STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967845	01/25/2018
NAME OF PROVIDER OR SUPPLIER **TRANQUILITY HAVEN, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1346 WILDERNESS LANE** **TITUSVILLE, FL 32796**	

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

0000 - Initial Comments

A Complaint Investigation #2017012115 was conducted on and . Tranquility Haven LLC Assisted Living Facility License #11805 had deficiencies at the time of the visit.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observations, record review and interview, the administrator did not take into consideration the information provided on the resident health assessment form (1823) and admitted 1 of 5 sampled residents (#4) who required total care with activities of daily living, was bedridden which exceeded the admission criteria for an Assisted Living Facility and did not obtain an admission hospice interdisciplinary care plan and did not obtain after a significant change (hospice admission) and updated Resident Health Assessment form (1823) for 1 of 5 sampled residents (#3).

Findings:

1. Review of the hospice record for resident #3 revealed she was admitted to hospice services on . . . . Further review of the hospice record revealed there was no hospice interdisciplinary care plan that was required to specify the services to be provided by hospice and those being provided by the facility and that were developed and implemented by a licensed hospice in consultation with the facility.

Record review for resident #3 revealed there was no updated 1823 form completed for the significant change (hospice admission).

2. Record review for resident #4 revealed she was admitted to the facility on . The resident health assessment form 1823 was dated . . . , the health care provider noted she was total care with ambulation, bathing, dressing, toileting and transfers and was bed ridden, all which exceeded the admission criteria for an Assisted Living Facility.

On . . . at 2 PM, the human resource director confirmed there was no hospice interdisciplinary care plan and updated 1823 form. She acknowledged the findings for resident #4. She contact the hospice agency nurse, who faxed the hospice interdisciplinary care plan to the facility.

Review of the hospice interdisciplinary plan revealed the hospice nurse signed it on . The space for the facility to sign acknowledging the receipt of the plan was left blank.

Class III

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

Based on record review and interview, the facility failed to maintain a written record of a significant changes and did not document that the family and health care provider was contacted for the development of a , and hospice admission for 2 of 5 Sampled residents (#3 and #4).

Findings:

1. Review of the hospice Record for resident #3 revealed she was admitted to hospice services on . The hospice record noted on the resident had a healing 1.5 (length) x .1 width.
Record review for resident #3 revealed there was no documentation of the significant change, (hospice admission and). There was no documentation that the family and health care provider was contacted.

2. Review of a hospice note for resident #4 that was dated that noted, "Open area on bottom/facility aware!"
Hospice nursing updated comprehensive assessment noted on -.5 centimeters (cm), .5 cm diagonal area on - . On barrier cream to - 2 areas .5 cm right cheek.

Record review for resident #4 revealed there was no documentation regarding the open area and on the resident's bottom and that the family and heath care provider were contacted.
There was no documentation found in the facility's documentation regarding the hospice admission.

On at 1 PM, the human resource manager confirmed the findings.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on record review, staff schedule review, timesheet review, observations and interview, the facility did not maintain an accurate staff schedule, did not have staff in both buildings to provide supervision to meet the needs of the residents.

Findings:

Observations on at 10:45 AM revealed the facility consisted of two houses that were located next to each other with different addressees.

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Review of the staff schedule for revealed the schedule noted the time the staff was scheduled to work, the number of the house they were scheduled to work in and the name of the staff. Review of the staff schedule compared to the time sheets revealed there were days and times when there was only one staff working, which meant the residents were left unsupervised in one of the buildings as follows:

On , the schedule noted staff a worked 5:45 AM-4 PM in house 1346; Staff F worked 9:45 PM-8 AM in house 1346; Staff b worked 1:45 PM-12 AM in house 1350. According to the schedule after 12 AM Staff F left house 1350 there was no staff assigned to house 1350 and Staff F was the only staff working from 12 AM-5:45 AM and she worked alone until staff C arrived at 1:45 PM. Review of the time sheets revealed staff b arrived to work at 2 PM and left at 12 AM (she did not arrive at 1:45 PM).

