STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968388	02/21/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Connerton Court	21021 Betel Palm Ln Land O Lakes, FL 34638	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0079 - 58a-5.019(4) Fac - Staffing Standards - Levels S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

The complaint surveys, CCR# 2013012665 & CCR# 2013012852, were conducted on [redacted] &

The Connerton Court, assisted living facility, had deficiencies at the time of the visit.

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

Based on observation and interview although the facility meets the required staffing hours for the current census there was not sufficient direct care staff in the memory care unit to meet the needs of the 16 residents residents in the unit.

Findings include:

During observation on [redacted] and [redacted] of residents in the memory care unit, it was observed that all 16 residents required constant supervision and redirecting. Only three employees were available.

During the two days of observation the noise level was very high; there was one resident that was sitting in his wheelchair pushing the door that leads to the outside common area. Every time he pushed on the door a loud buss would begin and cause some other residents to come to the door. The resident care aide had to come over to the key [redacted] to reset it each time to quiet the alarm. The buzzing continued for approximately 30 minutes. The aide tried to re-direct the residents but failed. The resident continued and the aide could not leave the area she had to keep resetting the door code to stop the loud buzz.

At approximately 11:40a.m. on [redacted] during a discussion with the director of wellness it was stated some of residents could be aggressive. He stated the staff has been able to redirect the resident to control the behavior. The director stated when someone from the assisted living facility acts out and becomes difficult to handle the facility has the resident brought to the memory care unit until they calm down and become reasonable.

Observation on [redacted] at approximately 11:45 a.m. of resident #3 who walked out of his [redacted] in the Conner of the dining [redacted] in the same [redacted] resident was moving the plastic glasses the employee has just placed on each table. Another resident was trying to leave and pushing the door which set off the buzzer and was threatening to bust out of the door if someone did not open it for him. One direct care ran to stop the

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resident #3 from in the corner the other was trying to stop the resident from pushing the door and was resetting the key . The third staff, a med tech was in the process of doing a med pass when a doctor came to the med cart and requested the med tech go over a resident's medication with her. The med-tech had to replace the bubble packs in the cart and lock it to address the doctor's needs. At the same time a female resident started to yell at a male resident and banged the chair at a table- yelling for the other resident to leave. An aide ran to her and took the male resident away from the table. The staff was trying to set up for the noon meal and redirect the residents that were acting out. The staff placed pitchers of drinks on the counter and residents were starting to walk up to the counter and filling their glasses with the drinks. In the meantime, the housekeeping arrived to clean the area where the resident and a kitchen staff showed up with a tray of food causing the door to buzz loudly which once again caused residents to go to the door.

The commotion was constant and not conducive to a calm environment in the memory care unit. Even the residents were seated at the table there are certain residents that yell out and others needing one to one assistance for feeding-the staff were constantly trying to intervene where needed, assist with feeding and attempting to maintain a sense of calm. One resident would not allow staff to take him to the table for the meal. An observation on and again on (at noon) the staff would bring the plate of food to the resident in order to gain his interest. Only then would the resident will then allow the employee to hold his hand and help to lead him in his wheelchair to the table all the while as he is focused on the plate of food.

One resident got up from the table walked over the the serving area & picked up a dish of Jell-O desert from the serving tray. He began eating it with his fingers. Other residents were getting up and helping themselves to the thicken water, water, no concentrated sweet drink and iced tea etc. while staff were involved assisting or re-directing the other residents

Resident #7 is on a mechanical soft diet and has to be feed. On day of the survey the wellness director fed the resident but if he stopped to address another issue the resident would yell out for his attention.

On during the noon meal the staff who was feeding resident #7 had to get up to assist with another resident. They would walk by resident #7 and put a spoon full of food in the residents mouth them continue on to the next resident needing some assistance. The resident would chew her food and then yell out again and a staff would give her another spoon full of food and so on it went until the meal was over.

The unit was a constantly in turmoil with one incident after another that does not seem to let up. The wellness director stated he tries to come over and help the staff but can't always because of the demands he has in the assisted living side.

Class III

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

A. Based on observation and interview the facility failed to ensure they served the portion sizes as directed by the dietitian when serving the residents meals.

