STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964702	02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH COURT OF ORANGE CITY	**202 STRAWBERRY OAKS DRIVE ORANGE CITY, FL 32763**

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

0000 Initial Comments

A complaint investigation (CCR # 2016014320) was conducted at Savannah Court at Orange City (Lic. # 9243) on . Savannah Court at Orange City had deficiencies at the time of the investigation.

0025 Resident Care - Supervision

Based on observations, record reviews, resident and staff interviews, the facility failed to provide care and services to meet the needs of Resident #6, evidenced by staff's negligence to follow up adverse behaviors for Resident #6, resulting in 3 residents (Resident #10, Residents #7, Resident # 3) being subjected to . The staff's negligence has the potential for all residents of the facility to be at risk.

The findings include:

A record review was conducted of the facility 24 hour communication log on . On an entry dated , an entry read "Resident # 6 is trying to get Resident #7 to touch his penis and also Resident # 3."

An interview was conducted with Employee B, a Caregiver, on at 11:59 AM. She confirmed Resident #6 was known for being "fresh". The employee stated, "He is fresh with everybody." The employee was asked if the female residents were alert and oriented and gave him consent, she said "I doubt it, everybody in here is ."

An interview with Employee F, a Caregiver ,on at 3:01 PM confirmed that on Resident #6 was found sitting on the couch in the lobby with his penis exposed out of his pants and Resident #3 hands were on him. She said the RCC was notified and then Employee F expected her to notify "whoever."

A phone interview was conducted with Employee E on at 12:20 PM who confirmed she worked on the night of the with Employee F. She stated when she walked by the front doors, Resident #6 was observed taking his penis out of his pants and Resident #3 had her hands on his penis. Then later in the night, he was doing the same thing with Resident #7.

Employee E was asked if both the residents were able to consent to this behavior and she said, "No, they are both and I don't think they really understand what they are doing. The employee confirmed the Resident Care Director was texted about the events of that night when they happened. Employee E also confirmed the staff did not notify the family for Resident #6 because this was not

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considered "major" in the opinion of staff.

An interview was conducted with Employee C, a Caregiver, on at 12:28 PM. She stated that Resident #6 "is a very active man". She said staff has to keep their eyes on him at all times to keep the other residents safe. She said she observed him trying to grab another resident's yesterday ( ).

She explained that a few weeks ago that Resident #9 reported to staff that Resident #6 brought Resident #7 into his . She and other staff knocked on his , which was locked. When they opened the door, they observed Resident #6 had his pants down, and Resident #7 was backed into a corner.

She stated, "We have to keep our eyes on him all the time. If we see Resident #6 is by himself then we're okay."

She continued to say that any notifications to physicians or family members would be made by the Resident Care Coordinator (RCC).

In a later interview at 1:15 PM on , Employee C was asked if she had ever called Department of Children and Family services to report this to the hotline. She said "No, I didn't know what to do. I didn't know what my options were. I don't even know where to find a family members phone number. The RCC always does that."

She continued to say that "everybody here knows what Resident #6 does. Employee F & I have cried to him telling them that he is hurting these residents and that he is abusing them, and he tells me that they want it." She said Resident #6 starts by sitting next to them and rubbing their arms, and then starts touching the more and in other parts of their bodies.

An interview with the (RCC) on at 12:39 PM confirmed Resident #6 has been known to have been displaying inappropriate touching of residents. She stated "We had a time where he was actually caught with another resident but we have to constantly keep an eye on him and move him away from other residents. She was asked if she had ever directed staff to place him on 1:1 supervision to ensure the safety of the residents, and she stated she did not.

She confirmed she worked on and observed Resident #7 standing over Resident #6 with her shirt raised and he was fondling her . When asked what interventions she took, she said she told Resident #6 he needed to go back to his . She then brought it to the staff's attention and told them to keep an eye on him, and then she left.

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She said later that night the staff called again and let me know he was caught with Resident #3 and Resident #7, exposing his ⌄ to them . She confirmed she did not tell any of the upper management after being alerted to these events. She confirmed she did not call DCF to report to incidents, or follow up with physicians for further clinical assessment. She did not fill out any incident report.

An observation was made on at 1:00 PM of Resident #6 sitting on the couch in the main lobby. A staff member wheeled Resident #3 in her wheelchair and placed her next to Resident #6. Following this, it was observed that staff left the two unsupervised. At 1:13 PM, Employee C moved Resident #3 away and said "everybody knows what he does, I don't know why they would let anyone sit next to him".

