STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964598	11/30/2015
NAME OF PROVIDER OR SUPPLIER SAVANNAH GRAND OF AMELIA ISLAND	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 AMELIA TRACE COURT FERNANDINA BEACH, FL 32034	

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

0000 Initial Comments

On , 2015 a biennial relicensure survey was conducted at Savannah Grand Assisted Living. Deficient practice was identified during the surveys.

0008 Admissions - Health Assessment

Based on record reviews and interviews, the facility failed to obtain a completed Health Assessment for 2 (#4 and #12) out of 4 residents sampled for completed Health Assessments.

The findings include:

Review of Resident #4 Health Assessment (1823) was conducted on / . Resident #4 Form 1823 Section B was not completed by the Examiner. Section B was not checked yes or no to indicate if Resident #4 needed help with taking her medications.

Review of Resident #12 Health Assessment (1823) was conducted on / . Resident #12 1823 did not indicate what type of diet the resident was receiving nor if the resident needs could be met in an assisted Living Facility (ALF). Resident #12 Form 1823 Section B also was not completed by the Examiner. Section B was not checked yes or no to indicate if Resident #12 needed help with taking his medications.

Interview was conducted with the Administrator at 1:40 pm on / . The administrator confirmed that Resident #4 and Resident #12's Health Assessment (1823) were incomplete.The administrator confirmed that Section B was not checked yes or no to indicate if Resident #4 needed help with taking her medications. The administrator also confirmed that Resident #12 1823 did not indicate what type of diet the resident was receiving, if the resident needs could be met in an assisted Living Facility (ALF), nor if the resident needed help with taking his medications.

Interview was conducted with Employee B at 2:07 pm on / . Employee B confirmed that Residents #4 and #12 health assessments (1823) were incomplete. Employee B stated that she will called the doctor office to inform them that the facility needed a completed 1823 for resident #4 and #12. (Evidence Photos obtained)

Class III

0085 Training - Nutrition & Food Service

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964598	**11/30/2015**
NAME OF PROVIDER OR SUPPLIER **SAVANNAH GRAND OF AMELIA ISLAND**	STREET ADDRESS, CITY, STATE, ZIP CODE **1900 AMELIA TRACE COURT** **FERNANDINA BEACH, FL 32034**	

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

Based on personnel file review and staff interview the facility failed to ensure the designee for dietary services received two hours of continuing education annually.

The findings include:

Review of the personnel file for Employee E revealed she had received a certificate of training on . There was no evidence of two hours of continuing education in food service annually since that date.

During an interview with the administrator on / at 2:47 pm she acknowledged that the dietary manager had not received two hours of continuing education annually.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Savannah Grand Of Amelia Island
1900 Amelia Trace Court
Fernandina Beach, FL 32034

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 by representatives 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than 29, 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 surveyors. Should you have any questions please call this office at -4201.

Sincerely,

for Jana Meyering, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

JD/JM/sm
Enclosure
XG90

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