STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964850	**04/05/2018**
NAME OF PROVIDER OR SUPPLIER **SAVANNAH COURT OF HAINES CITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **301 PENINSULAR DRIVE** **HAINES CITY, FL 33844**	

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

0000 - Initial Comments

Assisted Living Facility

On , , , 2018 Complaints CCR#2018003020 and CCR#2018001391 surveys were conducted at Savannah Court of Haines City. Deficiencies were identified during the visit. (license # 9382)

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and interview the facility failed to ensure 3 of 6 (#11, #2, #9) residents whose records were reviewed included a completed Health Assessment Form (1823) to include their type of assistance required with medications.

Findings included:

A record review was conducted for Resident #11 on . It revealed an 1823 dated . The 1823 was not marked to indicate if the resident will require any assistance with their medication.

A record review was conducted for Resident #2 on . It revealed an 1823 dated . The 1823 was not marked to indicate if the resident will require any assistance with their medication.

A record review was conducted for Resident #9 on . It revealed an 1823 dated . The 1823 was not marked to indicate if the resident will require any assistance with their medication.

Duirng an interview with the Business Office Manager on at 3:20 PM, they stated they did not know why they were not completed but would make sure they were.

Class III

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

Based on record review and interview, two of two residents(#3, #11) who were admitted to hospice while residing in the facility did not have an interdisciplinary care plan which specifies the services provided by hospice and services provided by the facility. Additionally, the facility failed to ensure 1 of 1 (#3) sampled residents had a face-to-face medical examination by a health care provider recorded on the Agency for

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Healthcare Administration (AHCA) Health Assessment Form 1823 following a significant change in condition. The facility also failed to determine the appropriateness of 1 (#10) resident who requires medication administration.

Findings include:

Resident record review on revealed that Resident #3 was admitted to Hospice on . Resident #11's record revealed that this individual was admitted to Hospice . Interview with the administrator 3:30 PM on she stated that she thought the care plan that hospice left each time they came to see the resident was acceptable. The Administrator did not know that the interdisciplinary care plan was an agreement for care by the hospice and facility and family or responsible party signed off on the agreement. The resident care coordinator stated the facility will start to hold a meeting with hospice, family and facility each month. They will have a care plan devolved at each meeting.

During a review of Resident #3's record it revealed Resident #3 had an AHCA Form 1823 dated . It also revealed Resident #3 was admitted in Hospice dated . The record did not include a new AHCA Form 1823 following a significant change in condition.

During an interview with the Marketing Director on at 1:47 PM, they stated, "She (Resident #3) should have a new 1823. I will check on it."

During a review of Resident #10's record it included an 1823 dated stating the resident required medication administration due to severe .

During the entrance conference at approximately 9:00 AM the Marketing Director stated they had med techs who assisted with medications. They do not staff nurses.

Class III

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

Based on record review, interview and observation the facility failed to provide sufficient qualified staff to provide resident supervision and to provide resident services to meet their needs.

Findings included:

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On during the hours of the survey (9 AM-4 PM), direct care staff were observed conducting many tasks to include providing assistance with medications, toileting residents, preparing and serving meals and assisting residents with Activities of Daily Living (ADL'. During resident interviews on conducted on between 9:00 AM and 4:00 PM, multiple residents stated when they pull their call light at times they have to wait an extended period of time and sometimes staff don't respond at all.

In an interview on at 10:40 a.m., when asked, "What does staff help you do? Are your needs being met?" Resident #11, who is , stated, "They're supposed to help you wash up. If you call, they are supposed to come. You used to have to call 3 or 4 times and they would come. At night, they don't come." When asked, "How often are you changed/toileted?" Resident #11 stated, "Most of the time I go by myself. They wait for me to call them. No, they don't come and check on me."

In an interview on at 11:45 a.m., when asked, "Are your needs being met?" Resident #10 stated, "They're supposed to help me get dressed, most of the time they don't." When asked, "Do you feel there's enough staff on all shifts?" he answered, "Not enough. They keep bringing in workers. Sometimes they're short. There's supposed to be two people, sometimes there's only one. When you call, they take a long time to come."

At 12:15, the Resident Aide, the Medication Technician (Med Tech), and the Activity Director were observed coming into the dining , washing their hands, putting on gloves, and filling water glasses while the cook waited to serve food that was prepared to be served at 12:00 noon. The two Resident Aides, the Activity director, and the Administrator were observed assisting in the dining , and the meal was served late.

In an interview on at 11:45 a.m., when Resident #10 was asked, "What are the meal times?" he stated, "For example, breakfast is supposed to be 8:00, but it's usually 8:30. Almost every day. All 3 meals are late."

In an interview on at 11:41 a.m., a family member for Resident # 1 stated, "I am most worried at night when a certain staff member is there. Not changing him at night. I have came in while she is there and he will be wet. That is probably why he has the ."

