RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Plantation on Summers LLC (The)
Attn: Michael Bay, Administrator
147 SW Summers Lane
Lake City, FL 32025

Dear Mr. Bay:

This letter reports the findings of a complaint survey conducted from 12- , 2016 by representatives of the Agency for Health Care Administration. Enclosed is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's request as directives below:

The inspection resulted in findings of non-compliance in the following areas:

A 0025 – Resident Care – Supervision - The facility failed to provide the required oversight and notification to necessary parties of significant changes in resident status and behavior.

A 0010 – Admission – Continued Residency – The facility failed to assess the continued appropriateness of a resident for the facility, failed to address a resident's danger to staff and other residents and the facility's ability to safely meet the needs of residents.

A 79 – Staffing Standards – Levels – The facility failed to schedule the necessary levels of staff to safely meet the scheduled and unscheduled needs and provide required oversight of the residents in the facility.

You are directed to comply with the following requirements:

1). The facility must establish a written policy on assessing appropriateness of residents and monitoring resident behavior to determine if a resident continues to meet the residency criteria of the facility. This policy must include assessment for readmission post-hospitalization and who is monitoring documentation of resident observations. The policy shall also include steps to follow in documenting significant changes in residents, including notification of the health care provider and responsible party. **This must be completed by** .

2). All direct care staff must be trained on the policy above as part of the implementation. Documentation of the training, including sign-in sheets and any materials, must be maintained and available for review by the Agency upon request. This must be completed by .

3). The Agency has determined that the facility's current staffing has not met the residents' needs and the facility is immediately required to provide increased direct care staff. During the daytime and evening shifts, continuously from 7:00 am to 11:00 pm, the facility must employ 3

direct care staff members. On the overnight shift from 11:00 pm to 7:00 am, the facility must schedule 2 direct care staff members. The facility must also ensure that at least one staff member that is currently trained in first aid and is always on shift. These direct care staff members must also currently satisfy every required qualification, including background screening, competency test requirements, and continuing education requirements to meet their position descriptions as per State regulations. **This must be completed by** .

4). The facility's emergency plan must be updated to include steps for staff to follow if a resident displays violent or dangerous behavior. These steps must include who to notify and what procedures to follow to protect staff and other facility residents. All direct care staff must be trained on this policy. Documentation of this training, including material and sign-in sheets, must be maintained at the facility and available for review by the Agency upon request. This must be completed **by** .

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact Laura Manville, Survey and Certification Support Branch, at (727) 552-1955 or Charles Bory, Alachua Field Office, (386) 462-6232.

Sincerely,

Charles Bory for

Kriste J. Mennella
Field Office Manager

KJM/vs
Enclosures

_____
Received by:

_____Date

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910289	04/19/2016
NAME OF PROVIDER OR SUPPLIER **PLANTATION ON SUMMERS LLC (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **147 SW SUMMERS LANE** **LAKE CITY, FL 32025**	

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

0000 Initial Comments

On [illegible] 2016, a biennial licensure and two complaint surveys (CCR# 2016003355 & 2016003780) were conducted at Plantation on Summers Assisted Living Facility. Deficient practice was identified during the survey. The facility was not in compliance at this time.

0010 Admissions - Continued Residency

Based on interview and review of record, the facility failed to ensure that one of one residents sampled (Resident #12) could have his needs met in the facility and continue to reside in the facility without being a danger to other residents or himself. The facility readmitted the resident multiple times after hospitalizations due to violent behavior and Resident #12 subsequently stabbed another resident (Resident #11).

Findings include:

On [illegible] a review of Resident #12's observation records revealed the following:

Per the observation log notes, on [illegible] staff G wrote that at 8:30 AM she was called to the courtyard because Resident #12 was yelling and screaming at a female resident. Resident #12 was stating he never got the chance to taste the [illegible] of a woman. No information was provided as to what action was taken.

