STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964933	12/31/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Serenity House Assisted Living Facility	**15322 Matis Road Hudson, FL 34669**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= G
St - A - 0077 - 58a-5.019(1) Fac - Staffing Standards - Administrators S-S= G
St - A - 0079 - 58a-5.019(4) Fac - Staffing Standards - Levels S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= G

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

A complaint survey, CCR# 2013013319, was conducted on , through / /.

The Serenity House Assisted Living Facility had deficiencies at the time of the visit.

0025-Resident Care - Supervision 58A-5.0182(1) FAC

Based on observation, interview and record review, the assisted living facility failed to provide adequate supervision and awareness of the well-being of one of ten sampled residents (Resident #1). The facility failed to have trained and qualified staff supervising the resident, failed to communicate significant changes about the resident amongst the staff during shift changes, and failed to notify the resident ' s family of a significant change that led to the resident being hospitalized.

Findings include:

On at 12:50 PM, the surveyor interviewed Employee A by telephone. Employee A stated that she was scheduled to work at 6:00 PM on . Employee A stated that when she arrived at the facility, the administrator was not working. Employee A stated that the administrator ' s (Employee B) was on duty. Employee A stated that Employee B is not a trained staff person and is not on the schedule but was just working so the administrator could have Christmas Day off. Employee A stated that when she attempted to assist Resident #1 to bed, Resident #1 appeared to be in pain when she put weight on her leg. After several attempts, Employee A said she sent a text message to the administrator. Employee A said the administrator came to the facility from her house next door and assisted in putting Resident #1 to bed. At that time, Employee A said that the administrator said that Resident #1 had earlier in the day. Employee A went on to report that on the morning of when she went to assist Resident #1 in getting dressed, Resident #1 appeared to be in severe pain and cried out when Employee A tried to move her. Employee A said that after contacting the administrator, she called for an ambulance and Resident #1 was taken to the hospital.

On that same date at approximately 2:10 PM, the surveyor interviewed Resident #2. Resident #2 said that she was in the kitchen with Employee B on at around lunch time. Resident #2 said she could not see exactly what happened because Employee B was between her and Resident #1. Resident #2 said Resident #1

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was walking up the ramp leading to the kitchen and down. Resident #2 said Employee B helped Resident #1 up and helped her to the table for lunch. Resident #2 said Employee B was the only person at the facility on and said the administrator was not there and did not work that day. Resident #2 said Employee B is not a regular staff and " helps out sometimes. "

During an interview with the administrator on that same date at 2:45 PM, the administrator said she did work on Christmas and that she and Employee B " took turns " so " I could have Christmas with my family. " The administrator said she was only gone from the facility for " a few hours here and there. " The administrator said that Resident #1 did around lunch time and said she assessed the resident and said Resident #1 was " bearing her own weight " and " seemed fine. " The administrator confirmed that she did not document the in writing. The administrator also stated that Employee B is not an employee of the facility, is not paid by the facility, does not have an application on file, and has not had the training required for direct care staff of the facility.

On that same date at approximately 3:00 PM, the surveyor interviewed the daughter of Resident #1 by telephone. The daughter stated that Resident #1 had been admitted to the facility on . The daughter further stated that Resident #1 had been sleeping most of the day on so she called the administrator on to check on how Resident #1 was doing. At that point, the administrator told her that Resident #1 had a " slight tumble " earlier in the day but was fine. The daughter said she did not hear any more from the facility. On , the hospital contacted her because Resident #1 was being admitted with a broken hip.

On at 5:05 PM, the surveyor interviewed Employee B. Employee B said that early in the afternoon of , Resident #1 took a " soft " coming up the ramp to the kitchen. Employee B said that the administrator came right over and assessed the resident and said the resident walked to the couch with assistance and ate shortly after the incident. Employee B said that the administrator left before Employee A arrived that evening. Employee B said that she did not write anything down about what happened to Resident #1. Employee B also said she is not an employee of the facility and just helps out when the administrator needs assistance and confirmed that no other staff was in the facility when Resident #1 .

On at 10:30 AM, the surveyor interviewed the son of Resident #1 by telephone. The son confirmed that Resident #1 was still hospitalized and had surgery for a hip . The son also stated that he was the power of attorney and health care surrogate for Resident #1. The son stated that he talked to Resident #1 on the phone on but was not told about her . The son stated the facility staff did not call him and Resident #1 has and may not even " remember she . " The son stated that he found out about the on from his sister after Resident #1 was at the hospital.