Review of the time sheets revealed the following staff worked and were not on the schedule
Staff G (a salaried employee) worked in house 1350 from (12:00-3:00 AM-PM not noted)
Staff D worked 6 PM-8 PM there was no house number noted in the space that indicated the street address that the staff worked she noted "food, paper good, meds." Staff A worked alone from 12 AM-12 PM. There was no documentation to confirm there was a staff during this time to supervise the residents in house 1350.

On , the schedule noted staff H worked 5:45 AM-4 PM in house 1346; Staff I worked 9:45 PM-8 AM in house 1346; Staff C worked 1:45 PM-12 AM in house 1350. According to the schedule after 12 AM Staff C left house 1350 there was no staff assigned to house 1350, Staff H was the only staff working from 12 AM-5:45 AM, and she worked alone until staff C arrived at 1:45 PM.

Review of the time sheets revealed the following staff worked and were not on the schedule
Staff D worked 2:30-3 (AM-PM note noted)-there was no house noted in the space that indicated the street address that the staff worked, instead she noted "food, paper good, meds." Staff H worked alone from 12 AM-1:45 PM. There was no documentation to confirm there was a staff during this time to supervise the residents in house 1350.

On , the schedule noted staff H worked 5:45 AM-4 PM in house 1346; Staff I worked 9:45 PM-8 AM in house 1346; Staff C worked 1:45 PM-12 AM house 1350. According to the schedule after 12 AM Staff C left house 1350 there was no staff assigned to house 1350, Staff H was the only staff working from 12 AM-5:45 AM, and she worked alone until staff C arrived at 1:45 PM.

Review of the time sheets revealed the following staff worked and were not on the schedule
Staff A worked from 5:45 AM-12 PM in house 1346

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Staff B worked from 2 PM-6 PM in house 1350
Staff G worked 9 AM-5:45 PM in house 1350
Staff D worked 11 AM-3:30 PM there was no house noted in the space that indicated the street address that staff D worked; instead, she noted "food, paper good, and meds."
Staff C worked alone from 6 PM-9:45 PM and she noted that she worked in both houses,
Staff I worked alone from 9:45 PM-5:45 AM. There was no documentation to confirm there was a staff during this time to supervise the residents in house 1350.

On , the staff schedule noted staff H was the only staff that worked from 5:45 AM-1:45 PM Staff H
Review of the time sheets revealed that staff G arrived to work at 11:30 AM-6:15 PM and was not listed on the schedule. Staff H worked alone from 5:45-11:30 AM.

Record review for resident #1 revealed a resident health assessment form 1823 dated he had diagnosis that included , Gait Absorbability. He required assistance with ambulation, transferring, bathing, dressing, eating was independent, and supervision was required with and toileting. The health care provider noted he was a risk.

Record review for resident #2 revealed a resident health assessment form 1823 dated that included diagnosis of and memory , he required assistance with bathing, dressing, , toileting. He was independent with ambulation and transferring and required supervision with eating. The health care provider noted he was a risk

On at 2:30 PM the administrator confirmed between and in house 1350 there were two residents (#1 and #2) and there were 5 in house 1346 and there may have been times when there was only 1 staff available for both buildings. She said staff G was salaried and may have worked, and did not include it on her timesheet. She said the staff would go back and for to both houses to care for the residents. She was informed at the time that the buildings were separated not under 1 roof, there were two residents who resided in house 1350 who were left alone, both were risk and if there was an emergency in that house the staff would not know or would not be able to evacuate the residents from the facility in the event of a fire if they were in another building.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview, the facility failed to have record of semi-annual weights for 1 of 5

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sampled residents (#2) who required assistance with Activities of Daily Living.

Findings:

Record review for resident #1 revealed a resident health assessment form 1823 dated that noted he required assistance with ambulation, transferring, bathing, and dressing. Further record review revealed the last weight recorded was dated .

On at 3 PM, the human resource manager confirmed the findings.

Class III