STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969017	10/03/2018
NAME OF PROVIDER OR SUPPLIER **WATERMARK AT TRINITY (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **1960 BLUE FOX WAY** **TRINITY, FL 34655**	

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

0000 - Initial Comments

Assisted Living Facility

On , 2018, a change of ownership (CHOW) provisional licensure survey for the period of - in conjunction with a complaint investigation (CCR 2018013611), and a revisit to complaint (CCR 2018012334) was conducted at Watermark at Trinity (The). Deficient practice was identified during the surveys.

(License #12868)

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

Based on observation, interview, and record review, the Facility failed to:
1. Maintain an Interdisciplinary Care Plan ( ) which specified care and services provided by the Facility and those provided by Hospice for use, maintenance, and management for one sampled Hospice resident (#19); and,
2. Provide care and services to meet the required needs for use, maintenance, and management for one Hospice Resident (#19) of one sampled Hospice resident who used continuously.

Findings Included:

An observation with Resident #19, conducted on at 04:30pm, revealed that Resident #19 tripped over long tubing while answering the door of their back into the wall and pulled the tubing out of their nose. Resident #19 was observed while walking away from the door and almost tripped over two large portable tanks that were not in a secured rack or holder and were within Resident #19's path . When Resident #19 sat down at the dinette table, the resident attempted to place the tubing back in her nose from the back of head and around her neck. Resident #19 was unable to place the tubing in nose properly. Agency staff then turned on the resident's call light for Staff assistance.

A record review for Resident #19, conducted on , revealed that Resident #19 was admitted to Hospice services. The in Resident #19's record did not specify care and services provided by the Facility and those care and services provided by Hospice for use, maintenance, and management. The did not specify care and services provided by the Facility and those care and services provided by Hospice for Resident #19's risk status. There were no interventions or

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prevention measures described in Resident #19's .

During an interview with Staff A, conducted on at 06:30pm, Staff A acknowledged and confirmed that Resident #19's did not specify all required and risk needs for the resident.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, record review, and interview, the Facility failed to honor the rights of residents to a safe living environment by failing to ensure safe storage of portable tanks for one Resident (#19) of one sampled resident who uses .

Findings Included:

An observation of Resident #19, conducted on at 04:30pm, revealed that Resident #19 had two large unsecured portable tanks near the door with in the walk-path to the door. Resident #19 came close to running into these tanks after opening the . Resident #19 into the wall while opening the due to tripping on the long tubing. The tubing pulled out from Resident #19's nose and onto the floor.

A record review for Resident #19, conducted on , revealed that Resident #19 had an Interdisciplinary Care Plan ( ) between Hospice and the Facility. The did not specify care and services provided by Hospice and those care and services provided by the Facility regarding use, maintenance, and management.

A review of the Facility's Storage Policy and Procedure, conducted on , revealed that the Facility's Storage Policy stated that, "it is the policy of Watermark Retirement Communities, Inc. (WRC) and its affiliates to ensure that the tanks are stored properly ..."

During an interview with Staff A, conducted on at 06:30pm, Staff A agreed that the two portable tanks in Resident #19's not stored properly or safely.

A review of the National Fire and Protection Association (NFPA) and Occupational Safety and Health Administration standard for safe cylinder storage is that "all freestanding cylinders must be stored in a rack, a cart, or another enclosure to protect them. Unsecured cylinders could , breaking the valve and possibly resulting in a rapid release of the gas, propelling the cylinder and turning it into a

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dangerous projectile."

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2-3) FAC

Based on record review and interview, the facility failed to ensure that three of four employees (Staff B, C and K), whose records were reviewed had documentation, facility specific, in Emergency Preparedness and Evacuation Training and Elopement Response Training.

Findings Included:

On . . . . . a record review was conducted for Staff B, with a hire date of . . . . . There were no training certificates for Emergency Preparedness and Evacuation Training and Elopement Response Training present on file specific for this facility as required.

On . . . . . a record review was conducted for Staff C, with a hire date of . . . . . There were no training certificates for Emergency Preparedness and Evacuation Training and Elopement Response Training present on file specific for this facility as required.

On . . . . . , a record review was conducted for Staff K, with a hire date of . . . . . There were no training certificates for Emergency Preparedness and Evacuation Training and Elopement Response Training present on file specific for this facility as required.

An interview was conducted with Staff A at 3:49 PM on . . . . concerning the lack of required training for Staff B, C, and K. Staff A acknowledged that Staff B, C, and K's records lacked proof of the required training. Staff A then showed a list of trainings that the three employees had taken. There was no indication as to the length of time for each of the trainings discussed.

Class III

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

Based on record review and interview, the facility failed to ensure that three of four employees (Staff B, C and K) whose training records were reviewed had documentation, facility specific, in the facility's policies and procedures regarding (Training).

Findings Included:

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On , a record review was conducted for Staff B, with a hire date of . There were no training certificate for Training present on file specific for this facility as required.

On , a record review was conducted for Staff C, with a hire date of . There were no training certificate for Training present on file specific for this facility as required.

On , a record review was conducted for Staff K, with a hire date of . There were no training certificate for Training present on file specific for this facility as required.

An interview was conducted with Staff A on at 3:49 PM concerning the lack of required Training for Staff B, C, and K. Staff A acknowledged the lack required of facility specific training. Staff A then showed a list of trainings that were taken by the staff members. There was no indication as to the amount of time spent in each of the subjects.

Class III