An interview was conducted with Employee D, a Caregiver, on at 2:55 PM, and she stated she has seen Resident #6 take the hands of Resident # 7 and Resident #10, and she separates them. She said she knows to keep him away from women to prevent the incidents from reoccurring. She says she has told staff "all the time" about his behaviors.

In a second interview was conducted with Employee E, on at 3:13 PM who confirmed on she found Resident #6 with his penis out of his pants and Resident #7 hands were on his penis. She said she told Resident #6 to stop and he replied he just wants to hold hands. She confirmed the facility's administration was aware of what goes on with Resident #6. She said "We all know what he does".

A second interview was conducted with Employee F, on at 4:08 PM, she said Resident #6 is known for inappropriate behavior. She said she caught him two times with his pants down and his penis out with Resident #7. She stated "I don't think he forces them but they don't know what they were doing."

Review of the facility Policy and Procedure on and Neglect (no date) reads "The Community prohibits the or neglect of the residents it serves. This applies to all employees, consultants or any of its residents and or family members or any persons otherwise associated with the Community.

" " is defined as any intentional or negligent act or omission directly and proximately resulting in physical or mental injury to a resident of a facility. "Neglect" is defined as any act of omission or commission by any owner, operator, administrator, licensee or any agent servant , employee or other person under the employment. supervision or control of any one of more of the owners, operators, Administrators and which act is a direct and proximate cause of any physical or mental injury to a

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resident. (photographic evidence obtained)

A review of the facility Employee Handbook reveals all staff sign and date they are informed upon hire of the facility Policy. It included information that was defined as " contact that results in threats, force, or the inability to give consent". (photographic evidence obtained)

A review of the facility Accident/Incident Report reads "Resident and / or employee accident /incidents are to be reported and documented within 24 hours after accident / incident occurs."

The procedures instructs staff that accidents and incidents can include dangerous behaviors of resident or staff member, and alleged . All accidents or incidents are to be reported to the Executive Director and a Corporate Official. Accidents/incidents shall be documents on the company's incident report form immediately following the occurrence.

The policy mandated the Director and Licensed staff to "Investigate accidents/incidents involving residents/staff members." They are directed to "Implement corrective actions as appropriate" and to "document investigation and corrective action regarding the accident/incident." They are also directed to "Notify Agency for HealthCare Administration (AHCA) for any neglect or is suspected."(photographic evidence obtained)

Nothing in the policy included information about reporting to the hotline, and the Department of Children and Families was not mentioned in the policy.

An interview on at 1:48 PM with the interim Executive Director confirmed she was not aware of the concerns with Resident #6 and confirmed the RCC should have called her on Saturday when it happened.

A review of the facility Incident Report Log on reveals no incidents listed for Resident #6 inappropriate behavior since 2016.

CLASS I

0030 Resident Care - Rights & Facility Procedures

Based on observations, record reviews, resident and staff interviews, the facility failed to implement policy and procedures to ensure 3 residents residents (Resident #3, #7, and #10) remained free from and neglect; failed to notify responsible party with a significant change for Resident #1 and Resident #2; and failed to ensure all residents, staff, and visitors had the information needed to report

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, neglect, and explotation to the proper agencies. Staff's negligance perpetuated an environment where Resident #6 could engage in acts with 2 residents (Residents #3, #7) but put all residents at risk for mental and/or physical harm.

The findings include:

A record review was conducted of the facility 24 hour communication log dated was conducted on . It read "Resident # 6 is trying to get Resident #7 to touch his penis and also Resident # 3."

An interview was conducted with Employee B, a Caregiver, on at 11:59 AM. She confirmed Resident #6 was known for being "fresh". The employee stated, "He is fresh with everybody." The employee was asked if the female residents were alert and oriented and gave him consent, she said "I doubt it, everybody in here is ."

A phone interview was conducted with Employee E on at 12:20 PM who confirmed she worked on the night of the with Employee F. She stated when she walked by the front doors, Resident #6 was observed taking his penis out of his pants and Resident #3 had her hands on his penis. Then later in the night, he was doing the same thing with Resident #7.

Employee E was asked if both the residents were able to consent to this behavior and she said, "No, they are both and I don't think they really understand what they are doing. The employee confirmed the Resident Care Director was texted about the events of that night when they happened. Employee E also confirmed the staff did not notify the family for Resident #6 because this was not considered "major" in the opinion of staff.

