Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968462	A. BUILDING: _____ B. WING _____	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILL ASSISTED LIVING FACILITY	8239 CESSNA DR, SPRING HILL, FL 34606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced re-licensure survey with limited mental health and emergency power plan monitoring and a COVID-19 focused control survey were conducted on , - 22, 2021, at Spring Hill Assisted Living Facility. Deficiencies were identified.	A 000		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide adequate resident supervision and failed to implement their established smoking policy resulting in actual harm to 1 of 9 residents who smoke and use supplemental [illegible], Resident #13. Findings: On [illegible] at 10:45 AM, an interview was conducted with Resident #1. The resident stated she heard that [Resident #13's name] was smoking on the porch with his [illegible] on and he	A 025		

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A 025	Continued From page 2 caught on fire. The staff called 911 and he was transported to a hospital. She further stated, "I did not see him, but I saw when the ambulance picked him up because it was crazy by then. Other people have caught him smoking before with his on." On , at approximately 1:50 PM, an interview was conducted with Resident #10. She stated, "[Resident #13' name] was very careless about smoking while using his . He was told repeatedly by me and others that he was putting himself in danger as well as all of us, and he projected a very carefree attitude as though he didn't really care." She confirmed observing him at least 6 or 7 times smoking with his in his while hooked to his concentrator over the course of a month since he moved in. She further stated, "The tubing was stretched across the house from his room to the porch. He ignited himself on fire, can you imagine if it had traveled through the tubing into his room where there are tanks, what could have happened? Scary!" On , at 2:10 PM, an interview was conducted with Resident #12. He stated he was "really rattled" by what happened to Resident #13, he'll have nightmares, he's sure. He stated he hardly got any sleep last night. Resident #12 stated he, too, uses and is a smoker, "Imagine how the situation could have been much worse with even more catastrophic consequences." Resident #12 related, it was Sunday morning, , and all the residents were in their rooms, after breakfast, and he and his roommate had just finished watching church on You Tube, "When a knock came to my door - it must have been 10:15 - 10:30 AM, and it was [Resident #13' name], his , and	A 025		

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A 025	Continued From page 3 were horribly , and he was holding his in his ." He said at that point he immediately contacted Staff B, Resident Caregiver who called 911. He stated this was not the first time Resident #13 had smoked while using , he said he would tell him all the time, "Dude, what do you think you're doing? You are going to start yourself on fire and could hurt others in the process!" He concluded, "I was aware that this happened before here several years ago, only that person ." On , a review of Resident #13's AHCA (Agency for Health Care Administration) Form 1823, Resident Health Assessment for Assisted Living Facilities showed his diagnoses as: , history of , , , sleep , , and history of subdermal hematoma. He was admitted to facility on . He requires assistance with self-administration of medications, bathing, and ambulation, he uses a walker for ambulation. He requires daily observance of wellbeing and whereabouts, and daily reminders of important tasks. Listed under nursing services, " (02) use - continual flow rate of gas continual flow rate of gas through is 2 liters of ..." On , a review of a Hernando County Fire and Emergency Services Pre-Hospital Care Report, incident number 21-21145, dated , showed Resident #13 received on-scene treatment starting at 10:56 AM, for of the , , , , and . Resident #13 reported at 10 on a scale of 0 to 10. The report narrative read, "Called for a reported /Explosion at 8239	A 025		

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A 025	Continued From page 4 CESSNA DR in the city of Spring Hill. On arrival, found a 55 year [old] Male patient [kilograms]. Chief complaint of Airway ; Events surrounding incident: Sta.1 dispatched to Spring Hill ALF for a chief complaint of to the . Upon arrival found 55yo [year old]. M [male patient] found sitting on a chair stating he was smoking with his on and it blew up into his . Patient had a mild hoarseness when he was breathing and talking. Observed patient to have 2nd. degree to nares, lashes, and to and of . Patient was treated for airways (sic) , see interventions. Med Trans 1 responded and due to patient size they were unable to fly but rode along with M-1 to Tampa General taking over patient care. Medications and listed below given by Med Trans. Patients vitals were monitored continuously monitored throughout and remained the same. Patients LMA [level mental awareness] remained intact the entire transport. Patient treated and transported to Tampa General unit without incident. Med Trans administered: - , 5mg x3 - 2.5mg x2." On , at approximately 12:30 PM, an interview was conducted with Assistant Administrator A and Administrator B. After a review of the facility's smoking policy, and the smoking policy and procedure acknowledgement of understanding forms, Administrator B confirmed the facility had not continued that practice of residents receiving the smoking policy paperwork since of 2016. She also confirmed that the care staff people do not document any observations, but care staff come to administration, and someone addresses the concerns. When asked for documentation, she stated she did not have documentation.	A 025		

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A 025	Continued From page 5 Administrator B stated she and her husband, Administrator A, assess each resident at the time of admission to determine if they can safely smoke and follow the rules. When asked if there was documentation of such an assessment she stated, "No." On at approximately 10:00 AM, an interview was conducted with Staff B, Resident Caregiver. She stated she does not document her observations or contacts with residents. She stated she is not required to document at all. She confirmed she was the staff person who responded to the incident involving Resident #13. She stated it happened about 10:30 AM, on Sunday, . On at 9:40 AM, an interview was conducted with Administrator A. He confirmed they had initiated a policy in 2016 (after an incident where a resident from sustained while using while smoking), but did not follow it. On at 10:55 AM, an interview was conducted with Resident #10, who resided in the same building with Resident #13. She stated soon after Resident #13 moved in, around the middle of , she began to observe Resident #13 smoking while using his . Resident #10 further stated she went to the office to lodge a concern with the Administrative Assistant. She stated the facility "did nothing about it." On , at 9:58 AM, a telephone interview was conducted with Resident #13' brother. The brother said Resident #13 is a moderate smoker, and that he had witnessed him in the past exhibiting risky behavior while smoking and using	A 025		

