PRINTED: 02/14/2019

|                          |  | ID HUMAN SERVICES   |                     |  | FORM APPROVED     |
|--------------------------|--|---|---------------------|--|-------------------|
| CENTER                   | S FOR MEDICARE &   | MEDICAID SERVICES   | _                   |  | OMB NO. 0938-0391 |
|                          | MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIENCLIA (X2) MULTIPLE CONSTRUCTION LAN OF CORRECTION . A. BUILDING   |   | CONSTRUCTION        | (X3) DATE SURVEY<br>COMPLETED  |                   |
|                          |  | 10G027  | B. WING             |  | C<br>01/17/2019   |
| NAME OF PE               | ROVIDER OR SUPPLIER  |   | - 1                 | TREET ADDRESS, CITY, STATE, ZIP CODE   |                   |
| SHNI AND                 | CENTER MARIANNA-FA   | ACH ITY II  | 3                   | 700 WILLIAMS DRIVE   |                   |
| CONLAND                  | OLIVIER IIIAMAMA   |   | N                   | IARIANNA, FL 32446   |                   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | BE COMPLETION     |
| W 000                    | INITIAL COMMENTS   |   | W 000               |  |                   |
| W 104                    | contained within CCR conducted 01/17/201: Marianna Facility II III was found not to be ir 483, Subpart I, Requ Care Facilities. GOVERNING BODY CFR(s): 483.410(a)(1 The governing body r | 9 at Sunland Center<br>Itermediate Care. The facility<br>n compliance with 42 CFR<br>irrements for Intermediate   | W 104               |  |                   |
|                          | Based on observatio<br>review, the governing<br>operating direction for  | not met as evidenced by:<br>n, interview and record<br>body failed to exercise<br>1 of 7 houses to provide<br>irs for water temperatures.                                   |                     |  |                   |
|                          | On 1/17/18 at approx<br>the Pierce House was<br>and the facility's main<br>conducting water tem  | imately 10:00am, a tour of<br>s conducted with life safety  |                     |  |                   |
|                          | that room # 1, room #<br>have hot water. Staff<br>had been out since th  | imately 10:06am, an<br>and Staff E who reported<br>48, and the kitchen did not<br>D reported that the water<br>the hurricane in October and<br>g water in bowl in microwave |                     |  |                   |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

02/08/2019

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

|                          |  | ID HUMAN SERVICES  |                      |     |  |  | FORM                 | : 02/14/2019<br>APPROVED   |
|--------------------------|--|--|----------------------|-----|--|--|----------------------|----------------------------|
| STATEMENT C              | S FOR MEDICARE & I<br>OF DEFICIENCIES<br>CORRECTION  | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MUL<br>A. BUILD |     | CONSTRUCTION                           |  | (X3) DATE :<br>COMPL |                            |
|                          |  | 10G027   | B. WING              |     |  | _  | 01/1                 | ;<br> 7/2019               |
| NAME OF PR               | ROVIDER OR SUPPLIER  |  |                      | ST  | REET ADDRESS, CITY, ST                 | TATE, ZIP CODE   |                      |                            |
| SUNLAND                  | CENTER MARIANNA-FA   | ACILITY II   |                      | 1   | 00 WILLIAMS DRIVE<br>ARIANNA, FL 32446 |  |                      |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG    |     | (EACH CORREI<br>CROSS-REFEREI          | S PLAN OF CORRECTION<br>CTIVE ACTION SHOULD E<br>NCED TO THE APPROPRI<br>DEFICIENCY) |                      | (X5)<br>COMPLETION<br>DATE |
| W 104                    | maintenance had bee On 1/17/19 at approx interview with client # have hot water in her another client's bathro On 1/17/19 at approx interview with the Hur Supervisor (HSSS) re submitted a work ordwater in the shower to review conducted of computer with HSSS submitted.  On 1/17/19 at approx with the Program Operevealed that he was did not have hot wate the kitchen. POA repetude the thing the house of the house hou | house. Both staff reported in notified.  imately 10:15am, an  1 revealed that she did not bathroom and had to use  nom to bath.  imately 10:27am, an  man Services Senior  wealed that on 11/13/18 she  er for room #8 due to cold  the staff assistant. Record  vork order receipt on  confirmed a work order was  imately 1:30pm, an interview  erations Administrator (POA)  not aware that Pierce house  r in room #1, room #8, and  orted that staff had not  entire the staff of the staff of the  entire that they were heating  owave. |                      | 104 |  |  |                      |                            |
|                          | exceed 110 degrees I   | not met as evidenced by:   |                      |     |  |  |                      |                            |

