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
	AL11932678	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SWEET WATER AT LARGO	11290 WALSINGHAM ROAD LARGO, FL 33778

(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 Assisted Living Facility A complaint survey, CCR# 2012012787, was completed on . The Sweet Water at Largo, assisted living facility, had deficiencies found at the time of the visit.	A 000		
A 008	58A-5.0181(2) FAC Admissions - Health Assessment (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a face-to-face medical examination completed by a licensed health care provider, as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days prior to the individual ' s admission to a facility pursuant to Section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations; 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living; 3. Any nursing or services required by the individual; 4. Any special diet required by the individual; 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication; 6. Whether the individual has signs or symptoms of a communicable which is likely to be transmitted to other residents or staff; 7. A statement on the day of the examination that, in the opinion of the examining licensed health care provider, the individual ' s needs can be met in an assisted living facility; and	A 008		

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A 008	Continued From page 1	A 008		

8. The date of the examination, and the name, signature, address, phone number, and license number of the examining licensed health care provider. The medical examination may be conducted by a currently licensed health care provider from another state.
(b) A medical examination completed after the resident ' s admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, 2010. The form is hereby incorporated by reference. A faxed copy of the completed form is acceptable. A copy of AHCA Form 1823 may be obtained from the Agency Central Office or its website at www.fdhc.state.fl.us/MCHQ/Long_Term_Care/ <http://www.fdhc.state.fl.us/MCHQ/Long_Term_Care/> Assisted_living/pdf/AHCA_Form_1823%.pdf. The form must be completed as follows:
1. The resident ' s licensed health care provider must complete all of the required information in Sections 1, Health Assessment, and 2, Self-Care and General Oversight Assessment.
a. Items on the form that may have been omitted by the licensed health care provider during the examination do not necessarily require an additional face-to-face examination for completion.
b. The facility may obtain the omitted information either verbally or in writing from the licensed health care provider.
c. Omitted information received verbally must be documented in the resident ' s record, including the name of the licensed health care provider, the name of the facility staff recording the information and the date the information was provided.
2. The facility administrator, or designee, must complete Section 3 of the form, Services Offered

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A 008	Continued From page 2	A 008		

or Arranged by the Facility, or may use electronic documentation, which at a minimum includes the elements in Section 3. This requirement does not apply for residents receiving:
a. Extended congregate care (ECC) services in facilities holding an ECC license;
b. Services under community living support plans in facilities holding limited mental health licenses;
c. Medicaid assistive care services; and
d. Medicaid waiver services.
(c) Any information required by paragraph (a) that is not contained in the medical examination report conducted prior to the individual ' s admission to the facility must be obtained by the administrator within 30 days after admission using AHCA Form 1823.
(d) Medical examinations of residents placed by the department, by the Department of Children and Family Services, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b).
(e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.426, F.S., and this rule.
(f) Any orders for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility issued by the licensed health care provider conducting the medical examination may be attached to the health assessment. A licensed health care provider may attach a do-not- order for residents who do not wish to be administered in the case of or
(g) A resident placed on a temporary emergency

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A 008	Continued From page 3	A 008		

basis by the Department of Children and Family Services pursuant to Section 415.105 or 415.1051, F.S., shall be exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement shall be entered on the facility ' s admission and discharge log and counted in the facility census; a facility may not exceed its licensed capacity in order to accept a such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission.

This Statute or Rule is not met as evidenced by:
Based on observation, record review and interviews, the facility failed to assure the required health assessments (form 1823) were completed in its entirety and/or failed to obtain clarification for 5 (Residents #1, #2, #3, #4 and #5) of 5 sampled residents which could cause [redacted] when trying to determine the current needs of the residents.

Findings include:

A review of Resident #1's current health assessment (form 1823) was just completed on [redacted] following hospital admission and discharge for a hip [redacted] (still within the correction period).
A review of the most recent 1823 dated [redacted] was missing the following required information: height, weight.

