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	AL11922141	**08/06/2019**
NAME OF PROVIDER OR SUPPLIER **RENAISSANCE RETIREMENT CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **300 WEST AIRPORT BLVD.** **SANFORD, FL 32771**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

A biennial re-licensure survey in conjunction with Complaint Investigations 2019008581 and 8582 was conducted at Renaissance Retirement Center on . . and . . . Deficiencies were identified at the time of the survey.

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

Based on resident record review and interview, the facility failed to obtain an accurate and complete Agency for Health Care Administration (AHCA) Form 1823 Health Assessment for 4 of 9 sampled residents (#1, #12, #13 & #16) by a health care provider as required.

Findings:

1. Resident #13's record revealed admission date . . . . . . An 1823 Health Assessment found on page 2, section C, question 5 was marked yes for requiring 24-hour nursing , , care and did not have a date signed by the physician on page 4 and to include the complete address. "Photographic evidence obtained"

2. Resident #16's record revealed admission date . An 1823 Health Assessment found on page 4 did not have the completed information of the physician who signed to include the complete address. "Photographic evidence obtained"

On at 12:45 PM, an interview with the Administrator confirmed the findings.

3. Resident #1's current 1823, dated . . . , indicated that she required both assistance with medications and she was able to administer her medications without assistance.

On at 11:45 a.m. the administrator confirmed the finding.

Photographic evidence obtained.

4. Record review for resident #12 revealed a resident health assessment form 1823, dated , on page 4, the section for the printed name of the examiner, medical license number, telephone number, title of the examiner and address of examiner were all left blank.

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On at 3 PM, the administrator confirmed the findings

Class III

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

Based on record reviews and interviews, the facility failed to document a grievance for 1 of 20 sampled residents (#2), failed to treat residents with consideration and respect by failing to answer the call bell in a timely manner for 1 of 20 sampled residents (#11) and failed to provide a safe living environment, free from , for 1 of 20 sampled residents (#9.)

Findings:

1. On at 10:22 a.m. resident #2 said on two occasions he was served only side dishes and no meat, the facility runs out of food all of the time, and the facility holds food meetings but he does not go because it was pointless. He said he told his concerns to the chef.

Review of the facility's grievance log and food meeting minutes revealed no documentation regarding his concerns.

At 2:29 p.m. the chef said the resident told him last week that he ordered food towards the end of the meal and the kitchen had run out of food. He said the resident was not a complainer so if he reports something then it's true. He said he addressed the concern with one of the chefs but did not document the grievance.

Photographic evidence obtained.

2. On at 11:30 AM resident #11 said this morning around 7:15 AM he rang the call light for someone to come to assist him with getting ready for breakfast. He said the staff did not arrive until almost two hours later to assist him and by that time the dining room had closed, the staff assisted him in his wheelchair to the dining room, he asked the dietary staff if they could just give him a couple of boiled eggs and the kitchen staff did give him two eggs and bread because they could not toast the bread.
Review of the call log for resident #11 revealed at 7:17 AM the resident called, the log noted the call was acknowledged and the time was 48 minutes 43 seconds, the response time to assist the resident was 1 hour 37 min 56 seconds.
On at 1 PM The administrator said the reason the call was answered late was because there

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were 11 calls at the same time.

3. On at 10 AM, resident #9 said on an occasion staff H who was a caregiver yelled at one of the residents to lift her up while in her wheelchair in nasty way. She said she yelled at staff H and call her a bitch because that what she was asking for.

Personnel record review for staff H revealed a corrective action form/written warning dated that noted:
Descriptions of issues:

Over the last month, there have been multiple resident complaints regarding the care you deliver a how you speak to them. It has been reported by multiple residents that you speak to them in a very short and demeaning tone. Multiple residents have also reported that you are very ruff in delivering care and have requested that you no longer care for them. It was reported that you were yelling at a resident with profanity after you were called a "bitch." Today it was witnessed that you were yelling at caregivers on 2 separate occasions today. It was also reported today that you complained about a co-worker's job performance in front of the co-worker, other co-workers and a resident.

Violation of work policies/rules:
The community strives to maintain a positive work environment and maintains Meridian Core Values. You have failed to uphold our mission statement that states "We enrich the lives of our residents, families and employees through extraordinary experiences...because everyone deserves a great life. Our core values state that: We will demonstrate nurturing, empathetic and loving attitudes to others; We will provide great delight and happiness by engaging our residents and families and we will respect the rights and dignity of all individuals. Lack of customer service as hurt our communities' image and its ability to provide excellent care for our residents. Belittling , antagonistic and intimidating behavior with your co-workers is unacceptable.