Based on observation and interview the facility failed to regulate water temperature and ensure that the temperature of the water does not

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| THE MENT OF THE CONTROL TO MAN OCCUPACE     |   |  |                               |  |  |  |  |
|---|---|--|-------------------------------|--|--|--|--|
| NTERS FOR MEDICARE &                        | MEDICAID SERVICES                                     |  | OMB NO. 0938-039              |  |  |  |  |
| EMENT OF DEFICIENCIES<br>PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | (X3) DATE SURVEY<br>COMPLETED |  |  |  |  |

B. WING 10G027 01/17/2019

|                                     |  | 100027   | D. 117/10         | _   |   | 01/ | 17/2019                    |  |  |
|-------------------------------------|--|--|-------------------|-----|---|-----|----------------------------|--|--|
| NAME OF PROVIDER OR SUPPLIER        |  |  |                   | П   | STREET ADDRESS, CITY, STATE, ZIP CODE   |     |                            |  |  |
|                                     |  |  |                   | Ι.  | 3700 WILLIAMS DRIVE   |     |                            |  |  |
| SUNLAND CENTER MARIANNA-FACILITY II |  |  |                   |     | MARIANNA, FL 32446  |     |                            |  |  |
| (X4) ID<br>PREFIX<br>TAG            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY) | E   | (X5)<br>COMPLETION<br>DATE |  |  |
| W 426                               | (Pierce house room 4 The Findings: On 1/17/19 at approx observation and wate pierce house with life maintenance staff. W room 4, tub which reg Interview with facility reported not being aw water registered at 1' On 1/17/19 interview that the house no lon | Fahrenheit for 1 of 7 house tub)  imately 10:00 am or temperatures taken in safety and facility's ater temperature taken in isstered at 116 degrees. Is maintenance staff who ware of that the bath tub 16 degrees.  with Staff D who reported ger keep water temperature supposed to test water | W                 | 426 |   |     |                            |  |  |

AND

PRINTED: 02/14/2019 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ B MING IC25910061 01/17/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3700 WILLIAMS DRIVE SUNLAND CENTER MARIANNA-FACILITY II MARIANNA, FL 32446 (X433F) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 1000 Initial Comments 1000 An unannounced complaint survey (CCR2019000702) was conducted on 1/17/2019 at Sunland Center Marianna Facility II Intermediate Care. At the time of the complaint there was state deficient practice identified. 13000 59A-26.015 (1)-(2)(a)-(q) FAC Plant Maintenance 13000 SS=D and Housekeeping (1) The facility must maintain the interior and exterior of buildings accessible to clients and all equipment, furniture, and furnishings in a clean manner and in such condition such that client safety and well-being are not jeopardized. (2) Each licensee must establish written policies designed to maintain the physical plant and overall ICF/DD environment in such a manner that the safety and well-being of clients are ensured. The building and mechanical maintenance program must be under the supervision of a qualified person, as determined by the facility. All mechanical and electrical equipment must be maintained in working order, and must be accessible for cleaning and inspecting. All mechanical systems must be

ticensee must:

hazards:

window panes and screens; and other similar LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

tested, balanced and operated prior to being placed into service and maintained in good working order. The facility must have a written plan for maintenance, including record keeping. sufficient staffing, equipment, and supplies. The