On , the surveyor reviewed records received from the hospital, dated . The surveyor noted that " records for Resident #1 indicated Resident #1 had a " left femur "

Class II

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

Based on observation, interview and record review, the facility failed to insure that 10 of 10 sampled residents were residing in a safe living environment with functional plumbing and access to working and failed to have trained, qualified staff providing care and oversight for the residents.

Findings include:

On at 8:40 AM, the surveyor interviewed a representative of the county health department. The health department representative stated that she visited the facility on in response to a complaint. The health department representative stated the conditions in the facility were " terrible " and said that toilets in both had backed up into the and the shower drains and said the smell was " overpowering. " The health department representative said that when she went to the administrator ' s home next door, the administrator confirmed she had not contacted a plumber and called while the health department representative was present.

On that same date at 11:10 AM, the surveyor interviewed Resident #3. Resident #3 stated that the facility ' s toilets backed up " many times " and the waste would not go down. Resident #3 said that " a friend of the staff " who " lived nearby " would come out and fix it and " we had to wait until he could fix it. " Resident #3 said that there were times the residents couldn ' t shower and times the water in the kitchen didn ' t work. Resident #3 said that yesterday ( ) was " the worst. "

On that same date at 11:30 AM, Resident #2 was interviewed and said the facility ' s toilets were backing up off and on for several weeks. Resident #2 said the waste backed up into the shower drains so the residents couldn ' t shower and even after the toilets were fixed temporarily, no one cleaned out the showers so Resident #2 did it. Resident #2 said the toilets didn ' t work for a long time on so the residents couldn ' t use the .

On that same date at 12:55 PM, the surveyor interviewed Employee A by telephone. Employee A stated that the problem with the plumbing had occurred multiple times and said as a result, there were residents who went more than a week without showers. Employee A said that on , she texted the administrator in the morning and advised her both toilets were backing up and the administrator responded via text message that there was " nothing she could do " until a friend of hers was available to look at the that night. Employee A said that both were flooding and she tried putting towels down by the to keep the water out of the hallways. Employee A said that several residents spent the day sitting outside due to the smell from the . Employee A said that after the health department showed up, the administrator called a plumber and the plumber came out within an hour.

On that same date during a tour of the facility conducted from 9:20-10:10 AM, the surveyor noted the following:

There was a smell of /feces in both .

The screen on the window in was unsecured and appeared propped on the window.

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The stove in the kitchen did not appear to have an oven door or handle.

There was a large pile of dirt and a hole by what appeared to be the access to the system in the front yard, near the porch and gazebo where the residents were sitting. There were also three piles of feces in the yard. When interviewed at approximately 12:30 PM, the administrator said the feces were from the horse that was kept in a fenced area on the property.

On , the surveyor reviewed inspection reports from the local health department, dated and . Both reports were labeled " unsatisfactory. " The report dated noted that " sewage backing into facility, flooded both , overflowing into hallway ....making hallway inaccessible to residents. "

The report dated noted that a " mild, offensive musty odor " was still present in the . The report also noted that the area around the system was still dug up and the cover was not secured so it was not safe for residents.

When interviewed on at 12:55 PM, Employee A stated that she was scheduled to work at 6:00 PM on . Employee A stated that when she arrived at the facility, the administrator was not working. Employee A stated that the administrator ' s (Employee B) was on duty. Employee A stated that Employee B is not a trained staff person and is not on the schedule but was just working so the administrator could have Christmas Day off.

On that same date at approximately 2:10 PM, the surveyor interviewed Resident #2. Resident #2 said Employee B was the only person at the facility on and said the administrator was not there and did not work that day. Resident #2 said Employee B is not a regular staff and " helps out sometimes. "

During an interview with the administrator on that same date at 2:45 PM, the administrator said she did work on Christmas and that she and Employee B " took turns " so " I could have Christmas with my family. " The administrator said she was only gone from the facility for " a few hours here and there. " The administrator also stated that Employee B is not an employee of the facility, is not paid by the facility, does not have an application on file, and has not had the training required for direct care staff of the facility.

Class II

Based on observation, interview and record review, the administrator of the assisted living facility failed to insure that the facility was in good repair and failed to maintain functional plumbing for 9 of 10 sampled residents (Resident #2-10) and failed to provide adequate care and oversight of residents, including insuring that qualified and trained staff were caring for the residents and insuring that staff and family members were aware of a significant change for 1 of 10 sampled residents (Resident #1).