An interview was conducted with Employee C, a Caregiver, on at 12:28 PM. She stated that Resident #6 "is a very active man". She said staff has to keep their eyes on him at all times to keep the other residents safe. She said she observed him trying to grab another resident's yesterday ( ).

She explained that a few weeks ago that Resident #09 reported to staff that Resident #6 brought Resident #7 into his . She and other staff knocked on his , which was locked. When they opened the door, they observed Resident #6 had his pants down, and Resident #7 was backed into a corner.

She stated, "We have to keep our eyes on him all the time. If we see Resident #6 is by himself then

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we're okay." She said that yesterday, on , Resident #6 was trying to feel Resident #2.

At 1:15 PM she stated she and another staff member have attempted to tell him to stop, that he was harming these ladies, but it was not effective.

She was asked if anyone ever followed up with the families of the women, and she was unsure. She also said she did not know how to report to the hotline. She did not know how to get in contact with resident's family members to report problems to them, either. She said that the RCC calls families.

In an interview with the Resident Care Coordinator (RCC) on at 12:39 PM, she confirmed she was aware of the behaviors Resident #6 was displaying. She stated "We had a time where he was actually caught with another resident but we have to constantly keep an eye on him and move him away from other residents."

She was asked if he was ever placed him on 1:1 supervision to ensure the safety of the residents, and she replied "No." She was asked how the facility was going to keep other residents safe. She said "We make sure that he's not with anybody else, and he has never been combative."

She confirmed she worked on and observed Resident #7 standing over Resident #6 with her shirt raised and fondling her . When asked what interventions she took, she said she told Resident #6 he needed to go back to his . She then brought it to the staff's attention and told them to keep an eye on him, and then she left.

She said later that night the staff called again and let me know he was caught with Resident #3 and Resident #7, exposing his to them . She confirmed she did not tell any of the upper management after being alerted to these events. She confirmed she did not call DCF to report to incidents, or follow up with physicians for further clinical assessment. She did not fill out any incident report.

She also failed to notify the families of the women.

The physician's office for Resident #7 was contacted at 2:14 PM on . The facility did not contact them after the events, and they confirmed that if occurred to their patient they would have wanted to know about it.

An observation on /2017 at 1:00 PM of Resident #6 sitting on the couch in the main lobby. Staff was wheeling Resident #3, and they placed her next to Resident #6. The staff member left and the two residents were left unattended.

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An observation was conducted on at 1:13PM of Employee C removing Resident # 3 away from Resident #6 and placing her in the hallway. She said that staff knew better than to place anyone next to Resident #6.

A review of the facility Incident Report Log reveals no incidents listed for Resident #3 or #7 for the night of with the inappropriate touching that involved Resident #6.

A review of the records for Resident's #3, #7 and #10 reveal no documentation of the events with Resident #6 or evidence the residents physicians or family were notified.

An interview was conducted with Employee D, caregiver, on at 2:55 PM who stated she has also told administration about Resident #6's behaviors.

An interview with Employee F, a Caregiver, on at 3:01 PM, confirmed on Resident #6 was found sitting on the couch in the lobby with his penis exposed out of his pants and Resident #3 hands were on him. She said she told the RCC, and then "she notifies whoever."

An interview was conducted with Employee E, on at 3:13 PM who confirmed on she found Resident #6 with his penis out of his pants and Resident #7 hands were on his penis. She said she told him "You gotta stop it, we are here for their protection." She said his reply is that he just wants to hold hands. She said the Administration has been made aware of what he is doing.

An interview was conducted with Employee H, on at 4:08 PM. She stated Resident #6 is know for inappropriate behavior. She said she caught him twice with his pants down and his penis out with Resident #7. She stated "I don't think he forces them but they don't know what they were doing."

A review of the facility Employee Handbook reveals all staff sign and date they are informed upon hire of the facility Policy. It included information that was defined as " contact that results in threats, force, or the inability to give consent". (photographic evidence obtained)

Review of the facility Policy and Procedure on and Neglect no dated reads "The Community prohibits the or neglect of the residents it serves. This applies to all employees, consultants or any of its residents and or family members or any persons otherwise associated with the Community. It explained that when a resident has been abused by another resident, staff is to make action to get the to stop.

There was no evidence at the time of the investigation that an intervention was put into place to get

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Resident #6 to disengage in any behaviors following the events of .