(a) Maintain the building in good repair, safe and free of the following: cracks in the floors, walls, or ceilings; peeling wallpaper or paint; warped or loose boards; warped, broken, loose, or cracked floor covering, such as tile, linoleum or vinvl; loose handrails or railings; loose or broken

TITLE

(X6) DATE 02/08/19

PRINTED: 02/14/2019 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ B MING IC25910061 01/17/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3700 WILLIAMS DRIVE SUNLAND CENTER MARIANNA-FACILITY II MARIANNA, FL 32446 (X433F) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 13000 Continued From page 1 13000 (b) Maintain all electrical, lighting (interior and exterior), signal, mechanical, potable water supply, hot water heaters, heating, air conditioning, fire protection and sewage disposal systems in safe, clean and functioning condition: (c) Maintain all electrical cords and appliances in a safe and functioning condition: (d) Maintain the interior and exterior finishes of the buildings as needed to keep them clean and safe, to include painting, washing, and routine maintenance; (e) Maintain all furniture and furnishings in a clean and safe condition: (f) Maintain the grounds free from refuse, litter, insect, vermin, and vermin breeding areas; and, (g) Maintain screens on windows and doors in good repair, free of breaks in construction. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the governing body failed to exercise operating direction for 1 of 7 houses to provide needed building repairs for water temperatures. (Pierce house) The findings included: On 1/17/18 at approximately 10:00am, a tour of the Pierce House was conducted with life safety and the facility's maintenance staff, Upon conducting water temperatures, room # 1, room

water

#8, and the kitchen were found to have no hot

On 1/17/19 at approximately 10:06am, an interview with Staff D and Staff E who reported that room # 1, room #8, and the kitchen did not have hot water. Staff D reported that the water had been out since the hurricane in October and staff had been heating water in bowl in microwave

| Agency f  | or Health Care Adminis  | tration  |                     |   |   |                               | D: 02/14/2019<br>M APPROVED  |
|---|---|--|---------------------|---|---|-------------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/C<br>IDENTIFICATION NUMBE   |                     | (X2) MULTIPLE CONSTRUCTION  A BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED |  |
|   |   | IC25910061   |                     | B. WING                                 |   | 01/                           | 17/2019  |
| NAME OF P   | ROVIDER OR SUPPLIER   |  |                     | RESS, CITY, STA                         | ITE, ZIP CODE   |                               |  |
| SUNLAND   | CENTER MARIANNA-F   | ACILITY II   |                     | AMS DRIVE                               |   |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  |                     | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE      |  |
| 13000   | Continued From page   | 2  |                     | 13000                                   |   |                               |  |
|   | to clean kitchen in the house. Both staff reported maintenance had been notified.  On 1/17/19 at approximately 10.15am, an interview with client #1 revealed that she did not have hot water in her balthroom and had to use another client's bathroom to bath.   |  |                     |   |   |                               |  |
|   |   |  |                     |   |   |                               |  |
|   | On 1/17/19 at approximately 10:27em, an interview with the Human Services Senior Supervisor (HSSS) revealed that on 11/13/18 she submitted a work order for room #8 due to cold water in the shower to the staff assistant. Record review conducted of work order receipt on computer with HSSS confirmed a work order was submitted. |  | ild<br>cord         |   |   |                               | na dia dia dia dia dia dia dia dia dia di  |
|   | with the Program Ope<br>revealed that he was<br>did not have hot wate<br>the kitchen. POA repo  | imately 1:30pm, an inter<br>rations Administrator (f<br>not aware that Pierce h<br>r in room # 1, room #8,<br>roted that staff had not<br>antion that they were he<br>owave. | POA)<br>ouse<br>and |   |   |                               |  |
|   |   |  |                     |   |   |                               | - Constitution of the Cons |

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