STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965596	10/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAINES MANOR ALF	**301 SOUTH 10TH STREET HAINES CITY, FL 33844**

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

0000 - Initial Comments

Assisted Living Facility

A complaint investigation (CCR# 2018014078 & 2018014318) was conducted in conjunction with a revist to an complaint investigation at Haines Manor Assisted Living Facility (ALF) (License #9965) in Haines City, FL on . . . . . Haines Manor ALF had deficiencies at the time of the investigation.

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

Based on record review and interview, the facility failed to ensure that residents had documentation of a face-to-face medical examination (AHCA form 1823) after experiencing a significant change for 1 (Resident 5) of 7 resident records reviewed.

Findings Included:

Record Review conducted on revealed Resident #5 had an 1823 completed on . . . . . There was no updated 1823 for the significant change of entering hospice that occurred on for Resident #5.

Interview conducted on . . . . at 1:25pm was conducted with the Assistant Administrator. The Assistant Administrator confirmed there was no updated 1823 completed for Resident #5 when they started receiving Hospice care.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on observation, interviews and record review, the facility failed to provide staff that were qualified and trained to perform their assigned duties in meeting the behavioral needs of the residents.

Findings included:

An observation during lunch was conducted on . . . . . beginning at 12:08pm. During the observation, Resident #9 stood up at the table, towered over Resident #8 while vigorously and violently pulling Resident #8's left arm and hand back and forward and yelling. There were three staff present, and staff immediately told the Resident #9 to stop and Resident #9 eventually let Resident #8's hand go after 10

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seconds. Staff moved the aggressor, Resident #9 to a nearby table less than three feet from the victim, Resident #8.

An interview was conducted with the Asssitant Administrator on at 12:28pm and revealed facility administration expects the staff to separate residents when there is a verbal and physical altercation between residents to resident.

Employee record review revealed Staff A with a date of hire of did not receive the required training on resident behavior and needs.

Employee record review revealed Staff B with a date of hire of did not receive the required training on resident behavior and needs.

Employee record review revealed Staff C with a date of hire of did not receive the required training on resident behavior and needs.

An interview with the Assistant Administrator was conducted on at 2:31pm. The Assistant Administrator reviewed the employee files and confirmed their training did not include the required resident behavior and needs portion.

Class III

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

Based on interview and employee record review, the facility failed to ensure 1 of 4 (Staff A) staff received in-service training within 30 days of employment, for staff who provide direct care to residents.

Findings Included:

Focused employee record review conducted on revealed Staff A with a date of hire did not have recognizing and reporting resident , neglect and , training, resident rights, incident reporting or assistance with the activities of daily living (ADL) and behavioral needs.

An interview with the Asssitant Administrator was conducted on at 2:31pm. During the interview, the Assistant Administrator reviewed Staff A's file and confirmed the staff was missing training for , Neglect and , , ADL & Behavioral Needs Training, Resident Rights Training, and

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Incident Reporting Training.

Class III

L240 - LMH - Licensing - 429.075; 58A-5.029 (1)(a)

Based on record review and interview, the facility failed to obtain a limited mental health (LMH) license prior to admitting one or more mental health residents.

Findings Included:

Focused record review of Resident #2's record revealed they receive Supplemental Security Income (SSI), [illegible] and have a mental illness diagnosis.

Focused record review of Resident #3's record revealed they receive [illegible], SSI and have a mental illness diagnosis.

Focused record review of Resident #4's record revealed they have a mental illness and receive SSI and [illegible].

An interview with the Asssitant Administrator was conducted on [illegible] beginning at 3:35pm revealed the facility does not have an LMH license.

Class III