AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964849	**09/09/2016**
NAME OF PROVIDER OR SUPPLIER **SAVANNAH COURT OF LAKE WALES**	STREET ADDRESS, CITY, STATE, ZIP CODE **12 EAST GROVE AVENUE** **LAKE WALES, FL 33853**	

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

0000 Initial Comments

Assisted Living Facility

A complaint investigation, (CCR# 2016009217), was conducted at Savannah Court of Lake Wales (Lic. #9383) on [redacted] in conjunction with a revisit survey. Savannah Court of Lake Wales, Assisted Living Facility, had a deficiency at the time of the investigation.

0165 Risk Mgmt & QA: Adverse Incident Report

Based on record review and interview, the facility failed to maintain documentation of a reportable event to the Central Office for one of one resident sampled (#1).

Findings included:

Interview with the administrator at 1:20pm on [redacted] revealed that Resident #1 had "eloped from the facility approximately 5 weeks earlier, prompting her/her facility to notify the local police department to assist them in searching for the individual." Although a major incident report was furnished describing the episode, no one-day and fifteen-day formal reports pertaining to this event and evaluating it in greater detail had been filed with the Agency. Further interview with the administrator at 1:50pm on [redacted] indicated that "she didn't believe circumstances warranted the need to send in any documentation to the Agency's attention."

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[illegible], 2016

Administrator
Savannah Court of Lake Wales
12 East Grove Avenue
Lake Wales, FL 33853

RE: Revisit & **CCR# 2016009217**

Dear Administrator:

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

Attached are the provider's copies of the State (5000-3547) Forms, which indicate the deficiencies that were identified on the day of the visits. 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.

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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,

Paul J Brown

For Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosures: State Forms (5000-3547)
XG90