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Findings include:

On at 8:40 AM, the surveyor interviewed a representative of the county health department. The health department representative stated that she visited the facility on in response to a complaint. The health department representative stated the conditions in the facility were " terrible " and said that toilets in both had backed up into the and the shower drains and said the smell was " overpowering. " The health department representative said that when she went to the administrator ' s home next door, the administrator confirmed she had not contacted a plumber and called while the health department representative was present.

On that same date at 11:10 AM, the surveyor interviewed Resident #3. Resident #3 stated that the facility ' s toilets backed up " many times " and the waste would not go down. Resident #3 said that " a friend of the staff " who " lived nearby " would come out and fix it and " we had to wait until he could fix it. " Resident #3 said that there were times the residents couldn ' t shower and times the water in the kitchen didn ' t work. Resident #3 said that yesterday ( ) was " the worst. "

On that same date at 11:30 AM, Resident #2 was interviewed and said the facility ' s toilets were backing up off and on for several weeks. Resident #2 said the waste backed up into the shower drains so the residents couldn ' t shower and even after the toilets were fixed temporarily, no one cleaned out the showers so Resident #2 did it. Resident #2 said the toilets didn ' t work for a long time on so the residents couldn ' t use the .

On that same date at 12:55 PM, the surveyor interviewed Employee A by telephone. Employee A stated that the problem with the plumbing had occurred multiple times and said as a result, there were residents who went more than a week without showers. Employee A said that on , she texted the administrator in the morning and advised her both toilets were backing up and the administrator responded via text message that there was " nothing she could do " until a friend of hers was available to look at the that night.

On that same date during a tour of the facility conducted from 9:20-10:10 AM, the surveyor noted the following:

There was a smell of /feces in both .

The screen on the window in was unsecured and appeared propped on the window.

The stove in the kitchen did not appear to have an oven door or handle.

There was a large pile of dirt and a hole by what appeared to be the access to the system in the front yard, near the porch and gazebo where the residents were sitting. There were also three piles of feces in the yard. When interviewed at approximately 12:30 PM, the administrator said the feces were from the horse that was kept in a fenced area on the property.

On , the surveyor reviewed inspection reports from the local health department, dated and . Both reports were labeled " unsatisfactory. " The report dated noted that "

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sewage backing into facility, flooded both , overflowing into hallway ....making hallway inaccessible to residents. "

During the interview with Employee A on at 12:55 PM, Employee A stated that she was scheduled to work at 6:00 PM on . Employee A stated that when she arrived at the facility, the administrator was not working. Employee A stated that the administrator 's (Employee B) was on duty. Employee A stated that Employee B is not a trained staff person and is not on the schedule but was just working so the administrator could have Christmas Day off. Employee A stated that when she attempted to assist Resident #1 to bed, Resident #1 appeared to be in pain when she put weight on her leg. After several attempts, Employee A said she sent a text message to the administrator. Employee A said the administrator came to the facility from her house next door and assisted in putting Resident #1 to bed. At that time, Employee A said that the administrator said that Resident #1 had earlier in the day. Employee A went on to report that on the morning of when she went to assist Resident #1 in getting dressed, Resident #1 appeared to be in severe pain and cried out when Employee A tried to move her. Employee A said that after contacting the administrator, she called for an ambulance and Resident #1 was taken to the hospital.

During an interview with the administrator on that same date at 2:45 PM, the administrator said she did work on Christmas and that she and Employee B " took turns " so " I could have Christmas with my family. " The administrator said she was only gone from the facility for " a few hours here and there. " The administrator said that Resident #1 did around lunch time and said she assessed the resident and said Resident #1 was " bearing her own weight " and " seemed fine. " The administrator confirmed that she did not document the in writing. The administrator also stated that Employee B is not an employee of the facility, is not paid by the facility, does not have an application on file, and has not had the training required for direct care staff of the facility.

On that same date at approximately 3:00 PM, the surveyor interviewed the daughter of Resident #1 by telephone. The daughter stated that Resident #1 had been admitted to the facility on . The daughter further stated that Resident #1 had been sleeping most of the day on so she called the administrator on to check on how Resident #1 was doing. At that point, the administrator told her that Resident #1 had a " slight tumble " earlier in the day but was fine. The daughter said she did not hear any more from the facility. On , the hospital contacted her because Resident #1 was being admitted with a broken hip.

