTAGE OF OVIEDO	445 ALEXANDRIA BLVD. OVIEDO, FL 32765

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (#2023013868) was conducted at Savannah Cottage of Oviedo on and . The facility had deficiencies at the time of the survey.	A 000		
A 030 SS=J	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.	A 030		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 030	Continued From page 1 (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.	A 030		

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A 030	Continued From page 2 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.	A 030		

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A 030	Continued From page 3 (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making [illegible] for health care services, the provision of or arrangement of transportation to health care [illegible], and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally [illegible], the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free	A 030		

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A 030	Continued From page 4 telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to	A 030		

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A 030	Continued From page 5 call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated or under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide ( ) without delay to 1 of 2 sampled residents who , without advance directives or a ( ) (#5), failed to ensure the staff who performed the had a valid certification and failed to ensure the Automated External Defibrillator ( ) was used as part of its resuscitative efforts.	A 030		

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A 030	Continued From page 6 Findings: Review of resident #5's record revealed a facility admission date of . Review of the Form 1823 (health assessment form) dated , indicated resident's medical history included , major behavioral disturbance, , and . The form 1823 also indicated resident was alert and oriented x 3, required precautions, and assistance with bathing, , grooming, toileting, ambulation, and transfers. Review of the medical record for resident #5 did not find any advance directives or and noted on the facility's data application a "No" answer to the question of "do you have a ?". Review of the facility incident report read, in part, that on at approximately 7:45 am Med Tech A went to assist the resident to the dining room for breakfast. The resident said they were not feeling well, did not want to eat breakfast, and asked to be taken to the TV room, to where resident was taken at approximately 7:50 am. At approximately 11:30 A, Med Tech A checked in with the resident and asked if they wanted to go to the dining room for lunch. The resident said no, so Med Tech A told resident she would bring lunch to him/her in the TV room to eat with another resident. At approximately 12:15 PM Med Tech A arrived to the TV room to find the resident sitting in their wheelchair, slumped over the table and unresponsive. At approximately 12:16 PM Med Tech A called for Nurse C who responded at approximately 12:20 PM. Nurse C arrived to find the resident not breathing and	A 030		

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A 030	Continued From page 7 without a , ... At approximately 12:22 PM Med Tech A took the resident to their room and Nurse C called 911. . . was not initiated until approximately 12:23 p.m., 8 minutes later, after Med Tech A and Nurse C placed the resident on the bed. Nurse C then began and continued until 12:45 PM when emergency personnel arrived. Resident was pronounced . . . . at 1:10 PM by emergency personnel. During an interview on at 1:21 PM Nurse C read the . . . . . incident report and acknowledged that the details of her involvement were correct. Continued interview noted the nurse stated she was certified in , however, on at 2:10 PM, review of Nurse C's . card dated revealed the training was obtained online and not in person, as required. Nurse C, during this interview at 2:30 PM., acknowledged her . was obtained through on-line training stating she did not know the training had to be done in person and stated it had been too long ago for her to track down the date she had last taken . . in person. Interview on . at 4:20 PM continued with Nurse C and when asked why was not initiated in the TV room where the resident was first found unresponsive, she stated it was because there were other residents and family members present. During an interview with Nurse C on at 9 AM, when asked if the facility's Automated External Defibrillator ( ) was used on resident #5, nurse C replied "no". When asked why, she replied "because when I saw her, I just went into my mode". Upon questioning as well as observation of the , it was located inside the	A 030		

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A 030	Continued From page 8 nurse's station and observation of the electrode pads noted an expiration date of along with the tag used to document maintenance inspections noting it to be blank. On at 9:25 AM, the house manager provided an , cartridge with an expiration date of stating the new pads were delivered 2 weeks ago and at that time they didn't need to be replaced so they were being stored in her office, located in another licensed facility on the same property. She (house manager) stated going forward, the house manager will now be responsible for checking the AEDs. Continued interview noted the house manager stated the facility did not have a policy specific to the use of the but that its use was expected during the course of performing . House manager also stated she did not ask the staff if the was used at the time of resident #5's . She went on to say as a nurse herself, she believed should have been performed in the TV room where the resident was first found unresponsive, but then also said she understood why it was not, in order to protect resident #5's dignity because other residents and families were present. Review of Med Tech A's personnel record revealed a hire date of . The personnel record contained a card dated obtained through an on-line course and a certificate noting her last 1-hour training was on . On at 1:45 PM, interview with the administrator confirmed Med Tech A had not had training since . Resident #5 was found by staff on at 12:15 p.m. to be unresponsive, without a , , and without , , was not initiated immediately but instead it was approximately 8	A 030		