A review of 4 of Resident #2's 1823s from [redacted] to [redacted] revealed 3 of 4 assessments had missing information including:

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A 008	Continued From page 4 '- missing the height and weight '- missing the actual date of the examination (based on the fax date of , it was determined to be the exam date.) '- missing height and weight, missing the medication order sheet, what type of medication assistance or adminstration was needed, missing the date of birth. A review of Resident #4's current 1823 signed and dated revealed the following information was missing: height and weight, any known . A review of Resident #5's current 1823 signed and dated on revealed the following information was missing: facility address, , height and weight. An interview with the manager on at 2:00 p.m. revealed she was aware that the health assessments sometimes were missing information. She said the health assessments were often incomplete when residents returned from the hospital. She additionally acknowledged the missing information from the assessments above. There was no explanation as to why clarification was not obtained for the missing information. Widespread	A 008		
A 010	58A-5.0181(4) FAC Admissions - Continued Residency (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (e) of this subsection, criteria for continued residency in any licensed facility shall be the same as the criteria for admission. As part of the continued residency	A 010		

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A 010	Continued From page 5	A 010		

criteria, a resident must have a face-to-face medical examination by a licensed health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 58A-5.0131, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule. The form must be completed in accordance with that paragraph. After the effective date of this rule, providers shall have up to 12 months to comply with this requirement.
(a) The resident may be bedridden for up to 7 consecutive days.
(b) A resident requiring care of a pressure may be retained provided that:
1. The facility has a LNS license and services are provided pursuant to a plan of care issued by a licensed health care provider, or the resident contracts directly with a licensed home health agency or a nurse to provide care;
2. The condition is documented in the resident ' s record; and
3. If the resident ' s condition fails to improve within 30 days, as documented by a licensed health care provider, the resident shall be discharged from the facility.
(c) A ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:
1. The resident qualifies for, is admitted to, and consents to the services of a licensed hospice which coordinates and ensures the provision of any additional care and services that may be needed;
2. Continued residency is agreeable to the resident and the facility;
3. An interdisciplinary care plan is developed and

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A 010	Continued From page 6	A 010		

implemented by a licensed hospice in consultation with the facility. Facility staff may provide any nursing service permitted under the facility ' s license and total help with the activities of daily living; and
4. Documentation of the requirements of this paragraph is maintained in the resident ' s file.
(d) The administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility.
(e) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C.
(5) DISCHARGE. If the resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident ' s needs, as determined by the facility administrator or licensed health care provider, the resident shall be discharged in accordance with Section 429.28(1), F.S.

This Statute or Rule is not met as evidenced by:
Based on observation, interviews and record review, the facility failed to meet readmission criteria into an assisted living facility following hospitalization for 1 (Resident #2) of 5 residents sampled, which placed the residents at risk for receiving inappropriate care and services by unqualified facility staff and placing staff at risk of injury.

Findings include:

Example 1

A record review revealed the Resident #2 was

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admitted to the facility on . Review of the health assessment (form 1823) dated revealed he had poor gait and balance, needs supervision with ambulation in the activities of daily living (adl) portion of the assessment.

A more recent assessment dated revealed his ambulation needs had changed to " needs assistance " but toileting and transferring remained as needing supervision only. On , all adls including toileting were changed to needs assistance and " bed bound " was listed in the physical or sensory limitations section. Nowhere was it indicated that the resident was . Where Section D. asks, "In your professional opinion, can this individual's needs be met in an assisted living facility, which is not a medical, nursing or facility", the physician checked off yes, but added the handwritten comment, "with extra help".

A review of an incident report dated at 5:15am stated the resident was found resident on the floor with his left elbow caught in the bed rail (hospital bed with 1/4 rails). It further documented that 911 was called and the resident was sent to a local hospital for evaluation.

The history and physical from the hospital dated revealed this was a 2nd ER visit (called back by the hospital) due to confirmation of a hip that had not been confirmed during the visit.

Further review of the resident's record revealed no documentation at all by facility staff to address the resident's need for extra help.

Observations of Resident #2 by surveyors during the survey included the following:

9:30am, Observed resident, no one was in there.

9:45am, 2 caregivers were observed wheeling him back to his . Client was picked up

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under each arm by caregivers and shifted on to the bed. The client did not assist or participate at any time with this transfer, his legs did not move at all which was confirmed by the caregivers. They proceeded to place a clean cloth on his bedlinens and positioned him on the bed and the cloth and left the order to give him privacy with the surveyor. The surveyor found caregivers who went in to clean the resident up. They were asked why he wasn't taken to the of using the bed but they said that he was too heavy to lift. They proceeded to clean him up while he was in the bed. An attempt was made to interview the resident however due to periods of , was determined to be an unreliable witness due to limited mental and

10:20am - During interview with direct care Staff #D, she stated the client is too heavy to move and requires 3 staff members to perform some of his care. She also stated other staff members have allowed the resident to always urinate or soil himself in disposable briefs and clean him afterwards because it is hard getting him into the

1:00pm observed the resident in the common television area sitting in a wheelchair. Another attempt to interview him was made but found to be unreliable.

