STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967538	R 07/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERHAVEN ASSISTED LIVING, LLC	**520 LANYARD LANE DE BARY, FL 32713**

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

0000 - Initial Comments

A follow-up visit to a biennial survey was conducted at Summer Haven Assisted Living Facility (License #11576) on . Summer Haven Assisted Living had deficiencies at the time of the visit.

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on record review and family and staff interview, the facility failed to have a resident meet minimum admission criteria for 2 Residents (Resident #5 & #6) out of 3 sampled residents.

The findings include:

1) A review of Resident #5 Florida Health Assessment Form (1823) signed by the physician and dated revealed the resident required 24 hours nursing / care. (photographic evidence obtained)

An interview with the Administrator on at 10:56 AM confirmed the 1823 for Resident #5 listed he needs 24 hour nursing or care and does not fit criteria for admission in assisted living.

2)A review of Resident #6 (1823) signed by the physician and dated revealed the resident has a to the .

A review of Resident # 6 Home Health Plan of Care (-) revealed she was receiving skilled nursing services for care to the right .

An interview with the Administrator on at 9:29 AM confirmed Resident #6 was admitted with a and is still receiving care from home health services. He stated "I know she didn't fit criteria when I admitted her but if I give her a notice she will have to go to a nursing home."

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

Based on observation, resident and staff interviews, the facility failed to provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. for Resident # 5 out of 5 residents currently living

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at the facility.

The findings include:

Upon initial tour of the facility a note was found posted on the door for Resident #5 which read " Your days /time use for the phone are on Wednesday and Saturday. (photographic evidence obtained) It included information of the only people he was allowed to call, and sated he could only use the phone from 3 PM to 5 PM, 2 days a week.

An interview with the Administrator on at 9:40 AM confirmed the resident is only allowed to use the phone at the facility from 3-5PM 2 days a week. He stated " The guardian asked us to do this because they don't want him calling all day".

An interview with Resident #5 on at 11:20 AM confirmed the facility does not let him use a phone except 2 times a week from 3-5pm. He said they don't only not let me use the phone they took my own phone away and won't let me have it back.

CLASS III

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

Based on observation, record review, and staff interview, the facility failed to assist with self administration of medication appropriately for 1 (Resident #6) of 2 sampled residents.

The findings include:

An observation was conducted on at 9:40 AM of Employee B, assisting Resident #6 with her prescribed morning medications. The employee was observed giving 1 tablet of 2.5 milligrams (mg) 1 tablet to the resident along with her other prescribed AM medication.

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A review of the medication label for Resident #6 reads . . . . . 2.5 mg 4 tablets weekly with a fill date of . . . . . quantity of 16. There are 9 pills observed still in the medication bottle.

A review of a physician order dated revealed 2.5 mg 4 tabs weekly.

A review of the . . . Medication Observation Record (MOR) for Resident #6 read . . . . . 2.5mg give 4 tabs every day and is signed daily since . (photographic evidence obtained)

An interview with Employee B on at 9:50 AM confirmed Resident #6 only received 1 instead of the 4 pills as ordered. The Employee was then observed obtaining 3 more pills of . . . . . and assisting the resident.

An interview with the Administrator on at 10:00 AM confirmed the MOR was wrong and that the resident should only be getting the medication on Tuesday and not daily. He confirmed there were still 9 pills remaining in the bottle and the medication was last filled on .

CLASS III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on observation, record review and staff interviews, the facility failed to maintain an accurate daily Medication Observation Record (MOR) for residents who receive assistance with self-administration of medications for 1 out of 2 residents sampled.

The findings include:

An observation was conducted on . . . . . at 9:40 AM of Employee B, assisting Resident #6 with her morning prescribed medications. The employee assisted in giving 2.5 milligrams (mg) 1 tablet to the resident along with her other prescribed AM medication.

A review of the medication label for Resident #6 reads 2.5mg 4 tablets weekly.

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A review of a physician order dated . . . . . reveals . . . . . 2.5mg 4 tabs weekly.

A review of the , Medication Observation Record (MOR) for Resident #6 reads 2.5mg give 4 tabs daily (there are some words can be seen to the side which read "only / hold . . . . . " The MOR is signed daily since . " (photographic evidence obtained)

An interview with Employee B on at 9:50 AM confirmed Resident #6 only received 1 instead of the 4 pills as ordered and had signed the MOR on both and /2017 that she had given the medication.

An interview with the Administrator on at 10:00 AM confirmed the MOR for Resident #6 did not list the correct physician orders for her . . . . . and should be given only on Tuesday and not daily.

CLASS III

0058 - Pharmacy & Dietary; Uncorrected Deficiencies - 429.42(1-2) FS; 58A-5.033(3)(a) FAC

Based on observation, record review, and staff interview, the facility failed correct previous deficient practice related to unlicensed staff assisting residents with self administration of medication in accordance with Florida Statute 429.256 (4) for 1 of 2 sampled Residents, Resident #6.

The findings include:

An observation was conducted on at 9:40 AM of Employee B, assisting Resident #6 with her prescribed morning medications. The employee was observed giving 1 tablet of 2.5 milligrams (mg) to the resident along with her other prescribed morning medication.

A review of the medication label for Resident #6 revealed the following information: it was 2.5 mg, with instructions to give 4 tablets weekly. The fill date was , with a quantity of 16. During the medication pass observation, there were 9 pills observed still in the medication bottle.

A review of a physician order dated . . . . . revealed Resident #6 was prescribed 2.5

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mg, 4 tabs weekly.

A review of the , Medication Observation Record (MOR) for Resident #6 read 2.5mg, give 4 tabs every day. It was signed as being given daily since . (photographic evidence obtained)

An interview with Employee B on at 9:50 AM confirmed Resident #6 only received 1 instead of the 4 pills as ordered. The Employee was then observed obtaining 3 more pills of and assisting the resident.

An interview with the Administrator on at 10:00 AM confirmed the MOR was wrong and that the resident should only be getting the medication on Tuesday and not daily. He confirmed there were still 9 pills remaining in the bottle and the medication was last filled on .

In accordance with 429.42 F.S. & 58A-5.033 F.A.C., the facility must now employ or contract with a licensed registered nurse. Consultation services must begin within 14 days of the notice of uncorrected deficiencies. The facility must have available for review by the agency, a copy of the consultant's license and a signed and dated review of the corrective action plan within 10 days subsequent to initial on-site consultation visit. The facility must provide the agency with, at minimum, quarterly on-site corrective action plan updated until the agency determines after written notification by the consultant and the facility administrator that deficiencies are corrected and that staff have been trained to ensure that proper medication standards are followed and that consultation services are no longer required. The agency must provide the facility with written notification of such determination.

CLASS III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation and staff interview, the facility failed to provide for elapsed time of 14 hours or greater from the evening meal to the beginning of the morning meal affecting 5 out of 5 residents currently living at the facility.

The findings include:

Upon entering the facility on at 8:45 AM 2 residents (Resident 1# and #4) were observed sitting at the dining eating breakfast.

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An interview with Employee C on at 9:10 AM was asked what times the meals are served she replied Breakfast is 9-9:30 AM, lunch is at 12 and dinner is 5-5:30 PM.

An interview with Employee D on at 9:12 AM confirmed residents get served dinner from 5-5:30 PM.

An observation was conducted on at 9:15 AM of Resident #5 and #6 being served breakfast.

The Administrator on at 11:10 AM confirmed there are 16 hours between dinner and breakfast.

CLASS III