RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Crown Court
109 North Seminole Avenue
Inverness, FL 34450

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 , 2017.** 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 Chuck Bory at 386-462-6201.

Sincerely,

Charles Bory for

Kriste J. Mennella
Field Office Manager

KJM/CB
Enclosure

Alachua Field Office
14101 N W Hwy 441, Suite 800
Alachua, FL 32615-5669
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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966366	12/13/2016
NAME OF PROVIDER OR SUPPLIER CROWN COURT	STREET ADDRESS, CITY, STATE, ZIP CODE 109 NORTH SEMINOLE AVENUE INVERNESS, FL 34450	

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

0000 - Initial Comments

An unannounced biennial survey was conducted on 12/12/2016 through 12/13/2016 at Crown Court (facility license number 10580). Deficiencies were identified. The facility was not in compliance at the time of the survey.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, record review and interview, the facility failed to ensure supervision to meet the needs of 1 of 11 residents (Resident #11).

Findings:

During the medication observation on / beginning at 8:50 AM, Resident #11 was observed to approach the medication cart for his medications. He stated he had not been feeling well for about a week. He stated he had not eaten in the facility during that time. He stated he still did not feel like he would be coming down for lunch today. He was ambulating independently and his color was good. He was clear in his speech and responded appropriately to questions. He was given 8 medications including an , from packs, which he swallowed with water.

Observations of Resident #11's / at 12:00 PM and 3:00 PM, revealed that Resident #11 lived in the facility attic. His actual separated by a door from the hallway and stairway leading to his . The stairway had steep stairs with missing or broken handrails. The carpeting on the stairs was dirty. The walls had holes and scratches. The hallway leading to the door of his only 1 of 3 fluorescent light bulbs working so it is dimly lit. The floor had plywood with wire cages for resident belongings on each side of a walkway about 3 feet wide. The ceiling was not finished. The brown paper covering the roofing insulation had torn away exposing pink insulation, with some insulation hanging down from the roof and some had away leaving bare wood spots.

During an interview with Resident #11 on / at 3:00 PM, he stated "staff comes up here periodically" to check on him. He had no details. He had no dates or names or descriptions of staff who had visited him. He stated he was sick and would not be eating downstairs. He said he was not sure what he had but it was "like a ." No symptoms were obvious. He stated he goes down to get his medications at the medication cart daily. He stated he had lived there for about a year.

On /, a review of Resident #11's record revealed a Resident Health Assessment (AHCA Form 1823) completed upon admission on and updated and signed by the Physician's ARNP on /. His weights were completed through 2016. In and 2016 it says

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"OOF." The staff stated that means out of facility. There were no notes about the resident. The 1823 states the ALF will provide the "preparation for the resident's meals." The ARNP checked the box stating the resident "needs assistance with self-administration of medications." Review of the Resident Sign In /Out Logs back through 2016, revealed the resident had not signed for anything. It revealed the resident had been in and then moved to the "attic." There was no information about the what the resident does or when he goes in/outside the facility.

During interviews with Staff A, from first shift, and Staff C, from second shift, on at approximately 10:00 AM and 3:30 PM, they stated they do not keep records of any checks they do on Resident #11. Staff C stated she checks on Resident #11 when she works. She stated she works a short week, Saturday, Sunday and Monday. Sometimes she works on Tuesdays. Staff A had no further information other than he had been living up there for about a year. She stated he does not use the In/Out Log. She had no information how she knew his whereabouts. He frequently does not join the other residents for activities or meals. Further, the facility manager, on / at approximately 3:15 PM, stated the staff do not have anything in a communication log but do communicate at each shift change. There was no documentation of any supervision or how they kept up with his general whereabouts or when he is out of facility. She stated he wanted to move to the attic.

During an interview with the Administrator on / at 12:30 PM, he stated Resident #11 has refused to cooperate with the Sign In/Out log. He stated the resident has a fire exit he has been using like his own personal entrance to avoid staff. He confirmed the resident could leave the facility at any time and no one would know his location. He confirmed they have not kept any documentation of any checks they may have completed on the resident.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, record review and interview, the facility failed to ensure medical information was secured for 1 of 6 residents (Resident #12).

Findings:

Observation of the top of the medication cart located in the central area of the second floor on / at 8:50 AM, revealed Resident # 2's Medication Observation Record (MOR) for 2016, in plain view of anyone passing by the cart. The cart was in a high traffic area at the top of the curved stairway.

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During an interview with Staff A, Medication Technician, on 12/12/2016 at 8:53 AM, she confirmed she left the MOR for Resident #2 on top of the medication cart, available for anyone to read.

During an interview with the facility director and manager on / at 3:30 PM, they confirmed the importance of maintaining confidentiality during medication passage.

No further information was provided regarding information access.

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation, record review and interview, the facility failed to dispose of contaminated medications nor implement proper techniques for 4 of 8 residents (Resident #6, #7, #8, #9).

Findings:

During Medication Pass observation on / beginning at 8:50 AM with Staff A, a Medication Technician (MT), the following issues were noted:

Resident #6's 40 mg was dropped from the pack onto the med cart. The MT picked it up with her fingers, asked the resident if she wanted it and then gave it to her. The resident swallowed it.

Resident #8's 20 mg was dropped onto the med cart from the pack. The MT picked it up with her fingers, put it in the med cup and handed it to the resident. The resident swallowed it.

Resident #9's 2 mg onto the med cart from the pack. The MT picked it up with her fingers and put it into the med cup and gave it to the resident. The resident swallowed it.

The MT put her fingers on the rim of Resident #6 & #7's med cup when she handed them the medications.

During an interview on at 9:00 AM the facility manager confirmed they have policies for those issues. No further information was provided.

Class III

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

Based on observation and interview, the facility failed to ensure a safe hallway and stairway for 1 of 4 floors (4th floor).

Findings:

Observations of Resident #11's room on / at 12:00 PM and 3:00 PM, revealed that Resident #11 lived in the facility attic. His actual separated by a door from the hallway and stairway leading to his . The stairway had steep stairs with missing or broken handrails. The carpeting on the stairs was dirty. The walls had holes and scratches. The hallway leading to the door of his only 1 of 3 fluorescent light bulbs working so it is dimly lit. The floor had plywood with wire cages for resident belongings on each side of a walkway about 3 feet wide. The ceiling was not finished. The brown paper covering the roofing insulation had torn away exposing pink insulation, with some insulation hanging down from the roof and some had away leaving bare wood spots.

During an interview with Resident #11 on / at 3:00 PM, he stated "staff comes up here periodically" to check on him. He had no details. He had no dates or names or descriptions of staff who had visited him. He stated he was sick and would not be eating downstairs. He said he was not sure what he had but it was "like a ." No symptoms were obvious. He stated he goes down to get his medications at the medication cart daily. He stated he had lived there for about a year.

During an interview with the Administrator on / at 12:30 PM, he confirmed improvements were necessary to the hall and stairway for the fourth floor. He stated that Resident #11 has a fire exit he has been using like his own personal entrance to avoid staff. He confirmed the resident could leave the facility at any time and no one would know his location. He confirmed they have not kept any documentation of any checks they may have completed on the resident.

Class III