Corrective Action:
As a member of the Renaissance Team, you are expected to treat all residents with respect and dignity and to uphold our mission and core values at all times. Continued failure to uphold our mission statement, core values and failure to treat our residents and co-workers with dignity and respect may lead to further disciplinary action and may include termination.

The form was not signed by staff H, only the supervisor. There was no documentation that the form was provided to the staff.

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Review of the facility's -Neglect- , policy revealed it noted:
: Acts or failure to act, either intentional or reckless, which causes or is likely to cause physical or emotional harm to a resident. can be either verbal or physical.

An employee alleged to have abused a resident will be placed on suspension pending the outcome of the investigation. If the investigation is substantiated, the employee will be terminated.

at 12:20 PM the administrator said the staff H, was suspended in because she was disrespectful to staff and was terminated on due to her behavior and the behavior of her daughter.
The administrator was asked to provide documentation of the facility's investigation into the multiple resident's complaints regarding and resident who said they were handled " ruff "that were noted on the corrective action.

The administrator said at the time staff H, was written up and there was an investigation regarding her cursing the resident, she said the resident also cursed her. The administrator said she did not have any documentation to confirm that an investigation was conducted regarding the residents' concerns and the outcome.

There was no evidence that the facility had conducted an investigation and spoke to the residents regarding the concerns of staff h and the measures taken to ensure that the residents were protected from further . The facility allowed staff h to continue to provide care to resident's after there were multiple complaints regarding her behavior and treatment of the residents. The facility did not follow its policy to suspend the employee and conduct an investigation when the resident complaints of were made.

Class III

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observations and interview, the facility failed to ensure the unlicensed staff (G) who assisted a resident (#1) with self-administration of medications followed the correct procedures.

Findings:

Observations made during a medication pass for resident #1 on at 11:13 a.m. revealed the resident stood next to the medication cart. Unlicensed caregiver G unlocked the cart, removed two

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bubble packages, said the name of each medication aloud, popped each pill into a cup, then handed the cup to the resident, who took the meds without assistance. The caregiver observed the resident take the medication then she signed the Medication Observation Record (MOR.)

Caregiver G read only the name of the medications aloud and not the prescription label, as required.

At 11:30 a.m. caregiver G confirmed the findings.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record reviews and interview, the facility failed to ensure the Medication Observation Record (MOR) for 1 of 9 sampled residents (#14) was properly updated.

Findings:

Resident #14's record revealed a facility admission date of . His current 1823 health assessment form, dated , indicated that he required assistance with self-administration of medications.

Review of his MOR revealed that on , , and both his and were not signed as given. The MOR nor his record contained documentation to indicate why.

On at 11:45 a.m. the administrator confirmed the findings and was unable to provide additional documentation.

Photographic evidence obtained.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation, resident record review and interview, the facility failed to ensure medications was locked and stored safe in a storage receptacle, room at all times for resident #16 who requires assistance with self-administration of medications from the direct caregiver staff daily.

Findings:

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Observation on at 11:20 AM, over the counter medications 300 milligrams (mg), 400 mg, and and Mullen found on the small table in resident #16's living room. "Photographic evidence obtained"

On at 11:25 AM, an interview with resident #16 who stated, that every day the staff assist him with his medications.

Resident #16's record review revealed admission date on . The Medication Observation Record (MORs) reviewed for and reveal assistance every day with self-administration of medications signed. "Photographic evidence obtained"

On at 2:30 PM, an interview with the Administrator confirmed the finding.

Class III

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

Based on personnel record reviews and interview, the facility failed to ensure that 4 of 4 sampled staff (A, B, C, and H) received the required in-service training.

Findings:

In personnel record reviews on of Staff C, it revealed the staff was hired on and did not receive the required pre-service training before providing personal care to residents.

In an interview on at 3:00 pm with the administrator, she confirmed the findings.

2. Personnel record review for staff H a care giver hired , revealed there was no documentation to confirm that she had received at least 2 hours of pre-service orientation prior to interacting with residents that covered resident rights and the facility's license type and services offered by the facility. That included the signature of the staff and the administrator.

There was also no training, the business office manager provided an agenda dated for neglect and that staff was included in. The agenda did not list the duration the training nor did the agenda note if the staff was trained on the facility's prevention policies and

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procedures.

On at 1 PM, the executive director said the facility used a training provided by one the consultants (name mentioned) to provide that training that did not include the facility's policies and procedures.

3. Staff A's personnel record review revealed hire date . There was no documented evidence that the 2-hour pre-service orientation training was completed after being hired after .

4. Staff B's personnel record review revealed hire date . There was no documented evidence that the 2-hour pre-service orientation training was completed after being hired after .

On at 2 PM, an interview with the Business Office Manager confirmed the finding.

Class III

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

Based on personnel record review and interview, the facility failed to provide documentation on the training requirements and certificates for 1 of 7 sampled staff (A) as required.

