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
	AL11910470	A. BUILDING: _____ B. WING _____	12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERFORD AT CARPENTER'S CREEK	5918 NORTH DAVIS HIGHWAY PENSACOLA, FL 32503

(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 complaint survey for complaint number 2022016399, was conducted at The Waterford at Carpenter's Creek on [redacted]/2022. Complaint survey revisits for complaint numbers 2022014804 and 2022002665 were conducted in conjunction. New deficiencies were identified, and all previous deficiencies were found to be corrected at the time of the survey.	A 000		
A 165 SS=E	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the	A 165		

AHCA Form 3020-0001

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

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A 165	Continued From page 1 resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) [redacted], neglect, or [redacted] must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident.	A 165		

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A 165	Continued From page 2 The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to report an adverse incident of resident-on-resident [redacted] for 3 of 3 (residents #4, 5, and 6) residents sampled for [redacted]. The findings include: A record review was conducted of resident #4, which revealed, on [redacted] at approximately 8:30 PM, that resident #4 was noted coming out of resident # 5's room. Resident # 5 was documented as stating that resident #4 had asked her for inappropriate relations. Further review of the record revealed that, approximately 5 minutes later, resident #4 was seen coming out of resident # 6's room. Review of resident #6's record revealed that resident #4 had	A 165		

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A 165	Continued From page 3 inappropriately touched resident #6. On [redacted], at approximately 2:40 PM, an interview was conducted with resident #6. Resident #6 stated that Resident #4 had come in to her room to visit with her and wanted her to be his girlfriend. Resident #6 stated that resident #4 "got fresh" with her and touched her inappropriately. Resident #6 went on to state that the police were notified, and that the neighbor's family had moved him out. On [redacted], at approximately 3:00 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that she was notified of the incident and had instructed the nurse to place resident #4 on one-on-one supervision until his daughter arrived and to notify the police. When asked if the DON filed the incident as an adverse incident, the DON stated she did not. CLASS III	A 165		

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