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A 025	Continued From page 6 his . He further stated he had strongly warned him against it, telling him he was placing himself and others in danger. An interview with Staff B Resident Caregiver on , at approximately 12:20 AM. She stated she makes rounds often, but does not specifically monitor the smokers on the porches. A review of the facility's smoking policy and procedures found only six of 23 staff members signed the acknowledgement of understanding. All acknowledgements were all dated or . The policy read, "Residents that have the ability to smoke in a safe manner and use will be monitored daily. All residents, non-smokers, smokers (sic) and residents on that smoke will be given a copy of our policy on smoking and use. They will be required to read and sign this policy." A review of a list of resident smokers, provided by the facility, revealed 46 of 59 residents were identified as smokers. Nine residents were identified as smokers who use . On , a review of the smoking policy and procedure forms showed only 10 of the current 46 smokers had acknowledged receipt of the policy. All were signed on or . CLASS I	A 025		
A 026 SS=D	59A-36.007(2) FAC Resident Care - Social & Leisure Activities (2) SOCIAL AND LEISURE ACTIVITIES. Residents shall be encouraged to participate in social, recreational, educational and other activities within the facility and the community. (a) The facility must provide an ongoing activities	A 026		

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A 026	Continued From page 7 program. The program must provide diversified individual and group activities in keeping with each resident's needs, abilities, and interests. (b) The facility must consult with the residents in selecting, planning, and scheduling activities. The facility must demonstrate residents' participation through one or more of the following methods: resident meetings, committees, a resident council, a monitored suggestion box, group discussions, questionnaires, or any other form of communication appropriate to the size of the facility. (c) Scheduled activities must be available at least 6 days a week for a total of not less than 12 hours per week. Watching television is not an activity for the purpose of meeting the 12 hours per week of scheduled activities unless the television program is a special one-time event of special interest to residents of the facility. A facility whose residents choose to attend day programs conducted at adult day care centers, senior centers, mental health centers, or other day programs may count those attendance hours towards the required 12 hours per week of scheduled activities. An activities calendar must be posted in common areas where residents normally congregate. (d) If residents assist in planning a special activity such as an outing, seasonal festivity, or an excursion, up to 3 hours may be counted toward the required activity time. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide an ongoing activities program for 59 of 59 residents. Findings: During the tour of the facility on ,	A 026		

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A 026	Continued From page 8 beginning at approximately 1:00 PM, no evidence of an activities calendar was observed in 6 of the 6 resident facility buildings. On , at approximately 2:15 PM, during an interview with Resident #12, he stated, the facility "doesn't offer activities, most of the people just stay in their rooms and watch T.V., they really don't do anything." A review of the facility's monthly activities calendar showed it was dated . On , at approximately 10:30 AM, an interview was conducted with Assistant Administrator B. She stated the facility had discontinued activities since the onset of COVID-19 and plan to start up again next month. She confirmed the last month the facility offered activities to the residents was . She stated the facility discontinued the activities for the safety of the residents. "We were waiting until all the residents were . With these new variants, we just want to be sure. We let them know once they are all , we will start the activities." During an interview with Resident #24, on , at approximately 12:35 PM, he stated, "A couple months ago the television in Building 5 was struck by lightning and hasn't worked since. This place doesn't want to spend money to fix things they don't follow through on taking care of this place properly, and so we go without." Class III	A 026		
A 030 SS=D	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures	A 030		

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A 030	Continued From page 9 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; . . . . . , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- . . . . or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities;	A 030		

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A 030	Continued From page 10 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . 429.28 Resident bill of rights.-	A 030		

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A 030	Continued From page 11 (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility.	A 030		

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A 030	Continued From page 12 (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual	A 030		

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A 030	Continued From page 13 without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968462	A. BUILDING: _____ B. WING _____	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILL ASSISTED LIVING FACILITY	8239 CESSNA DR, SPRING HILL, FL 34606

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A 030	Continued From page 14 . . . . . Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated . . . . . or . . . . . under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe and decent living environment for 11 of 11 residents in residential building 5. Findings: During an interview with Resident #8 on , at approximately 12:30 PM, he stated, "The . . . porch leaks really bad." On . . . . . , at 12:33 PM an observation of the porch showed water damage under the eaves and soffits. On the day of the observation there had been no rain in a few days so no	A 030		

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A 030	Continued From page 15 puddles of water were evident. During an interview with Resident #24, on , at approximately 12:35 PM, he stated, "A couple months ago the television in building 5 was struck by lightning and hasn't worked since. This place doesn't want to spend money to fix things they don't follow through on taking care of this place properly. Just like the . . . porch it is leaking really badly, and nothing is being done about it." On . . . . . , at 4:25 PM, an interview was conducted with Administrator B. She stated she was not aware of any leakage on the porch in building 5. Class III	A 030		