On [illegible], staff wrote that Resident #11 reported that Resident #12 said he planned to grab a middle school student and cut their head off and watch them [illegible]. Resident #12 stated that he was going to Walmart to get a big knife and slice all employees heads off and then do the same thing to his [illegible], Resident #11. He stated that he wanted to bite a female and suck all their [illegible]. In addition, Resident #11 reported that Resident #12 threatened to cause him injury. Local law enforcement was called and Resident #12 was transported to a crisis stabilization unit (CSU) from [illegible].

On [illegible] at 10:00 am, Resident #11 reported that Resident #12 was acting out and threatened to beat up staff. Staff checked on Resident #12 who was arguing and fist fighting with himself. Per the observation notes, local law enforcement was called and warned Resident #12 he could be "[illegible]" if he continues the behavior.

On [illegible] at 8:30 am, Resident #12 was cursing at another male resident. Staff attempted to calm him. He then cursed at staff and then chased staff around. Resident #12 threatened staff if police was called he would come back to the facility and "bust" staff up. Resident #12 attempted to punch staff but

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was stopped by another resident. Local law enforcement was called, resident continued to be non-[illegible] and was cursing at the officer. Resident #12 was hospitalized in a local behavioral center.

On [illegible] at 12:16 PM, an interview was conducted with Staff B. Staff B stated that on [illegible] Resident #12 [illegible] Resident #11 with a knife causing physical injury then chased her (Staff B) with the same knife.

On [illegible] a review of the law enforcement report (2016-011478) was conducted. The report revealed that on [illegible], Resident # 12 was [illegible] and charged with premeditated attempted [illegible] and aggravated assault against Resident #11.

On [illegible] at 12:15 PM, an interview was conducted with a local police investigator who verified that Resident # 12 is being held in jail for attempted homicide for willful intent to commit premeditated and aggravated assault with/intent to commit a felony to Resident #11.

Class II

0025 Resident Care - Supervision

Based on interview and record review, the assisted living facility failed to contact the case manager and/or health care provider when 1 of 11 sampled residents experienced a significant change in behavior (Resident #12). The facility also failed to provide supervision and services necessary to meet the needs of Resident #11 in the facility. As a result, Resident #12's behavior escalated and Resident #12 acted out violently, causing significant injury to another facility resident.

Findings include:

On [illegible] a review of resident #12 daily observation notes was conducted. The notes reviewed showed that the facility failed to put in additional services and safety procedures to ensure that Resident #12 would not inflict any harm to Resident #11 and other residents in the facility. The logs specifically indicated the following:

The Observation log notes revealed that on [illegible] staff G wrote that at 8:30 AM she was called to the court yard because Resident #12 was yelling and screaming at a female resident and stating he "never got the chance to taste the [illegible] of a woman." No information was provided as to what action was taken by the facility and the record did not contain any documentation of notification to Resident #12's health care provider, psychiatrist or mental health case management agency.

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On / staff wrote in the observation log that Resident #11 reported that Resident #12 said he planned to grab a middle school student and cut their head off and watch them . Resident #12 stated that he was going to Walmart to get a big knife and slice all employees ' heads off and then do the same thing to his (Resident #11). Resident #12 further stated that he wanted to bite a female and suck all their . In addition, staff documented that Resident #11 reported that Resident #12 threatened to cause him injury. Local law enforcement was called and Resident #12 was transported to the crisis stabilization unit (CSU) from / - / . There was no documentation upon his return to the facility of any interventions, coordination with providers or changes in the level of supervision.

A continued review of the observation log revealed that on / / at 10 am, Resident #11 reported that Resident #12 was acting out and threatened to beat up staff. Staff checked on Resident #12 who was arguing and fist fighting with himself. Per the record, law enforcement was called and warned Resident #12 that he would be " " if he continued the behavior. There was no documentation of notification to Resident #12's psychiatrist, mental health or health care provider.