Findings include:

During observation of the residents lunch in the memory care unit it was revealed the food is brought in from the kitchen already served on plates and kept hot in a food cart. As the staff uncovered and served the meal it was observed that the dishes did not have equal portion sizes. Some residents appeared to receive twice the amount of food than others.

The staff stated there were a couple of residents that received larger portions. The staff confirms that most of the lunch served on had different portion sizes.

On at appropriately 1:00p.m. During a brief interview the cook stated he had placed the correct ladle to be used when serving the residents in front of each container of food. He stated the server must have given two ladles some dishes. The cook stated he would make sure they did no repeat this mistake.
On at approximately 11:50a.m. The cook came into the memory care unit with the food cart. He stated the portion sizes are correct this time. He stated there were two lunch plates that contained chicken for the two residents that have to shell fish. The med tech stated they did not have a resident that with to shellfish. The cook made a mistake; the residents were not in memory care they were in the assisted part of the facility.

B. Based upon record review and observation, 2 residents (# 6 & 7) residents did not receive their liquids thickened as ordered by the health care provider.

Findings include:

During observation of the noon meal on , residents #6 & 7 were both served a combination of liquids thickened to nectar & honey consistency.

A review on of diet orders for residents# 6 & 7 revealed that they were ordered (thickened liquids) as follows;

Resident #6 per 1823 of was ordered nectar thickened liquids. She was served both Honey & Nectar thickened liquids.

Resident #7 per 1823 of was ordered thickened liquids of un-specified consistency-she was served both nectar & honey thick liquids.

A review of the liquids brought into the dining kitchen staff revealed there were 2 containers from the food service vendor-pre-thickened. One was flavored water thickened to nectar consistency per the label. The other was apple juice pre-thickened to Honey consistency per the label.

Staff did not appear to notice the difference between the 2 containers and picked them up to serve the residents.

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Class III

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

Based on observation and interview the facility failed to ensure for 16 of 16 residents in the memory care unit were provided a safe living environment.

Findings include:

Observation on [redacted] and [redacted] during a tour with the facility ' s wellness director it was stated there are two ways to enter the memory care unit. One is to come into the memory care ' s court yard which is enclosed with eight foot fencing. There is a latched lock on the outside of the gate which allows staff and others to enter the courtyard. The latch must be lifted to unlock and open the gate. He stated it a short cut that everyone has been using.

The second entrance to the memory care unit is from a hallway that requires going from the main lobby area through one hall into another common area leading you into another common area. The entrance door has a door bell which unlocks when pushed and there is a key [redacted] on the inside of the unit that a code will allow the door to unlock to exit. This would be considered the long way around.

For that reason almost everyone was observed using the residents ' courtyard to gain entrance or to exit the memory unit.

On [redacted] and again on [redacted] the gate was left repeatedly unlocked. This presented a safety issue and potential elopement concern. The problem was reported to the administrator by this surveyor [redacted] & [redacted] about 2pm). After reporting the concern to management the gate was still found left unlocked.

Class III

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

Based upon record review and staff interview the facility failed to submit and retain an adverse incident report for 1 (#1) of 4 residents reviewed.

Findings include:

During the visit of [redacted] & [redacted] and review of the record of resident #1 it was determined that an adverse incident was never reported for an event which occurred on [redacted].

Per information in the closed record for this resident, on [redacted] the resident began choking while eating her noon meal. According to staff interviews (1:30 - 2:30pm) 911 was called, performed the Heimlich Maneuver initiated, then 911 was canceled by the facility's previous LPN (terminated) as it was determined that the resident was fine. Staff interviewed stated that about 15 minutes later she over-heard the LPN screaming to call 911. Staff further stated the resident was [redacted] and taken to the hospital by paramedics.

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During interview with the facility current management they said that they were unable to locate any adverse incidents concerning this event as it happened prior to them stepping in as facility management. The administrator in charge at the time of this incident is no longer employed as well.

It was suggested they submit a report to the agency for this event although it occurred over a year earlier.

Class III

AHCA
"THE AGENCY FOR HEALTH CARE ADMINISTRATION"

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Connerton Court
21021 Betel Palm Ln
Land O Lakes, FL 34638

Dear Administrator:

Re: **CCR# 2013012665** & **CCR# 2013012852**

This letter reports the findings of two complaint surveys that were conducted on . 20-21, 2014, by representative(s) of this office.

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

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

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

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