3:30 - During interview with direct care staff # E, she stated that the staff had a training a few weeks ago about proper transferring, but felt that the Physical teaching the class was unable to tell them how to transfer residents. Further record review revealed the resident had physical in the past and during an interview with the on at 4:40pm, revealed his recollection was that the resident had had a about 2 months ago and as a result had no functional movement on

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his left side. He said at that time, the resident could pivot, transfer and stand at the sink for 30 seconds but that due to reaching his capacity, stopped around . Additionally, he said he provided a class on at the request of the facility to teach direct care staff the proper body mechanics in transferring and lifting. Interview with the facility manager on at approximately 11:45am and again in the afternoon revealed she had been made aware by staff that they were unable to lift Resident #2 without 3 staff, that he could not assist in transfers. At that point, the manager said she arranged for staff to be trained in transfers and she was not aware that they continued to have difficulty moving him about. She also told the surveyor that there was no actual process to determine whether residents continue to meet admission and continued residency criteria, that she, the administrator and facility nurse bring their concerns to the nurse practitioner who visits residents on a weekly basis. She said the facility nurse was not in a direct care role but that she (the manager), the administrator and the nurse (a licensed practical nurse) were responsible to monitor for changes in condition and contact resident health providers whenever they noticed a change in condition. She went on to say that the resident could be transferred with 2 persons but was not able to say if he could provide assistance during the transfers.

An interview with the nurse (Staff A) on at 9:15 a.m. revealed one of her responsibilities was to determine if a change in condition occurred by directly checking the resident (whenever concerns were brought to her attention by direct care staff) or if she saw a concern on her own. She also would notify the physician and

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A 010	Continued From page 10 family when a change in condition exists. She acknowledged that Resident #2 probably needed a higher level of care based on his inability to assist with his transfer. PATTERN	A 010		
A 025	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, 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 individual. (c) 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; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents,	A 025		

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changes in the method of medication administration, or other changes which resulted in the provision of additional services.

This Statute or Rule is not met as evidenced by:
Based on observation, record review and interviews, the facility failed to document an awareness of the residents general health, safety, physical and emotional well-being for 4 (Residents #1, #2, #3 and #5) of 5 sampled residents, which by not having ongoing documentation, placed all residents at risk for not having their current and ongoing needs met.

Findings include:

A review of Resident #1's facility file revealed the resident was readmitted to the facility on following hospitalization for a right hip with surgery completed on . Review of the resident's file revealed no incident report. Further review revealed there were no notes at all regarding the status of this resident either before or after her hospital admission and no documentation that the health care provider or family had been notified of either the resident going out to the hospital on or her return on .

A review of Resident 2's facility file revealed the resident was admitted to the facility on . The health assessments after the initial assessment indicated he was a risk. Prior to , there were no notes to address what the resident's current needs were and how staff would address them. An incident report dated documented he was found on the ground and was sent to the hospital. Documentation on the incident report revealed his family was

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notified, however there was no documentation (other than the 1823 from the hospital dated) that gave any information about what his changed needs were. It did state now that the resident was bedbound and was appropriate for assisted living with extra help. Further review of this record did not address how this "extra help" would be provided or whether they even noticed that the assessment said he was bedbound, making him potentially inappropriate for continued residency.

A review of Resident #3 facility file revealed he had been admitted to the facility on . Diagnoses at admission included a history of with , high and poor mobility. He had identified by his nurse practitioner on . At that time the resident was referred to home health nursing for care, however no staff notes were available to show that staff had observed the beginning of the wounds prior to home health being ordered or whether there were any contributing factors like poor nutrition or intake or positioning and repositioning of the resident. It was difficult to see the care that he was receiving from staff or to tell whether they were even aware his general status. He was admitted to Hospice on /

A review of Resident #4's facility file revealed she was admitted to the facility on with , chronic back pain and was a risk. The most recent assessment dated revealed she needed supervision in all activities of daily living. The incidents dated and / revealed the resident had . There were 2 completed incident reports but no documentation that staff monitored her for

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either before or after either of the and no information about her general wellbeing at any time.
Interview with Resident #4 on at 9:52am revealed her daughter took her to the hospital where she was admitted for 3-4 days. Record review revealed the history and physical dated from the hospital admission describing how the resident had experienced pain for a period of a week or so and that the patient was referred finally to the emergency evaluation of ongoing pain with associated . While there were notes written by the advanced practice nurse practitioner (ARNP) dated after the hospitalization, there were none from facility staff their initially identifying the resident's complaint of pain and what staff did to address it.