There was no evidence at the time of the survey that after , any interventions were put into place to protect the other residents from Resident #6.

2) Review of the facility incident reports reveals Resident #2 was found on the floor on . The incident report did not reveal if the family or physician was contacted with the .

A review of an incident report dated 11/ reveals Resident #2 was found on the floor lying on her right side. The form does not reveal the family or physician was contacted.

A review of an incident report dated 11/ reveals Resident #2 resident out of her chair. The form does not reveals the family or physician was contacted.

A review of an incident report dated reveals Resident #2 was found on the floor. The form does not reveals the family or physician was contacted.

A review of an incident report dated reveals Resident #2 was found on the floor. The form does not reveals the family or physician was contacted.

A review of an incident report dated reveals Resident #2 found on the floor resident has an above her left eyebrow and in left cheek. The form does not reveals the family or physician was contacted.

A review of the facility progress notes for Resident #2 reveals no documentation of the above for the resident. There is documentation of a listed on with injury and but a facility incident report was not found.

A phone interview was conducted with Resident #2's son on at 11:15 AM who confirmed he gets called from the facility but wasn't aware of any in . He stated " I tried to call there a few weelks ago but the phones were messed up so maybe that's when it happened but I would think they could still call out."

An interview with the RCC on at 4:47 PM confirmed she had called the family and physician of the resident but did not documentation the calls. She stated " I only write a progress note once a month." The RCC then asked to see the facility incident report form and stated " I didn't know there was a place I could fill out that I called the family and the physician."

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3) A review of physician note dated for Resident #1 reads "Resident #1 had a on Sunday and fracutred 2 ribs. We re-x-rayed this in 2 days and found she had a . She is Short of breath today. She is at 84% with 4 liters of and does not look good her , is . Plan: patient will be sent to the hospital due to this with fracutre. , and desatting. "

A review of the facility incident report log reveals no documentation the resident sustained a on or around .

During an interview with the RCC on at 3:43PM, she was asked why there is no incident report from for Resident #1 . She answered "This was not a witnessed . The resident was having pain so we contacted hospice and they did chest chest x-ray and found out that she had 2 ribs. We didn't do an incident report because we didn't know about a . It happened on a Sunday and I don't work on Sunday and the staff would text or call me if she would have and they didn't do that with her. A few days before that she wouldn't get out of bed but she never said that she had ."

The RCC confirmed the physician listed the resident had a but he documented that in error. The RCC confirmed the facility Policy and Procedure is to fill out an incident report with any injury or accident and should have been done due to her having 2 ribs.

4) An observation was conducted during the initial tour of the facility and the required posting of telephone numbers for residents and staff to lodge a complaint was not found.

An interview with the Resident Relations staff on at 4:10 PM confirmed the postings were not found in the facility and residents and staff did not have access to those numbers.

CLASS I

0077 Staffing Standards - Administrators

Based on record reviews, and resident and staff interviews, the facility failed to supply a provision of care to meet the needs for all residents, related staff's lack of response following Resident #6 engaging in behavior with residents, and the lack of training provided to direct care staff in the subjects of recognizing and reporting , neglect, and . Staff's negligence has the potential for the high likelihood of physical and mental harm affecting all residents of the facility that rely on the administration to provide a safe, homelike environment.

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The findings include:

On , a record review was conducted of the facility's 24 hour communication log dated which stated Resident # 6 was trying to get Residents #3 and #7 to touch his penis.

A review of facility progress notes reveals on 11/ Resident #6 was caught in intimate settings on several occasions with several female resident's. Records showed "none of them are alarming or concerning until yesterday when he was found in another resident intercourse. Then again on Resident #6 and Resident #8 were found again. The facility has taken steps to keep both parties separated."

During an interview with Employee F, a Caregiver, on at 3:01 PM, she confirmed on , Resident #6 was found sitting on the couch in the lobby with his penis exposed out of his pants and Resident #3 hands were on him. She said the RCC was notified, "and then she notifies whoever".

An interview was conducted with Employee C on at 12:28 PM and she stated that Resident #6 was "a very active man" . She said a few weeks ago Resident #6 brought Resident #7 into his , which was reported to her by Resident #10. She said she knocked on his with staff, and it was locked. She said when they opened the door Resident #6 had his pants down and Resident #7 was backed into a corner.

