STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968729	**01/17/2018**
NAME OF PROVIDER OR SUPPLIER **THE MANOR AT LAKE JACKSON**	STREET ADDRESS, CITY, STATE, ZIP CODE **2301 US 27 S** **SEBRING, FL 33870**	

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

0000 - Initial Comments

Assisted Living Facility

On , , 2018, a complaint survey, (CCR# 2017014889), was conducted at The Manor at Lake Jackson, Assisted Living Facility. A deficiency was identified during the visit.

(License # 12574)

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

Based on interviews and record reviews, the facility failed to provide necessary supervision and services, including follow-up and interventions related to , for four Residents (#1, #2, #3, and #4) of four sampled Residents who were identified as high risks.

Findings included:

A record review of incident reports conducted on found that in , 2017, thirteen Residents had at the facility. In 2017, twelve Residents had at the facility. In 2017, twelve Residents had . In 2017, twelve Residents had . None of the reports reviewed had any documentation of an assessment of causative factors nor specified documented intervention measures implemented to prevent reoccurrence.

A focused record review conducted on revealed that Resident #1 was admitted on . According to Resident Caregiver Notes, dated , Resident #1 was having "increased and general decline." Agency for Healthcare Administration Forms 1823 dated and stated, " risk" and "assist" with Activities of Daily Living Level for ambulation and transferring. Monthly Report review found that Resident #1 had three in , 2017 and one in 2017. Frequent Resident Caregiver Notes, Incident Reports, and Acute Visit Requests document continued frequency of assessments. No documentation was provided specifying specific intervention measures put in place with each to prevent reoccurrence. Resident #1 had a diagnosis of and was on Hospice.

A focused record review conducted on revealed that Resident #2's Agency for Healthcare

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Administration Form 1823 dated on page one stated "gait , " and page two Activity of Daily Living Level stated "independent with ambulation and transfers." A review of a Incidents Report found Resident #2 had a that sent her to the hospital on with discharge instructions for " prevention and home safety." Resident #2 did have Acute Visit Requests for the in-house physician and/or Advanced Nurse Practitioner to assess due to and gait disturbance occurring on , , and . Resident #2 had a that occurred on at 10:05am. No documented intervention measures, prevention plan, or notifications wereprovided or found in review of Resident #2's record. There was also no updated AHCA form 1823 more current than the form dated despite the change in Resident #2's status. An Interdisciplinary Care Plan between the facility and the Hospice provider dated stated "promote a safe living environment" and for both entities to provide. No documentation was provided specifying specific intervention measures put in place with each to prevent reoccurrence. Resident #2 has a diagnosis of 's , memory loss, and

A focused record review conducted on revealed that Resident #3's Agency for Healthcare Administration Form 1823 dated made no mention of risk. On page two for Activities of Daily Living Level, the form stated "independent with ambulation and transferring." A review of a Monthly Report found that Resident #3 had one in 2017, two in 2017, and four in 2017. Resident Caregiver notes reviewed indicated that Resident #3 has had frequent since . No documentation provided specifying specific intervention measures put in place with each to prevent reoccurrence and no updated health assessment (Form 1823) indicating the change in Resident #3's functioning and status. Resident #3 has a diagnosis of and now resides at a Rehabilitation Center due to being unable to ambulate and inappropriate for and Assisting Living Facility.

A focused record review conducted on revealeded that Resident #4's Agency for Healthcare Administration Form 1823 dated Activities of Daily Living Level stated "assist with all." A Monthly Report review found that Resident #4 had one in , 2017, one in 2017, one in 2017, and four in 2017. Resident Caregiver Notes made no mention of any and the last note documented was on . No documentation provided specifying specific intervention measures put in place with each to prevent reoccurrence. Resident #4 had incident reports dated: at 07:05pm, (no time of incident specified), at 06:35am, at 07:25am. No documented intervention measures, prevention plan, or notifications provided. Resident #4 has a diagnosis of .

During an interview conducted on at 10:15am with the Health and Wellness Director in regards to what have occurred this month (, 2018) the Health and Wellness Director stated

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that, "I do not compile the [ ] report until the end of the month." When questioned as to what prevention measures were put in place after each , the Health & Wellness Director stated that, "If they have multiple , I let the doctor know."

During an employee interview conducted on at 11:30am regarding whether the facility monitored and provided intervention measures to prevent reoccurrence for Residents who frequently as the Administrator stated that staff would "walk away" from Resident #1 and he would ; "he never had safety awareness to be able to keep himself from falling."

Class III