On at 5:05 PM, the surveyor interviewed Employee B. Employee B said that early in the afternoon of , Resident #1 took a " soft " coming up the ramp to the kitchen. Employee B said that the administrator came right over and assessed the resident and said the resident walked to the couch with assistance and ate shortly after the incident. Employee B said that the administrator left before Employee A arrived that evening. Employee B said that she did not write anything down about what happened to Resident #1. Employee B also said she is not an employee of the facility and just helps out when the administrator needs assistance and confirmed that no other staff was in the facility when Resident #1 .

On at 10:30 AM, the surveyor interviewed the son of Resident #1 by telephone. The son confirmed that Resident #1 was still hospitalized and had surgery for a hip . The son also stated that he was the

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power of attorney and health care surrogate for Resident #1. The son stated that he talked to Resident #1 on the phone on , but was not told about her . The son stated the facility staff did not call him and Resident #1 has and may not even " remember she . " The son stated that he found out about the on from his sister after Resident #1 was at the hospital.

On , the surveyor reviewed records received from the hospital, dated . The surveyor noted that " ' records for Resident #1 indicated Resident #1 had a " left femur ."

Class II

Based on interview and record review, the facility failed to have the required amount of staff on duty to provide care and supervision to 10 of 10 sampled residents (Residents #1-10).

Findings include:

During an investigation at the facility on , the surveyor observed 9 residents. When interviewed on that same date at 9:40 AM, the administrator confirmed there were 9 residents in the facility.

On that same date at 9:55 AM, the surveyor reviewed the staff schedule for the week of - and for - . The facility is required to have 212 hours per week for 9 residents. For the week of - , the facility ' s staff schedule reflected 201 hours. For the week of - , the facility ' s staff schedule reflects 189 hours. This includes direct care hours for the administrator.

On that same date at 1:00 PM, Employee A was interviewed by telephone and stated that there is " never more than one person on duty " caring for the residents.

Class III

Based on observation, interview and record review, the assisted living facility failed to maintain a safe residence free of odors, hazards and flooded and with functional plumbing for 9 of 10 sampled residents (Residents #2-10). The toilets in both of the facility ' s backed up, flooding the common hallways with sewage. The administrator did not contact a licensed plumber for several hours until directed to do so by a representative from the local health department.

Findings include:

On at 8:40 AM, the surveyor interviewed a representative of the county health department. The health department representative stated that she visited the facility on in response to a complaint. The health department representative stated the conditions in the facility were " terrible " and said that toilets

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in both had backed up into the and the shower drains and said the smell was " overpowering. " The health department representative said that when she went to the administrator ' s home next door, the administrator confirmed she had not contacted a plumber and called while the health department representative was present.

On that same date at 11:10 AM, the surveyor interviewed Resident #3. Resident #3 stated that the facility ' s toilets backed up " many times " and the waste would not go down. Resident #3 said that " a friend of the staff " who " lived nearby " would come out and fix it and " we had to wait until he could fix it. " Resident #3 said that there were times the residents couldn ' t shower and times the water in the kitchen didn ' t work. Resident #3 said that yesterday ( ) was " the worst. "

On that same date at 11:30 AM, Resident #2 was interviewed and said the facility ' s toilets were backing up off and on for several weeks. Resident #2 said the waste backed up into the shower drains so the residents couldn ' t shower and even after the toilets were fixed temporarily, no one cleaned out the showers so Resident #2 did it. Resident #2 said the toilets didn ' t work for a long time on so the residents couldn ' t use the .

On that same date at 12:55 PM, the surveyor interviewed Employee A by telephone. Employee A stated that the problem with the plumbing had occurred multiple times and said as a result, there were residents who went more than a week without showers. Employee A said that on , she texted the administrator in the morning and advised her both toilets were backing up and the administrator responded via text message that there was " nothing she could do " until a friend of hers was available to look at the that night. Employee A said that both were flooding and she tried putting towels down by the to keep the water out of the hallways. Employee A said that several residents spent the day sitting outside due to the smell from the . Employee A said that after the health department showed up, the administrator called a plumber and the plumber came out within an hour.

On that same date during a tour of the facility conducted from 9:20-10:10 AM, the surveyor noted the following:

There was a smell of /feces in both .

The screen on the window in was unsecured and appeared propped on the window.

The stove in the kitchen did not appear to have an oven door or handle.

There was a large pile of dirt and a hole by what appeared to be the access to the system in the front yard, near the porch and gazebo where the residents were sitting. There were also three piles of feces in the yard. When interviewed at approximately 12:30 PM, the administrator said the feces were from the horse that was kept in a fenced area on the property.