Findings:

Staff A's personnel record review revealed hire date . There were certificates were dated but were not signed by the trainer for:

1. control training dated .
2. activities of daily living (ADLs) and behavioral needs training dated .
3. reporting major & adverse incident reporting and facility emergency procedures dated .
4. nutritional and safe food training dated .
5. resident rights training dated .

"Photographic evidence obtained"

On at 2 PM, an interview with the Business Office Manager confirmed the findings.

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Class

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observations and interview, the facility failed to ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances were maintained in good working order.

Findings:

Observations made on at 10 a.m. revealed the hallway carpeting located outside of resident , , contained stains and the ceiling outside of the , room and resident was peeling and contained a black substance.

Observations made on at 11 a.m. revealed a kitchen cabinet in resident had peeling paint, there were brown stains on the ceiling, the dining room light fixture was missing the cover, and an area of repair on the ceiling was not blended in to give a more aesthetic view.

The maintenance supervisor was present during the observations and confirmed the findings.

Photographic evidence obtained.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record reviews and interview, the facility failed to maintain a satisfactory fire inspection.

Findings:

Review of the facility's most recent fire inspection, dated , revealed the facility had violations. The report indicated that the violations must be brought into compliance by .

On at 12:10 p.m. the administrator said a reinspection was conducted however, she could not provide a report of the revisit findings. An opportunity was provided for her to obtain the report.

On at 11:50 a.m. the administrator said she was unable to provide additional documentation.

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Photographic evidence obtained.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(&) FS; 58A-5.0241 FAC

Based on facility records and interview, the facility failed to follow their policy and did not contact the Department of Children and Families as required under chapter 415 when there was allegation of and rough delivery of care to the residents of the facility.

Findings:

On at 10 AM, resident #9 said on an occasion staff H who was a caregiver yelled at one of the residents to lift her up while in her wheelchair in nasty way. She said she yelled at staff H and call her a bitch because that what she was asking for.

Personnel record review for staff H revealed a corrective action form/written warning dated that noted:

Descriptions of issues:

Over the last month, there have been multiple resident complaints regarding the care you deliver a how you speak to them. It has been reported by multiple residents that you speak to them in a very short and demeaning tone. Multiple residents have also reported that you are very ruff in delivering care and have requested that you no longer care for them. It was reported that you were yelling at a resident with profanity after you were called a "bitch." Today it was witnessed that you were yelling at caregivers on 2 separate occasions today. It was also reported today that you complained about a co-worker's job performance in front of the co-worker, other co-workers and a resident.

Review of the facility's -Neglect- , policy revealed it noted : Acts or failure to act, either intentional or reckless, which causes or is likely to cause physical or emotional harm to a resident. can be either verbal or physical.

An employee alleged to have abused a resident will be placed on suspension pending the outcome of the investigation. If the investigation is substantiated, the employee will be terminated.

The executive director is responsible for:

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Investigating the allegation, enlisting Adult Protective Services, the State regulatory agency and Ombudsman as needed and required.

On at 12:20 PM, the administrator/executive director said adult protective service was called but not by the facility, she said the facility should have contacted adult protective services.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on review of Florida health finder, record reviews, and interview, the facility failed to develop written policies and procedures for its emergency environmental control plan that addressed wellness checks by the facility staff to monitor residents for signs of and heat injury and a provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy, failed to, within 5 business days, notify in writing each resident and the resident's legal representative upon submission of the plan to the local emergency management agency that the plan had been submitted for review and approval and again when the plan was implemented, and failed to acquire a monoxide alarm.

Findings:

Review of Florida health finder on at 10 a.m. revealed the facility's plan was initially approved by the county on and a request was made by the facility for an implementation extension until .

Review of the plan's approval letter revealed the plan was most recently approved by the county on .

A request was made to observe the facility's monoxide alarm however, on at 10:50 a.m. the maintenance supervisor said the facility did not have a monoxide alarm.

A request was made to review the facility's written policies and procedures for its plan and the written notifications provided to the residents and their legal representatives however, on at 1 p.m. the administrator said the requested policies and procedures were not developed and said the required written notifications were not provided to the residents and their legal representatives, as required.

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Class III

Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC

Based on personnel record review, the agency for health care administration background screening website and interview, the provider did not maintain the current Level II Background screening eligibility results for 1 of 7 sampled staff (G) in her personnel files.

Findings:

Personnel record review for staff G hired . . . . revealed there was an ineligible level II background screening result in her record dated . . . .

Review of the agency's background screening website on at 11:45 AM noted she was eligible . . . . .

On . . . . at 11:50 AM the business office manager said the staff was ineligible at one time and did not work, when she became eligible, she reviewed the results and did not print them to place in her personnel record.

Unclassified