Per the observation log, on at 8:30 am, Resident #12 was swearing at another male resident. Staff attempted to calm him. He then swore at staff and then chased staff around. Resident #12 threatened staff if police was called he would come back to the facility and " bust " staff up. Resident #12 attempted to punch staff but was stopped by another resident. Local law enforcement was called, Resident #12 continued to be non- , and was swearing at the officer. Resident #12 was hospitalized in a local behavioral center. Upon release back to the facility, there was no documentation of contact with the health care provider, psychiatrist or case manager and no documentation of any changes in interventions or supervision/oversight for Resident #12.

On a review of the admission and discharge logs revealed that Resident # 11 was hospitalized on . On a review of the admission and discharge logs revealed that resident #12 was incarcerated on .

On at 12:16 PM, an interview was conducted with Staff B. Staff B stated that on Resident #12 Resident #11 with a knife causing physical injury then chased her (Staff B) with the same knife. Staff A stated she was the only staff member on duty at the facility at the time of the incident.

On at 12:15 PM, an interview was conducted with a local police investigator who verified that Resident # 12 is being held in jail for attempted homicide for willful intent to commit premeditated and aggravated assault with/intent to commit a felony to Resident #11.

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Class II

0030 Resident Care - Rights & Facility Procedures

Based on observations and interviews the facility failed to maintain a decent living environment for all 19 of 19 residents.

Findings:

On . . . . at approximately 9:45 AM, it was observed resident . . . . # had a buildup of dirt along the baseboard, a blanket for a curtain, and dirty air vents.

On . . . at 9:55 AM. resident . . . # was observed to have build up of dust in the air vents and a sheet for a curtain. It was further observed that several other had sheets or blankets for window coverings.

On at approximately 11:54 PM, it was observed that a staff member used a mop, that was sitting in a mop bucket full of filthy water, to mop up spills on the dining .

On at approximately 12:00 PM, during the dining review, it was observed that the dining had half an inch of dust build-up on the underside and legs of the tables. It was observed that the prep table in the kitchen was missing a large piece of which allowed the particle board to be exposed. This allows food particles to become imbedded in the particle board.

Class III

0079 Staffing Standards - Levels

Based on interview and review of records, the facility failed to ensure that sufficient staff was scheduled to provide the necessary oversight to meet the needs of the residents in the facility and to ensure resident safety.

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Findings include:

On , a review of the staffing schedule for the week of - revealed the following information: 8 AM-4 PM is the first shift with one care staff member scheduled (Staff A).

10 AM -6 PM is the second shift with one staff scheduled who also serves as the weekend cook (Staff B).

4 PM-12 AM is the 3rd shift with one care staff scheduled (Staff C).

A review of the facility census on revealed that the facility had 56 residents.

On , at 12:16 PM, an interview was conducted with Staff A. Staff A stated that the facility does not have sufficient staff on duty to support the level of safety required when caring for 56 limited mental health residents and only one staff scheduled to be on duty.

On , at 1:39 PM, an interview was conducted with Staff B. Staff B stated that on , Resident #12 , Resident #11 with a knife causing physical injury then chased her (Staff B) with the same knife. Staff B was the only staff on duty and had to run out of the building to escape Resident #12 and get a phone from a person outside the facility to call 911. Staff B stated that the facility does not have sufficient staff on duty to support the level of safety required when caring for 56 limited mental health resident and only one staff on duty. Staff B stated that "I work late shift. I get scared when I work because during the night, only one staff person works per a shift. Weekends, only one staff per a shift. I always keep the cordless phone in my pocket." Staff B further stated that she feels safer now that Resident #12 is gone from the facility. Staff B stated that she sometimes has specific male residents of the facility escort her on her rounds to make sure she is safe.

On , at 11:48 AM, an interview was conducted with the Administrator. He stated that he could not say whether the facility was adequately staffed as he had not completed an investigation about the assault by Resident #12.

Class II

0091 Training - Documentation & Monitoring

Based on record review and interview, the facility failed to have completed training certificates for 3 of 3 staff (Staff A, B and C).