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A 030	Continued From page 9 minutes later, after Nurse C and Med Tech A took resident to her room, some 30 from where she was found, placed her in bed and then initiated . In addition, the was not brought to the bedside for use, the pads were noted to be expired, and Nurse C who performed did not hold a valid certification. Further review of the resident's record noted he/she did not have advance directives or a to indicate what her wishes would have been regarding . Class I	A 030		
A 075 SS=G	429.255( ) FS Use of Personnel; Emergency Care ( ) (3)(a) An assisted living facility licensed under this part with 17 or more beds shall have on the premises at all times a functioning automated external defibrillator as defined in s. 768.1325(2)(b). (b) The facility is encouraged to register the location of each automated external defibrillator with a local emergency medical services medical director. (c) The provisions of ss. 768.13 and 768.1325 apply to automated external defibrillators within the facility. (4) Facility staff may withhold or withdraw or the use of an automated external defibrillator if presented with an order not to executed pursuant to s. 401.45. The agency shall adopt rules providing for the implementation of such orders. Facility staff and facilities may not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing	A 075		

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A 075	Continued From page 10 . . . . . or use of an automated external defibrillator pursuant to such an order and rules adopted by the agency. The absence of an order not to executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing . . . . . or use of an automated external defibrillator as otherwise permitted by law. (5) The agency may adopt rules to implement the provisions of this section relating to use of an automated external defibrillator. This Statute or Rule is not met as evidenced by: Based on observations and interview, the facility failed to replace the electrode pads on the Automated External Defibrillator (. . .) unit before they expired. Finding: On at 9 AM, observations noted the facility's . . . was located inside the nurse's station with electrode pads that had an expiration date of . . . . . On . . . . . at 9:25 AM, the house manager provided an , cartridge with an expiration date of . . . . . During an interview on . . . . . at 9:36 AM, the administrator said the new pads given by the house manager were delivered two weeks ago. She continued to say the resident care director at that time said the pads did not need to be replaced so the administrator stored them in her office, which was in another licensed facility located on the same property. (pads have adhesive gel so the gel will stick to the patient's skin and act as a conductor of electricity. If pads are expired, there might	A 075		

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A 075	Continued From page 11 be insufficient adherence to the skin , leading to the electric pulses not penetrating the skin properly. The machine will end up being less effective, and the patient will not receive a sufficient amount of electric pulses to stabilize their rhythm. https://www.mindray.com/en/media-center/blogs/how-often-do- -replacement-pads-need-to-be-replaced#:~:text=The%20reason%20why%20AED%20pads,not%20penetrating%20the%20skin%20properly.) Class II	A 075		
A 077 SS=G	429.176 FS; 429.52(.),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement.	A 077		

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A 077	Continued From page 12 Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to [illegible], are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances,	A 077		

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A 077	Continued From page 13 such as the . . . . . of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile . . . . . of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , . , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not . . . . . , serve as an administrator	A 077		

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	AL11964808	A. BUILDING: _____ B. WING _____	09/15/2023

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A 077	Continued From page 14 of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No =Ref-09393. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the administrator, who is responsible for the management of all staff and the provision of appropriate care to all residents, failed to ensure: 1. was initiated without delay to a resident who did not have advance directives or a and who became unresponsive, with no and no , 2. Staff who performed on a resident had a valid certification. 3. The electrode pads for the facility's unit were replaced before they expired. Findings: Review of resident #5's record revealed a facility admission date of . Review of the Form 1823 (health assessment form) dated , indicated resident's medical history included , major behavioral disturbance, , and . The form 1823 also indicated resident was alert and	A 077		

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A 077	Continued From page 15 oriented x 3, required . precautions, and assistance with bathing, . , grooming, toileting, ambulation, and transfers. Review of the medical record for resident #5 did not find any advance directives or and noted on the facility's data application a "No" answer to the question of "do you have a . ?". Review of the facility incident report read, in part, that on at approximately 7:45 am Med Tech A went to assist the resident to the dining room for breakfast. The resident said they were not feeling well, did not want to eat breakfast, and asked to be taken to the TV room, to where resident was taken at approximately 7:50 am. At approximately 11:30 A, Med Tech A checked in with the resident and asked if they wanted to go to the dining room for lunch. The resident said no, so Med Tech A told resident she would bring lunch to him/her in the TV room to eat with another resident. At approximately 12:15 PM Med Tech A arrived . . . to the TV room to find the resident sitting in their wheelchair, slumped over the table and unresponsive. At approximately 12:16 PM Med Tech A called for Nurse C who responded at approximately 12:20 PM. Nurse C arrived to find the resident not breathing and without a , ... At approximately 12:22 PM Med Tech A took the resident to their room and Nurse C called 911. . was not initiated until approximately 12:23 p.m., 8 minutes later, after Med Tech A and Nurse C placed the resident on the bed. Nurse C then began and continued until 12:45 PM when emergency personnel arrived. Resident was pronounced . . . at 1:10 PM by emergency personnel.	A 077		