Review of Resident #5 revealed he had been admitted to the facility on / . Further review of the health assessment dated revealed she needed supervision in all adls. It also identified her at risk for . Incident reports dated , / and / revealed she had 3 . There was no documentation found after the to describe any monitoring of her or to describe what her general status was before the or staff were to address her individual safety needs or status.

Consecutive interviews with direct care staff C, D, E, F and G beginning on at 10:40am. revealed they were not responsible to write notes of any kind except incident reports and the shift log. They described a log where they wrote notes to the oncoming shift and also communicated directly with the nurse or manager.

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A 025	Continued From page 14 An interview with the facility's licensed practical nurse (LPN) on at approximately 9:15 a.m. revealed direct care staff were not advised to document any type of note except change of shift notes. She said direct care staff know to address her directly or the manager with any concerns. She acknowledged that she did not write progress notes either but called directly to physicians for orders or changes in orders and that if home health care was needed, she would make the appropriate call. Additionally she said she called families and responsible parties but did not document this except on the incident reports. An interview with the manager on at approximately 11:00 a.m. revealed staff do not document saying staff tell me each shift what is going on. They have been instructed to call me if I am not on site. Widespread	A 025		
A 030	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (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 Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. (b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such	A 030		

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A 030	Continued From page 15	A 030		

procedure is implemented upon receipt of a complaint.
(c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with , 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456.
(d) The statewide toll-free telephone number of the Florida Hotline " 1(800)96- or 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents.
(e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility ' s policies with respect to such issues, for example, as resident responsibilities, the facility ' s and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements.
(f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law.
(g) The facility shall provide residents with convenient access to a telephone to facilitate the resident ' s right to unrestricted and private

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A 030	Continued From page 16	A 030		

communication, pursuant to Section 429.28(1)(d), F.S. The facility shall not prohibit 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 shall be, at a minimum, an accessible telephone on each floor of each building where residents reside.
(h) Pursuant to Section 429.41, F.S., the use of physical shall be limited to half-bed rails, and only upon the written order of the resident ' s physician, who shall review the order biannually, and the consent of the resident or the resident ' s representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical

429.28 Resident bill of rights.-
(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

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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 achieve 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 his or her spouse if both are residents of the facility.
(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) Access to adequate and appropriate health care 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

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nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual 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.

This Statute or Rule is not met as evidenced by:
Based on observation, interviews and record review, the facility failed to assure residents rights were honored in the area of providing appropriate toileting assistance when needed for 1 (Resident #2) of 5 residents sampled which could have resulted in the resident's loss of dignity.

Findings include:

A record review of Resident #2's most recent health assessment (form 1823) dated revealed he had a need for assistance in toileting. There was no indication the resident was of bowel or .

Observation of the resident's bed at approximately 9:45am revealed Staffs D and E preparing the resident's bed by placing a clean

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A 030	Continued From page 19 cloth over his sheets. He was then lifted by the same staff onto the bed and the sheets were drawn up over him. They then left the area allowing privacy and the surveyor began trying to interview him (unaware that he needed to use the that point. Almost immediately, the resident (although some of the time) told the surveyor he was embarrassed but that he had to use the . At that point the surveyor left the went to find the caregivers. The care staff were observed to go back into his after they came out, told the surveyor that they had gone in to clean him up and that they did not take him into the he was too heavy for them to get him onto the toilet. An interview with Staff D on at approximately 11:10 a.m. revealed she was aware of staff allowing the resident to complete his toileting in bed because he was too heavy to lift and that it would take 3 staff to get him into the . She said she didn't do that herself. Interview with the manager on at approximately 1:30 p.m. revealed she was unaware of how the caregivers were providing his toileting. She said she thought he was of both bowel and but acknowledged that it was not noted in his most recent health assessment that documented that he needed assistance only.	A 030		
A 078	58A-5.019(2) FAC Staffing Standards - Staff (2) STAFF. (a) Newly hired staff shall have 30 days to submit	A 078		

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a statement from a health care provider, based on a examination conducted within the last six months, that the person does not have any signs or symptoms of a communicable including . Freedom from must be documented on an annual basis. A person with a positive test must submit a health care provider ' s statement that the person does not constitute a risk of communicating . Newly hired staff does not include an employee transferring from one facility to another that is under the same management or ownership, without a break in service. If any staff member is later found to have, or is suspected of having, a communicable , he/she shall be removed from duties until the administrator determines that such condition no longer exists.