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Findings:

On . .. .,6 a record review was conducted on Staff A, B and C, which all provide direct care to residents. During the review, it was observed that required documentation was missing from the training certificates:

For Staff A, her Elopement and training certificates were missing the training providers dated signature.

For Staff B, her Activities of Daily Living and Behavior Needs training certificate was missing the the number of hours. Her training certificate was missing the hours of the training, the trainee's name and signature of provider.

For Staff C, her Activities of Daily Living and Behavior Needs training certificate was missing the number of the hours of training. Her Elopement training certificate was missing dated signature of provider and hours of training.

An interview was conducted on . .. . at 11:48 AM with the Administrator. He stated he is responsible for the incomplete training documentation for Staff A, B and C.

Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observation and interview, the facility failed to ensure that all existing architectural, mechanical, electrical, and structural systems, and appurtenances, are maintained in good working order for 19 of 19 residents reviewed.

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Findings:

On at approximately 9:15 AM, a tour of the facility was conducted. During the tour it was observed that a large brown couch in the common TV area had a large tear on the arm and seat. Outside in the patio area it was observed that two chairs that residents use where observed to be in disrepair.

On at approximately 9:45 AM, resident # was observed to have a large water stain on the ceiling. Resident # was observed to have large patches of popcorn texture falling off the ceiling and a rusty air vent grate.

On at approximately 12:00 PM, during the dining review, it was observed that the dining had half inch of dust build-up on the underside and legs of the tables. It was observed that the prep table in the kitchen was missing a large piece of which allowed the particle board to be exposed. This allows food particles to become imbedded in the particle board.

On at approximately 1:51 PM, during an interview with resident #10, she stated she has a cracked shower floor and it has been that way for a while. Its been so long that she can't remember when she told the Administrator about it.

On at approximately 2:12 PM, it was observed that resident #_ had a cracked shower floor.

On at approximately 11:48 AM, during an exit conference with the Administrator, he stated he is working on making needed repairs to resident . He also has a list of that are scheduled to have repairs made to them. The list consisted of #28, 8, 4, 1, 15, and 21. The observed were not on the list. He stated he would get rid of the furniture that was in disrepair.

Photos taken of observations.

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Class III

L241 LMH - Records

Based on interview and review of records, the facility failed to ensure that one out of three sampled residents (Resident#12) had a completed community living support plan on file.

1. On , a review of Resident #12's record was conducted. The review of file revealed no community living support plan for Resident #12.

2. A review of facility records revealed that Resident #12 received Optional State Supplemental benefits ( ) and further revealed that Resident #12 was identified as a Limited Mental Health (LMH) resident on the facility's admission/discharge log.

3. On at 11:48 AM, an interview was conducted with the Administrator. The administrator confirmed that Resident #12 did not have a community support plan on file at the facility.

Class III

Z815 Background Screening: Prohibited Offenses

Based on interview and record review, the facility failed to have a completed Level 2 Background Screening for 1 of 3 direct care staff (Staff C).

Findings:

On at approximately 8:30 AM, an interview was conducted with Staff C. During the interview, she stated she has been working on 12:00 PM through 8:00 AM shift for a month and that she provides care and services to residents.

On , a record review was conducted on Staff C, who was hired / . It was observed that her Level 2 Background Screening was still in process and had not yet been cleared.

On at approximately 11:48 AM, an interview was conducted with the Administrator, in

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reference to Staff C's Level 2 Background Screening (BGS) not being completed. He stated he did not know why the BGS wasn't completed for Staff C.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, , 2016

Administrator
Plantation on Summers LLC, The
147 SW Summers Lane
Lake City, FL 32025

RE: CCR #2016003355 & Biennial Licensure

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by representative(s) of this office.

Enclosed 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 , 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 surveyor(s). Should you have any questions please call this office at (386) 462-6201.

Sincerely,

Charles Boyd for

Kriste J. Mennella
Field Office Manager

KJM/amw
Enclosure

XG90

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