STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910289	**07/05/2017**
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 an unannounced Complaint Survey CCR#2017003782 was conducted at Plantation on Summers Assisted Living facility in Lake City. Deficiencies were identified as a result of this survey. The facility is not in compliance at this time. License#AL5191.

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

Based on record review and interview the facility failed to notify one resident gaurdian/power of attorney of three sampled residents (#1) of a change in a residents condition when the change occured.

Findings:

A record review showed on 11/ at 4:00 PM the resident refused her dinner. At 5:20 PM the facility staff went to check on the resident and the resident and her bed was covered in and . The staff tried to wake the resident, however, the resident could not be awakened for seven minutes. The resident could not speak, and was starring with a blank look. Emergency Medical Services ( ) was called and the resident was transported to the hospital. There is not documentation that the residents primary physician or family was notified.

A record review showed on at 5:20 PM the facility staff observed the resident sitting in the courtyard yelling and hitting herself in the head. The police department was called and took the resident to the local mental health facility (Meridian) to be screened after the resident agreed to go. There is no documentation to show the resident family or physician was notified. The residents adoptive mother was called by the resident on from a mental health facility in Gainesville.

A record review showed on at 5:20 PM the resident was taken to the local mental health treatment facility for treatment and evaluation. There is no documentation the residents family or physician was notified.

During an interview with the Administrator/Owner on at 12:35 PM, stated it is the facility's practice that, if the Administrative staff is gone (at 5:00 PM) the administrator prefers the on duty staff not notify the residents family of any issues. The Administrator prefers the administrative staff to notify the family, and not the on-duty staff. The Administrator stated the families are not notified immediately it maybe the next day.