(b) All staff shall be assigned duties consistent with his/her level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff shall exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident ' s record, and to report the observations to the resident ' s health care provider in accordance with this rule chapter.

(c) All staff must comply with the training requirements of Rule 58A-5.0191, F.A.C.

(d) Staff provided by a staffing agency or employed by a business entity contracting to provide direct or indirect services to residents must be qualified for the position in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor shall specifically describe the services the staffing agency or contractor will be providing to residents.

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(e) For facilities with a licensed capacity of 17 or more residents, the facility shall:
1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and
2. Maintain time sheets for all staff.

This Statute or Rule is not met as evidenced by:
Based on record review and interviews, unqualified staff provided or assisted with care dressing changes to 1 (Resident #3) of 5 sampled residents which could have resulted in the worsening of the resident's

Findings include:
A record review revealed Resident #3 was admitted to the facility on with diagnoses of post surgical of his right femur, history of a with , poor mobility listed- all listed on the most current health assessment (form 1823) dated . Activities of daily living (ADLs) were listed as: needs assistance with ambulation, bathing, dressing, toileting and transferring. Supervision was needed for eating and . Further record review revealed he was referred to home health for care beginning . The clinical notes from the home health agency read: cleanse wounds with normal , apply , change every 2-3 days and prn (as needed with he goal of having the heal in 3 weeks without complications. Documentation showed that the agency nurses did provide care to the resident as ordered. A Hospice consult was written by the nurse practitioner on // due to and . Hospice admitted the resident on // and 3 wounds were identified: 1. ; 2. Right hip, Stage

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2 and 3. right ishium, [illegible]. Hospice progress reports note he was initially scheduled to be seen by nursing 1 x every 14 days or as needed (prn) until [illegible] when they increased their visits to 2x week and as needed and then on [illegible] they increased it to 3x week and as needed. A note written on [illegible] revealed all 3 wounds were slowly improving.
Interview with resident caregiver (Staff E) on [illegible] at approximately 11:40am revealed she was not a licensed nurse. She further revealed if a [illegible] was dirty, we change the dressing, maybe on a Saturday when the nurse is not here or Hospice. When asked when she did this most recently, said Sunday ([illegible]) after the resident had a bowel movement and the bandage was dirty. She said it wasn't really a dressing change but that it was to put a new dry bandage over the [illegible] area after she cleaned it using the [illegible] spray [illegible]. She said she had done it more than one time. She acknowledged she was not qualified to do dressing changes. Another interview with Staff E at 3:15pm revealed that on Sunday, when the nurse came in, we let her know we had changed it.
An interview with another resident caregiver (Staff D) on [illegible] at approximately 11:10am revealed, "the nurse tells us to change it, I'm busy" but I don't do it. It is not part of my job description. When the nurse is not here, we have to deal with it.
A telephone interview with direct caregiver (Staff G) on [illegible] at approximately 8:30am revealed it was her responsibility to notify the nurse or the manager if they are on duty to change the dressing. If neither are at the facility, I remove the soiled dressing and clean the skin and put a clean dry dressing on it. She went on to say the nurse did not tell her to clean it or change the dressing but what are you going to do? She

Agency for Health Care Administration

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did not know if she should call Hospice or not.
An interview with the LPN (licensed practical nurse) (Staff A) during a telephone interview on at approximately 9:15am revealed she had been at the facility for 3 months. She also said that she did not provide care to residents at the facility, and that agency nurses provided all care or Hospice. Additionally, she said she did not direct any resident care staff to provide care either.
Attempts to interview Resident #3 were unsuccessful due to limited verbal communication.
Interview with the manager during the survey on at approximately 9:30am and several times throughout the survey acknowledged unlicensed staff were not qualified to provide dressing changes and said she was aware only that they applied bandaids as part of first aid after a appeared but that was the extent of it. She denied knowing that any of the direct care staff provided any care and acknowledged they were not qualified to provide care. She continued to say that all care was provided by home health nursing or Hospice and that the LPN on staff did not provide direct care to residents, that her role was to take physician orders and transcribe medication orders/treatments and communicate with health providers and families.
Review of the LPN's schedule revealed she was on site full time from 11:00am-7:00pm 5 days/week and both she, the manager and the administrator were on call 24 hours per day 7 days a week.
Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Sweet Water at Largo
11290 Walsingham Road
Largo, FL 33778

Dear Administrator:

Re: **CCR# 2012012787**

This letter reports the findings of a complaint survey that was conducted on , 2012, by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

For Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State Form 3020

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