STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964507	**04/03/2019**
NAME OF PROVIDER OR SUPPLIER **AUTUMN HOUSE**	STREET ADDRESS, CITY, STATE, ZIP CODE **7999 SPYGLASS HILL ROAD** **VIERA, FL 32940**	

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

0000 - Initial Comments

The re-licensure survey with Extended Congregate Care (ECC) and Limited Nursing Services (LNS) was conducted on . Autumn House, license #9049, had deficiencies at the time of the visit.

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

Based on observations, record reviews and interview, the facility failed to obtain a new 1823 health assessment form when 1 of 3 sampled residents (#9) experienced a significant change.

Findings:

On at 9:30 a.m. the administrator identified resident #9 and said he received a Limited Nursing Service for a on his .

Resident #9's record revealed a facility admission date of . His current 1823, dated , indicated that he had a diagnoses of 's .

A facility note, dated , indicated that he had an open area on his .

Observations made with nurse F at 2:51 p.m. revealed he had an uncovered on his that measured approximately 1 cm x 1 cm with an unmeasured depth.

His record did not contain a new 1823 when he developed the , which is a significant change.

At 3:30 p.m. the administrator confirmed the findings and was unable to provide additional documentation.

Class III

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

Based on observations, record reviews, and interviews, the facility failed to follow a health care provider's care order for 1 of 3 sampled residents (#9).

Findings:

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On at 9:30 a.m. the administrator identified resident #9 and said he received a Limited Nursing Service for a on his .

Resident #9's record revealed a facility admission date of . His current 1823, dated , indicated that he had a diagnoses of 's .

A facility note, dated , indicated that he had an open area on his .

A health care provider's order, dated , indicated that his treatment was to be changed to Xeroform, apply and cover with bandage, and change every 3 days until healed.

On at 2:22 p.m. his wife said he was left without a for the past days. She told nurse F on who said she would tell the night nurse since his was applied on that shift.

Observations made with nurse F at 2:51 p.m. revealed he had an uncovered , on his , that measured approximately 1 cm x 1 cm with an unmeasured depth.

At 2:58 p.m. nurse F said his wife told her after dinner yesterday that his was off. She was in the middle of a medication pass so she said she would inform the night nurse.

Documentation in his record revealed the last time a was applied to the was on .

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on observations and interviews, the facility failed to provide a clean and decent living environment and did not clean the wheelchair of 1 of 1 sampled residents (#13.)

Findings:

Observations made in one of the facility's memory care units on at 10:25 a.m. revealed resident #13 was sitting in a wheelchair that was labeled with her name. The chair contained dried food particles on the pedals, wheels, and seat cushion. Caregiver G confirmed the findings.

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At 10:33 a.m. the administrator also confirmed the findings on the chair and said the process for cleaning resident's equipment was the direct care staff should wipe off any spills and if the equipment needs to be power washed, a work order must be given to maintenance.

Photographic evidence obtained.

Class III

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

Based on personnel record reviews and interview, the facility failed to ensure 1 of 5 staff (B) submitted a written statement from a health care provider documenting freedom from communicable within 30 days after beginning employment and failed to ensure staff were qualified to perform their duties consistent with their level of education by allowing an unlicensed caregiver (B) to assist a resident (#15) with a bag.

Findings:

On at 9:30 a.m. the administrator identified resident #15 and said she received a Limited Nursing Service for a .

At 3:50 p.m. caregiver B said she assisted resident #15 with the by removing the bag, cleaning the site, then putting a new bag on.

Caregiver B was hired on . Her record did not contain a written statement from a health care provider documenting freedom from communicable , as required. In addition, the record did not contain documented evidence to indicate she received a minimum of 6 hours of training on the management of medications and assisting with the self-administration of medications in order to assist resident #15 with a bag.

On at 5:04 p.m. the administrator confirmed the findings.

Class III

0085 - Training - Nutrition & Food Service - 58A-5.0191(7) FAC

Based on personnel record review and interview, the facility failed to ensure the person responsible for the facility's food service and the day-to-day supervision of food service staff obtained a minimum of 2

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hours annual continuing education in topics pertinent to nutrition and food service in an assisted living facility.

Findings:

Review of the personnel record for the dietary manager, hired , did not reveal any training certificates in the areas of food and nutrition in an assisted living facility.

On at 3:30PM, the administrator confirmed the finding.

Class III

0086 - Training - ADRD - 58A-5.0191(10) FAC

Based on personnel record review and interview, the facility failed to ensure 1 of 4 direct care staff (C) received 4 hours of and Related (ADRD) continuing education annually and failed to ensure 1 of 5 staff (E) obtained ADRD level 1 training within three months of employment.

Findings:

Review of the personnel record for staff C, caregiver hired on , revealed ADRD level 1 and 2 training certificates. The most recent 4 hour annual update for ADRD training was dated .

On at 2:45 PM, the administrator confirmed the findings.

Observations made on at 10:20 a.m. revealed the facility had secured memory care units.

Nurse E was hired on . Her personnel record did not contain documented evidence to indicate she obtained 4 hours of initial ADRD training within 3 months of employment, as required.

At 5:15 p.m. the administrator confirmed the findings.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on personnel record reviews and interview, the facility failed to ensure the record for 1 of 5 staff (B) contained a copy of the job description.

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Findings:

The facility has a licensed capacity of 60.

Caregiver B was hired on . Her personnel record did not contain a copy of the job description given to her, as required.

On at 4:58 p.m. the administrator confirmed the findings.

Class

E210 - ECC - Training - 58A-5.0191(8) FAC

Based on personnel record reviews and interview, the facility failed to ensure the Extended Congregate Care (ECC) supervisor (E) obtained a passing assisted living facility core training competency test.

Findings:

On at 5:15 p.m. the administrator identified nurse E as the ECC supervisor. Nurse E's personnel record contained documentation to indicate she received core training on however, the record did not contain documented evidence to indicate she passed the competency test, as required.

The administrator confirmed the findings and said nurse E took the test twice but did not pass it.

Class III

N278 - LNS - Records - 58A-5.031(3) FAC; 429.07 (3)(c)2, FS

Based on record reviews and interview, the facility failed to ensure the nursing progress notes and nursing assessments completed for 1 of 6 sampled residents (#9) who received a Limited Nursing Service (LNS) contained all of the required information.

Findings:

On at 9:30 a.m. the administrator identified resident #9 and said he received a LNS for a on his .

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Review of his nursing progress notes revealed the notes did not consistently describe the outcome of services that were rendered and the general status of the resident's health, as required.

In addition, his nursing assessment, signed by registered nurse E, did not contain a written review of information collected from observation and interaction with the resident, including the resident's record and any other relevant sources of information.

At 3:30 p.m. the administrator confirmed the findings.

Photographic evidence obtained.

Class III