STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943102	11/21/2017
NAME OF PROVIDER OR SUPPLIER **SAVANNAH COURT OF THE PALM BEA**	STREET ADDRESS, CITY, STATE, ZIP CODE **2090 N. CONGRESS AVENUE** **WEST PALM BEACH, FL 33401**	

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

0000 - Initial Comments

A Relicensure survey was conducted on 11/ and at Savanah Court of the Palm Beaches, License # 8367. The facility had deficiencies at the time of the visit.

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record review and interview, the facility failed to ensure that all staff received ( ) Training, within 30 days of hire, for 1 of 3 sampled staff, (Staff D).

The Findings Included:

During an employee record review for Staff D, conducted on at approximately 1:00PM. It was revealed Staff D's employee file had no documentation that Staff D received the required training. Further review revealed, Staff D was hired on . At this time the facility was given the opportunity to locate the documentation.

During an interview with the Administrator and the Wellness Director on 11/ at approximately 3:30PM, they acknowledged the findings and no additional documentation was provided.

Class III

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

Based on observation and staff interview, the facility failed to have a weekly planned menus conspicuously posted or readily available to all residents residing in the unsecured section of the assisted living facility.

The findings included:

During observational tours conducted on at 11:50 AM, and on at 2:00 PM, in the facility's unsecured unit, no planned weekly menus were conspicuously posted in any of the common areas or in a way that would be easily available to the residents.
A daily menu was posted on a table at the entrance to the dining .

During interview with the Executive Director on at 3:45 PM, he was asked where the planned weekly menu was posted or easily available to the residents, he responded, "I was unaware a weekly menu had to be posted. We always post the daily menu." The Executive Director was informed of the regulatory requirement that menus are to be dated and planned at least 1 week in advance for regular

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and therapeutic diets and these planned menus are be posted or made easily available to the residents.

Class

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

Based on observation and interview, the facility failed to provide a safe environment for 16 of 16 residents in the Memory Care Unit.

The Findings Included:

During the Day 1 observational tour of the Memory Care Unit on between the hours of 9:30AM and 10:15AM, observation of the shared the Memory Care Unit, revealed a storage cabinet which had a lock on the outside of the door. Further review revealed the cabinet door was unlocked and contained Tide Laundry Detergent PODS, and a jar of (Cream) and other miscellaneous bottles of liquid in direct reach of the residents. Further observation revealed residents independently going into the spending several minutes in the supervision.

During Day 2 observational tour of the Memory Care Unit revealed the cabinet remained unlocked. And the Tide PODS were still in direct reach of the residents. At this time, it was discussed with the Wellness Director and she stated the closet should be locked at all times.

During a interview with the Administrator and the Wellness Director, they acknowledged the findings.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

During record review and staff interview, the facility failed to properly report 2 incidents alleging possible (physical and verbal) to the proper agency(ies), and failed to thoroughly investigate the allegations made by 2 of 9 residents interviewed (Residents #1 and #3)

The findings included:

1) On at 11:30 AM, during an interview with Resident #1, the resident stated she had been slapped in the face, near her mouth, 3 times by a Resident Care Associate, and these slaps had broken her dental bridge. She said the same associate tied her legs together with "a long towel or piece of cloth." Resident #1 said, "I can't defend myself with anything but words, so I cussed her out." The

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Resident identified the Care Associate by name, and stated that she had reported the incident to the Executive Director (ED) and Resident Services Director ( ) and they responded, "I can't believe [Staff C] would do that to you." Resident #1 said Staff C had not been back to take care of her, but she was still working in the facility.

On at approximately 12:30 PM, the Executive Director was asked for the Grievance and Incident Logs/documentation for the past 3 months. He stated there had been no Grievances or Incidents within the past 3 months. Review of these logs confirmed there had been no Adverse Incidents or Grievances filed over the past 3 moths.

On at approximately 12:45 PM, the Executive Director was asked if he had become aware of any allegations of . He stated that he had not been aware of any allegations of . I asked again to clarify, "Did any resident come to you with an allegation of ?" The ED stated he had no knowledge of any allegations of .

On at 2:34 PM, the stated, "On Friday [ ], I was notified by the resident of the allegation of . I spoke with the son, and we talked about the resident's behaviors, and we are supposed to be getting psych to come in and do an evaluation. In speaking with the son, it seems this is an ongoing behavior. An incident report was not filed. We weren't aware we needed to file a report." The was asked if there was a thorough investigation completed, and if so, where was the documentation of the investigation. The indicated there was no written documentation related to the investigation.

2) On at 11:25 AM, during interview with Resident #3 she stated, "[Staff E, Med Tech] started screaming at me, at the top of her lungs, that I am , and crazy, and making gestures at her head like I am crazy ...she could not stop screaming at me. I reported it to the director, and he gave me a different med tech. I have 5 witnesses that saw the whole thing...[Staff E] said she has been here 5 yrs and they can't fire her...[Staff D], another Med Tech, saw the whole thing.

On at 12:20 PM, the Executive Director admitted to receiving information regarding the allegation complaint about the Med Tech, but didn't feel it was " .". He stated, "We investigated and didn't feel there was any truth to the allegation ...the witnesses said it didn't happen. I removed that Med Tech from providing medications to [Resident #3]." The Executive Director stated he did not file a report, as he I didn't think there had to be any further action taken." A request was made for any documentation regarding the investigation of this incident. No documentation was provided.

A review of the facility's Policy documents the following: " B. - Any of the following

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verbalizations to, or in the presence of, a resident or visitor is . . . . . unless such verbalizations are prescribed as therapeutic intervention methods...Derogatory comments cause a resident to feel ridiculed and can include teasing, rude or harsh works, words of scorn or contempt and deliberate lies... . . . . of resident can also include certain acts or gestures that are never therapeutic, such as...2. Vulgar acts or gestures that cause an individual to feel ridiculed or scorned . Uncomplimentary acts, gestures or mimicry about a person's appearance, condition, mannerisms..."

In review of the facility's Policy, the Procedure for any allegation of (Physical or Verbal) is to be:
1. Any person witnessing or becoming informed of any or neglect shall immediately report such to the Executive Director. The Executive Director shall obtain a written incident report from the individual making the claim of ..it the individual making the claim is not an employee, the Executive Director shall complete the report...
3. The Director shall make a complete report of the incident and the corrective action taken. If or neglect is deemed possible or confirmed, a report must be filed with the Department for Children and Families.
. . . . by Staff
1. In the event that an employee of the The Community is accused of , said employee shall be immediately suspended until a full investigation of the charges can be conducted.
2. After consultation with DCF or DCH Investigators and the Regional Director of Operations, the ED shall inform the employee of any actions deemed necessary..."
The Executive Director did not follow the procedure outlined in the facility's Policy.

On at approximately 3:00 PM, the Executive Director provided copies of Adverse Incident Reports submitted to the Agency for Health Care Administration for the 2 allegations of . . . . . outlined above.
At 3:30 PM. the Executive Director stated he had contacted the hotline and reported the 2 allegations. The agency refused allegation #2, but took allegation #1 for further investigation.
The Executive Director and Resident Services Director acknowledged that a thorough investigation must be completed for each allegation, and the details of the investigation should be fully documented.

Class III