STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966519	R 01/11/2018
NAME OF PROVIDER OR SUPPLIER **SAVANNAH GRAND OF MAITLAND**	STREET ADDRESS, CITY, STATE, ZIP CODE **740 NORTH WYMORE ROAD** **MAITLAND, FL 32751**	

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

0000 - Initial Comments

A revisit from a Monitoring visit was conducted on . Savannah Grand of Maitland Assisted Living had deficiencies that remained uncorrected at the time of the visit.

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

Based on record review and interview, the facility did not provide care and services to meet the needs of the residents including effective cleaning and methods to the prevent the spread of a illness and did not notify the healthcare provider and legal representative of the outbreak of the for 2 of 2 sampled residents whom were currently sick (#11 and #12); and the facility failed to document a development of a that was a significant change for resident #10.

Findings:

1. During the tour of the second floor on at 10:45 AM, a nurse revealed there was some type of (illness) in the building staff and residents were sick with , and . The nurse gave the name of the some residents who were affected.

The agency surveyor called the agency's Registered Nurse (RNS) who was touring the memory care building to inform her. The RNS said when she entered the memory care building she observed staff wearing gloves and mask and they also had informed her there was a and there were currently 2 residents who were ill in the memory care unit and they were in their .

On at 11:30 AM, The administrator confirmed there were staff and residents whom were sick with a . The administrator was asked at the time, had she contacted the health department and she responded that she had not because she was not aware that she was supposed to. She was asked at the time what interventions were in place, she said the staff were hand washing. She was informed that residents were still in activities and eating together in the dining . She was informed that there should have been something placed on the door informing the visitors as to what was occurring. During the entrance conference, the resident care director mentioned that she was not feeling well and had her hand on her stomach. Neither of them mentioned at the time there was a illness affecting the residents and staff.

The administrator provided a list of all affected, there were 17 residents and 11 staff as of there were 2 residents in the memory care who were currently ill.

On at 2 PM and interview was conducted with the Epidemiologist from the Florida Department of

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health. She informed the administrator should have contacted her agency when two residents became ill, so that they could have provided guidance and measures to assist with preventing the to spread. She said the facility had no control measures in place.

The area where laundry was done had no hand washing soap nor was there enough based hand rub around the building. She said the staff that washed the clothing did not wear gowns. She said she was concerned that more residents and staff would become sick. She further said the staff should not have returned to work for 3 days after they were symptom free. She said she had the facility not to accept new admission for 72 hours and activities and dining together should cease.

2. Resident #11's record review revealed no documentation or no observation notes in the file that the physician and legal representative was notified regarding the stomach in which this resident was affected.

On at 11 AM, an interview with both the Administrator and Wellness Director Nurse who confirmed the finding.

3. Resident #12's record review revealed no documentation or no observation notes in the file that the physician and legal representative was notified regarding the stomach in which this resident was affected.

On at 11 AM, an interview with both the Administrator and Wellness Director Nurse who confirmed the finding.

4. On at 9:30 am, the nursing director identified resident #10 and said the resident had a on her .

The record for resident #10 did not contain documentation to indicate when the developed. In addition, there was no documentation to indicate a health care provider and family were notified.

On at 5:20 pm, the nursing director confirmed the findings and said the was first observed when resident #10 returned from the hospital on .

Class III