STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964507	R
NAME OF PROVIDER OR SUPPLIER **AUTUMN HOUSE**	STREET ADDRESS, CITY, STATE, ZIP CODE **7999 SPYGLASS HILL ROAD** **VIERA, FL 32940**	

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

0000 Initial Comments

A follow up visit to an Extended Congregate Care and Limited Nursing Services was conducted at Autumn House on . Autumn House license # 9049 had deficiencies at the time of the visit.

0078 Staffing Standards - Staff

Revisit conducted. Deficiency A- 078 remained uncorrected.

Based on personnel record review and interview the facility failed to ensure that 1 of 4 personnel records (E) contained a healthcare provider statement that indicated freedom from communicable including within 30 days of hire.

Findings:
Personnel record review for staff E, a caregiver hired on , revealed no evidence to confirm she provided the facility a healthcare provider statement that indicated freedom from communicable including .
During an interview on / at 12:55 PM with the administrator, she said she thought the staff member had gone to the doctor. She was provided an opportunity to provide the information.

An email was received from the administrator on / at 4:36 PM that contained negative results dated / . However, there was not a healthcare provider statement that indicated freedom from communicable .

Class III

0081 Training - Staff In-Service

Revisit conducted. Deficiency A- 081 remained uncorrected.

Based on personnel record review and interview the facility did not provide or arrange for 1 of 4 sampled staff (A) to attend the mandated in-service training.
Findings:
Personnel record review for staff A revealed she was hired by contract on / to oversee the Extended Congregate Care (ECC) and Limited Nursing Services (LNS) and provide supervision to the Licensed Practical Nurses. Continued review revealed no evidence to confirm she attended an in-service training regarding a 1-hour in-service training regarding the facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964507	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN HOUSE	**7999 SPYGLASS HILL ROAD VIERA, FL 32940**

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

In an interview on / at 12:55 PM with the administrator, she said the staff member did not have the training.
Class III

0090 Training -

Revisit conducted. Deficiency A- 090 remained uncorrected.
Based on personnel record review and interview the facility did not provide or arrange for 1 of 4 sampled staff (E) to attend an in-service training regarding the facility's ( ) policies and procedures.
Findings:
Personnel record review for staff E, a caregiver, revealed she was hired on . Continued review revealed no evidence to confirm she attended an in-service training regarding a 1-hour in-service training regarding the facility's policies and procedures.
In an interview on / at 12:55 PM with the administrator, she said the staff member did not have the training.
Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11964507 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN HOUSE	7999 SPYGLASS HILL ROAD VIERA, FL 32940

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0161 Reg. # 429.275(2) FS, 58A-5.024(2) FAC LSC	Correction Completed	ID Prefix AE210 Reg. # 58A-5.0191(7) FAC LSC	Correction Completed	ID Prefix AZ815 Reg. # 408.809, 435.02(2), 435.06 LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE** 10/3/16	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 7/26/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

EVENT ID: 5PTF12

STATE FORM: REVISIT REPORT ( )

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Autumn House
7999 Spyglass Hill Road
Viera, FL 32940

RE: Revisit to ECC and LNS survey

Dear Administrator:

This letter reports the findings of a revisit survey conducted on 26, 2016, by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

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. Should you have any questions please call this office at (407) 420-2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

BBT7

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Orlando, FL 32801
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