In an interview on at 1:00 p.m., Staff D stated they only toilet residents three times per day. "In the morning, after lunch, and before putting them to bed."

Reviewed Associate Warning and Discipline Notices for Staff A and B, dated , which stated that both staff took a break together, leaving the residents alone, without supervision.

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Class III

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

Based on interview and record review, the facility failed to ensure staff received required staff in-service training within 30 days of employment, for staff who provide direct care to residents for 3 (Staff A, Staff C and Staff E) of 3 employee records reviewed.

Findings included:
1. Employee record review revealed Staff A with a date of hire did not have control training, Elopement Response Training, Emergency preparedness & Evacuation Training, Incident reporting training or Nutritional & Safe Food Handling.

2. On at approximately 1:30pm an interview with the administrator and the marketing relations director was conducted concerning training in Staff C and Staff E's employee records. Interview with Administrator and Marketing Relations Director revealed that orientation training (where staff received in-service trainings required by rule) is completed by the Business Manager and/or the Resident Care Coordinator whom are not core trained.

3. Employee record review revealed Staff C with a date of hire of has training for Control, Elopement Response, Emergency Preparedness & Evacuation, Incident Reporting, Nutritional & Safe Food Handling, Recognizing/ Reporting , Neglect & , Resident Rights, and ADL and Behavioral Needs that was provided by an individual who is not core trained.

4. Employee record review revealed Staff E with a date of hire of has invalid training (provided by an individual who is not core trained) for Elopement Response, Emergency Preparedness & Evacuation, Incident Reporting, Nutritional & Safe Food Handling, Recognizing/ Reporting , Neglect & , and Resident Rights.

Class III

0082 - Training - / - 58A-5.0191(3) FAC

Based on interview and record review, the facility failed to ensure staff received valid training of required / training, within 30 days of employment, for staff who provide direct care to residents for 1 (Staff C) of 3 employee records reviewed.

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Findings included:
1. A review of Staff C ' s employee record on revealed a date of hire of . There was no valid proof of required / training for Staff C.

2. On at approximately 1:30pm an interview with the administrator and the marketing relations director was conducted concerning training in Staff C's employee records. Interview with Administrator and Marketing Relations Director revealed that orientation training is completed by the Business Manager and/or the Resident Care Coordinator whom are not core trained.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on interview and record reviews, the facility failed to ensure staff received valid training of required ( ) training, within 30 days of employment, for staff who provide direct care to residents for 2 (Staff C and Staff E) of 3 employee records reviewed.

Findings included:
1. A review of Staff C ' s employee record on revealed a date of hire of . There was no valid proof of required training for Staff C.

2. A review of Staff E' s employee record on revealed a date of hire of . There was no valid proof of required training for Staff E.

3. On at approximately 1:30pm an interview with the administrator and the marketing relations director was conducted concerning training in Staff C and Staff E's employee records. Interview with Administrator and Marketing Relations Director revealed that orientation training (where training is provided) is completed by the Business Manager and/or the Resident Care Coordinator whom are not core trained.

Class III

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

Based on observation and interview, the facility failed to ensure that residents without kitchen access were provided with access to snacks and failed to ensure that meal intervals were spread throughout the

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day, that food was served attractively and that the nutritional needs of the residents were met due to long delays in serving meals.

Findings included:

Interview conducted on at 9:30 am with the Marketing Relations Director revealed that the staff does not offer or remind the residents about snacks but the snacks of water and cookies are available for the residents throughout the day.

Interviews conducted on with Resident #4 at 10:00 am, Resident # 11 at 10:40 am, Resident #7 at 11:00 am and Resident # 10 at 11:45 am revealed that the facility does not offer snacks or drinks to residents. The residents are expected to remember that the facility has water and snacks at the front of the building.

During an interview with the Marketing Director on at 1:47 PM, they stated they do have residents with , who may not remember where the snacks are.

In an interview on at 11:45 a.m., when Resident #10 was asked, "What are the meal times?" he stated, "For example, breakfast is supposed to be 8:00, but it's usually 8:30. Almost every day. All 3 meals are late."

At 12:15, the Resident Aide, the Medication Technician (Med Tech), and the Activity Director were observed coming into the dining , washing their hands, putting on gloves, and filling water glasses while the cook waited to serve food that was prepared to be served at 12:00 noon. The two Resident Aides, the Activity director, and the Administrator were observed assisting in the dining , and the meal was served late.

During lunch observation on at 12:00 PM, most of the residents were in the dining the tables waiting for their lunch. The Cook had to wait to plate the residents food due to the aides performing other direct care tasks. The two facility aides and activity director were observed escorting residents to the dining assisting with the meal prep and serving. The food was served around 12:15 PM and the aides went around assisting the residents by cutting their food, refilling their glass, encouraging some of the residents to eat. Residents are having to wait for their food at each meal due to direct care staff having to provide resident care and prepare/serve meals.

Class III