STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964511	01/16/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Fresh Water At Hudson	14108 Old Dixie Highway Hudson, FL 34667	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)

List of Tags Cited:

St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0079 - 58a-5.019(4) Fac - Staffing Standards - Levels S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0084 - 58a-5.0191(5) Fac - Training - Assis Self-Admin Meds & Med Mgmt S-S= D
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

An unannounced complaint survey, CCR# 2013011135, was conducted on .

The Fresh Water at Hudson, assisted living facility, had deficiencies at the time of the visit.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC

Based on record reviews and interviews, the facility failed to ensure that the resident's health assessment (Form 1823) was completed in its entirety for 4 (Residents #1, #3, #5, and #8) of 5 residents sampled for record review.

Findings include:

Review of Resident #1's health assessment, Form 1823 dated revealed that the resident's height, and weight were not reported on page 1. The type of medication assistance the resident needed was not indicated on page 4, Section 2B.
Review of Resident #3's health assessment revealed that it was not dated by the physician. The only date written on the form was on page 5.
Review of Resident #5's health assessment dated revealed that the type of medication assistance the resident needed was not indicated on page 4, Section 2B. The resident's name and date of birth was not written on pages 4 and 5 of the health assessment.
Review of Resident #8's health assessment revealed that it was not dated by the physician. The resident's height and weight were not reported on page 1. The resident's name and date of birth were not written on pages 2 through 5 of the health assessment.
In the interview with the facility manager on at approximately 1:45pm, she stated that the nurse practitioner completed Resident #8's health assessment the day before and did not date the form.
In a later interview with the facility manager on at approximately 3:30pm, she acknowledged that the health assessment forms need to be completed.

Class III

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

Based on interviews and record reviews, the facility failed to document notification of the responsible party and doctor of a resident's change in condition or incidents for 4 (Residents #1, #2, #3, and #5) of 5 residents sampled for record review. The facility also failed to document information or observations about residents general heath, safety, and emotional well-being for 5 (Resident #1, #2, #3, #5, and #8) of 5 residents sampled for record review.

Findings include:

Review of the facility's admission and discharge log revealed the following admission dates: Resident #1 was admitted , Resident #2 was admitted , Resident #3 was admitted , Resident #5 was admitted and Resident #8 was admitted .
Review of Resident #3's hospice record revealed that she started care with hospice on . Her hospice skilled nursing (SN) routine visit report dated indicated that she had a on her .
Her eating level of difficulty was indicated as "no difficulty." Her SN routine visit report dated still listed the on her but her eating level of difficulty was indicated at "complete difficulty experienced 95% or greater of the time." The resident's SN routine visit report dated indicated that the resident had 3 wounds: , , and right hip, purple . The SN as needed (PRN) visit report dated revealed that the resident still had the 3 reported wounds. She had a decline that day. She had in her upper extremities. She was not eating or drinking. She had minimal responsiveness. The doctor was informed and the resident was sent to the hospital.
Phone interview with Resident #3's daughter (resident's power of attorney) on 01 at approximately 5:50pm revealed that she was not called about her mother's condition, including open wounds and not eating and drinking.
Review of the facility's internal report dated written by Resident #2 indicated that she was hit in the solar plexus (upper abdomen) by Resident #1 in their formerly shared .
Interview with the FM on at approximately 10:00am revealed that Resident #2 reported pain and did receive a x-ray. The incident was reported as unwitnessed.
Review of the facility's internal report dated revealed that Resident #5 was pushed by Resident #1. "Laceration" was checked on the report and an "X" was drawn on the back of the head on the diagram provided. The resident was sent to the hospital.
Interview with the FM on at approximately 10:00am revealed that after Resident #5 was pushed, she received stitches at the hospital for the cut to the back of her head.
Review of facility records for Residents #1, #2, #3, and #5 revealed that there were no notes or observations documented about contacting the residents' doctors or responsible parties about incidents or changes of condition. There were also no notes for Residents #1, #2, #3, #5 and #8 concerning general health, safety, and emotional well-being.
Interview with the FM at approximately 2:45pm revealed that she wrote no notes about the residents' behavior, their change in condition, or contacting doctor or family. At first she stated that she did not have time, but did finally state that she will start writing notes for residents.

Class III

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0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC

Based on observations, interviews, and record reviews, the facility staff failed to provide proper assistance with self-administered medications as ordered for 2 (Resident #7 and #10) of 2 resident's observed during the afternoon medication pass.