On , the surveyor reviewed inspection reports from the local health department, dated and . Both reports were labeled " unsatisfactory. " The report dated noted that "sewage backing into facility, flooded both , overflowing into hallway ....making hallway inaccessible to

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residents."

The report dated noted that a " mild, offensive musty odor " was still present in the . The report also noted that the area around the system was still dug up and the cover was not secured so it was not safe for residents.

Class II

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Serenity House Assisted Living Facility
15322 Matis Road
Hudson, FL 34669

Dear Administrator:

Re: **CCR# 2013013319**

This letter reports the findings of a complaint survey that was conducted on , 2013, through , 2013, by a representative of this office.

Attached is the provider's copy of the State (5000-3547) 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 **five** 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 (5000-3547) Form

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone (727) 552-2000; Fax (727) 552-1161

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2014

Serenity Assisted Living Facility
c/o Nicola Matthews, Administrator
15322 Matis Road
Hudson, FL 34669

Dear . Matthews:

This letter reports finding of a complaint survey conducted on , 2013, through , 2013, by a representative of the Agency for Health Care Administration. Within 5 business days from receipt of this letter, you are directed to comply with the tangible steps outlined below in order to correct the deficient practice. Attached are the deficiencies noted in the survey.

The investigation resulted in findings of noncompliance with the following areas:

1) A 152 – Physical Plant – Safe Living Environment - Class II
Your Assisted Living Facility failed to provide a safe environment with functional plumbing and in compliance with the requirements of the local health department.

2) A 25 Resident Care - Supervision - Class II
Your Assisted Living Facility failed to provide adequate oversight of the residents; including insuring that residents are supervised by trained and qualified staff and insuring that any significant change in the health and condition of the residents was communicated among staff and to the resident's responsible party.

3) A 77 Staffing Standards – Administrator- Class II
The administrator of the Assisted Living Facility failed to adequately maintain the facility in such a way as to insure the residents had access to functional plumbing, were in a safe environment free from hazards and odors and to insure the residents were under the care and supervision of qualified staff.

4) A 30 Resident Care – Rights and Facility Procedures – Class II
Your Assisted Living Facility failed to insure that the residents were provided a safe living environment in an adequately maintained building, free of odors and with functional plumbing and to have residents supervised by trained and qualified staff.

5) A 79 Staffing Standards – Levels – Class III
Your Assisted Living Facility failed to maintain the minimum number of staffing hours and failed to provide enough trained, qualified staff to care for the residents in your facility.

Your facility must comply with the following:

1) Your facility must contract with a licensed contractor to pump the facility's system and certify that the system is in compliance with code requirements. All documentation indicating compliance with this requirement shall be provided to the Agency for Health Care Administration. **THIS MUST BE COMPLETED WITHIN 5 DAYS FROM THE DATE OF THIS LETTER.**

2) Your facility must comply with all fire codes and requirements of the local health department, as evidenced by a current "satisfactory" health inspection. A copy of a current satisfactory health inspection must be provided to the Agency for Health Care Administration. **THIS MUST BE COMPLETED WITHIN 5 DAYS FROM THE DATE OF THIS LETTER.**

3) All direct care staff in your facility shall be re-trained in handling major incidents, including . This training must include your facility's policy regarding notification of the resident's family/responsible party. **THIS MUST BE COMPLETED WITHIN 5 DAYS FROM THE DATE OF THIS LETTER.**

4) Your facility must have an accurate, up-to-date staff schedule that reflects what staff are scheduled to work each shift. The schedule must reflect adequate staffing hours to comply with staffing requirements for the number of residents at the facility. **THIS MUST BE COMPLETED WITHIN 5 DAYS FROM THE DATE OF THIS LETTER.**

5) All employees of your facility must be up to date on the trainings required for their positions. All training documentation must be in employee files. Absolutely no staff, volunteers or outside persons are allowed to provide care to residents without having a Level II background screen and the required training for their position. **THIS MUST BE COMPLETED WITHIN 5 DAYS FROM THE DATE OF THIS LETTER.**

6) The facility's administrator shall be actively involved in the day-to-day operations of the facility. This shall include contacting outside entities as needed to maintain the building and grounds, managing the staff schedule and managing staff to insure that qualified staff are providing care for the residents in a safe environment. **THIS MUST BE COMPLETED WITHIN 5 DAYS FROM THE DATE OF THIS LETTER.**

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact Paul Brown, ALF Supervisor, at 727-552-2000.

Sincerely,

Paul Y Brown

FOR Patricia Reid Caufman
Field Office Manager