She stated "We have to keep our eyes on him all the time. If we see Resident #6 is by himself then we're okay." She said an incident happened yesterday on , where Resident #6 was trying to feel Resident #2.

A phone interview was conducted with Employee E, a caregiver, on at 12:20 PM who confirmed she worked on the night of the with Employee F. She stated when she walked by the front doors, Resident #6 was observed taking his penis out of his pants and Resident #3 had her hands on his penis. Then later in the night, he was doing the same thing with Resident #7.

Employee E was asked if both the residents were able to consent to this behavior and she said, "No, they are both and I don't think they really understand what they are doing. The employee confirmed the Resident Care Director was texted about the events of that night when they happened.

She was asked if the Administration knew about Resident #6's behaviors. She said "everybody knows what he does" but that direct care staff doesn't notify anyone but the Resident Care Coordinator when

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incidents happen.

An interview with the Resident Care Coordinator (RCC) on at 12:39 PM confirmed Resident #6 had been known to have inappropriate behaviors. She stated "We had a time where he was actually caught with another resident but we have to constantly keep an eye on him and move him away from other residents. She confirmed she never placed him on 1:1 supervision to ensure the safety of the residents. She said her plan was to make sure that he's not with anybody else.

She said she personally observed Resident #6 fondling Resident #7's and had to separate them on . She said following that she told Resident #6 to go to his . She told the staff to keep their eye on him, and she left.

She confirmed she was notified after she had left that he had been caught having Residents #3 and #7 grabbing his exposed penis. She did not notify and of the upper management, and decided to follow up with other management on the following Tuesday, , 3 days following the incident.

Nothing in the actions taken following the notification that he was displaying these behaviors included following up with the families or physicians of the , , or the victim, nor did it include calling the hotline.

A review of the facility Incident Report Log reveals no incidents listed for Resident #6 displaying any inappropriate behavior on or .

An interview on at 1:48 PM with the interim Executive Director confirmed she was not aware of the concerns with Resident #6 and confirmed the RCC should have called her on Saturday when it happened.

An interview with Employee C on at 1:15 PM said that she and the rest of the staff knew what Resident #6's behaviors were. She was asked if she ever notified the Department of Children and Families to report the alleged . She said "No, honestly I didn't know what to do. I didn't know what my options were. I don't even know where to find a family members phone number. The RCC always does that."

An interview was conducted with Employee H, on at 4:08 PM. She stated Resident #6 is know for inappropriate behavior. She said she caught him twice with his pants down and his penis out with Resident #7. She stated "I don't think he forces them but they don't know what were doing."

Review of the facility Policy and Procedure on and Neglect no dated reads "The Community

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prohibits the or neglect of the residents it serves. This applies to all employees, consultants or any of its residents and or family members or any persons otherwise associated with the Community. " " is defined as any intentional or negligent act or omission directly and proximately resulting in physical or mental injury to a resident of a facility. "Neglect" is defined as any act of omission or commission by any owner, operator, administrator, licensee or any agent servant , employee or other person under the employment. supervision or control of any one of more of the owners, operators, Administrators and which act is a direct and proximate cause of any physical or mental injury to a resident. It explained that when a resident has been abused by another resident, staff is to make action to get the to stop. (photographic evidence obtained)

A review of the facility Accident/Incident Report reads "Resident and / or employee accident /incidents are to be reported and documented within 24 hours after accident / incident occurs. It lists as part o the procedure that "All accidents or incidents are to be reported to the Executive Director and a Corporate Official."

Accidents/incidents were to be documented on the company's incident report form immediately following the occurrence, according to policy. It stated the the Director and Licensed staff shall Investigate accidents/incidents involving residents/staff members, implement corrective actions as appropriate, document investigation and corrective action regarding the accident/incident, and notify Agency for HealthCare Administration (AHCA) for any neglect or is suspected."(photographic evidence obtained)

A review of the facility Employee Handbook reveals all staff sign and date they are informed upon hire of the facility Policy. It included information that was defined as " contact that results in threats, force, or the inability to give consent". (photographic evidence obtained)

At the time of the survey investigation, there was no evidence the Administration had investigated or placed corrective actions in place. Additionally, AHCA was not notified of the .

The Administration also failed to ensure the reporting information was posted in a conspicuous location for staff, families, and visitors to reference in the vent they wanted to report suspected , neglect, or , .

This was confirmed by the Resident Relations official at 4:10 PM on .

CLASS I