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A 077	Continued From page 16 During an interview on at 1:21 PM Nurse C read the incident report and acknowledged that the details of her involvement were correct. Continued interview noted the nurse stated she was certified in , however, on at 2:10 PM, review of Nurse C's card dated revealed the training was obtained online and not in person, as required. Nurse C, during this interview at 2:30 PM., acknowledged her was obtained through on-line training stating she did not know the training had to be done in person and stated it had been too long ago for her to track down the date she had last taken in person. Interview on at 4:20 PM continued with Nurse C and when asked why was not initiated in the TV room where the resident was first found unresponsive, she stated it was because there were other residents and family members present. During an interview with Nurse C on at 9 AM, when asked if the facility's Automated External Defibrillator ( ) was used on resident #5, nurse C replied "no". When asked why, she replied "because when I saw her, I just went into my mode". Upon questioning as well as observation of the , it was located inside the nurse's station and observation of the electrode pads noted an expiration date of along with the tag used to document maintenance inspections noting it to be blank. On at 9:25 AM, the house manager provided an , cartridge with an expiration date of stating the new pads were delivered 2 weeks ago and at that time they didn't need to be replaced so they were being stored in	A 077		

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A 077	Continued From page 17 her office, located in another licensed facility on the same property. She (house manager) stated going forward, the house manager will now be responsible for checking the AEDs. Continued interview noted the house manager stated the facility did not have a policy specific to the use of the ... but that its use was expected during the course of performing . House manager also stated she did not ask the staff if the ... was used at the time of resident #5's . She went on to say as a nurse herself, she believed . should have been performed in the TV room where the resident was first found unresponsive, but then also said she understood why it was not, in order to protect resident #5's dignity because other residents and families were present. Review of Med Tech A's personnel record revealed a hire date of ... . The personnel record contained a card dated obtained through an on-line course and a certificate noting her last 1-hour training was on ... . On ... at 1:45 PM, interview with the administrator confirmed Med Tech A had not had ... training since ... . Resident #5 was found by staff on ... at 12:15 p.m. to be unresponsive, without a , , and without ..., ... was not initiated immediately but instead it was approximately 8 minutes later, after Nurse C and Med Tech A took resident to her room, some 30 from where she was found, placed her in bed and then initiated . In addition, the was not brought to the bedside for use, the ... pads were noted to be expired, and Nurse C who performed ... did not hold a valid certification. Further review of the resident's record noted he/she did not have advance directives or a to indicate what her wishes would have	A 077		

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A 077	Continued From page 18 been regarding . . . . . . In summary, the facility's administrator is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required. Therefore, the administrator was responsible for ensuring compliance in the areas where deficient practice was identified. Class II	A 077		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable _ to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects,	A 152		

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A 152	Continued From page 19 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observations and interview, the facility failed to maintain a clean-living environment and failed to make repairs to chipped wood and paint on columns located throughout the resident's common living area. Findings: During a tour of the facility on . . . . at 10:05 AM, the following was seen: Paint and wood were chipped from the base of white columns in the common area. Dried, splattered food and liquids on walls and baseboards. Dusty and dirty baseboards. Broken vinyl flooring in the resident's dining room. Garbage, a section of a metal fence, a dirty and wet table umbrella, and unraveled hose was on the ground in the outside courtyard. . . . . baskets stored outside next to the screened in patio. A table umbrella on the ground in the patio. Black substance on air conditioner ceiling vent	A 152		

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A 152	Continued From page 20 located in the alcove off the activity room. During an interview on at 2:13 PM, housekeeper E said she did not have a cleaning assignment but rather she created her own. She said it consisted of vacuuming and cleaning the common areas, cleaning resident rooms, washing dishes from meals, clean employee and common area bathrooms, shampoo carpets monthly and as needed and sweep and mop the dining room floor before she leaves at 3 PM. She said she cleaned walls in the dining room and common areas only as needed and the baseboards monthly or every other month. On at 2:05 PM, the administrator was shown the areas of concern, which were still there, and she confirmed the findings. Class III	A 152		