Findings include:

Observations of the dining at approximately 4:35pm revealed that the facility manager (FM) was assisting with self-administration of medication for residents. Resident #10 had pills on her plate and the FM did not watch her take them. Resident #10 did eventually take them when the FM was giving another resident medication. The FM was also observed providing assistance with medications for Resident #7 at approximately 4:40pm. She was observed touching the resident's medication with her bare hands.
Review of Resident #7's medication observation records (MORs) revealed that the resident received his 8:00pm scheduled medications 50mg, 50, 20mg) at 4:40pm.
In the interview with the FM on at approximately 4:40pm, she acknowledged that she gave Resident #7's 8:00pm medications at 4:40pm. The FM stated she gave it early because he likes to go to bed early. She also stated that she did not worry about Resident #10 taking the pills because she always takes them, but acknowledged she needs to watch her take them. The FM indicated that she gave Resident #10 her 5pm medications. Review of Resident #10's MORs indicated that the 5pm medications were Fish Oil 2000mg, Tart 50mg, and 5mg.

Class III

0079-Staffing Standards - Levels 58A-5.019(4) FAC
Based on observations, interviews, and record reviews, the facility failed to maintain a staff schedule for the facility and also failed to provide enough staff to accommodate services or supervision to the residents.

Findings include:

Observations during the tour of the facility on from approximately 9:40am to 5:00pm revealed that there was only one staff member, the facility manager (FM), who was available for resident care and supervision for a census of 13 residents. She was also observed making and serving lunch for the residents from about 11:30am to 12:30pm.
Interview with the FM on at approximately 5:40pm revealed that most of the residents have mental health issues or
Review of the facility's internal reports and interview with the FM on at approximately 10:00am revealed that Resident #1 had 2 reported incidents that involved aggressive behavior in Resident #5 was pushed by Resident #1 on and had to be sent to the hospital. The FM stated that Resident #5 received a cut to the back of her head and was sent to the hospital where she received stitches. Another internal report written by Resident #2 indicated that she was hit in the solar plexus (upper abdomen) by Resident #1 in their formerly shared Resident #2 reported pain and did receive a x-ray. The incident was reported as unwitnessed.
Interview with the FM on at approximately 10:20am revealed that she really tried to watch Resident #1 but she pushed Resident #5 and it was too late to stop her. The FM also reported that Residents #1, #5, and #11

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were and required her to change them (disposable briefs) every hour to 2 hours if needed. Resident #6 required help with transferring to his wheelchair.
Interview with Staff A on at approximately 4:15pm revealed that she felt that there was not enough staff at the facility. She stated that they usually work by themselves. They have all the residents by themselves.
In the interview with Staff C on at approximately 5:10pm, he also stated they needed more staff especially in the day time.
Interview with the FM on at approximately 10:20am revealed that she doesn't make the staff schedule anymore because it is always the same. She stated that she was aware that she needed a staff schedule and yesterday she tried to make one. She stated that Staff C lives in the facility 5 days a week. He comes Thursday afternoon about 4pm to 5pm and goes home Tuesday morning after breakfast. The FM worked Monday through Friday 6am to 6pm. The administrator usually comes every Tuesday and works in the day, 2 or 3 hours or at night for 12 hours, but the past 2 weeks he had been too busy to come to the facility. Staff A works weekends, Saturday and Sunday, 6am to 6pm and Staff B works Tuesday and Wednesday 6am to 6pm, and also on-call. The FM also wrote down the staff schedule at the surveyor's request.
The minimum staffing hours per week required for a census of 13 residents was 212. The facility had 216 staffing hours per week scheduled but those hours included 24 hours a day of work from Staff C from Friday to Sunday.
Interview with the FM and Staff C on at approximately 5:25pm revealed that Staff C worked and then slept between the meals when the other staff was on. He mainly helps with meals only when another staff member is working.
Even though Staff C is present in the facility for 24 hours a day, Friday through Sunday, he only works during breakfast and then lunch during the 6am to 6pm portion of the shift.

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC

Based on record reviews and interviews, the facility failed to ensure that direct care staff had documentation of completion of the required in-service training required within 30 days of hire for 3 (facility manager, Staff A, and Staff B) of 3 employees sampled.

Findings include:

Review of the individual employee records received by fax from the facility on and revealed the following dates of hire: facility manager's (FM) date of hire was ; Staff A's date of hire was ; and Staff B's date of hire was
Further review of the employee records revealed that the FM, Staff A, and Staff B did not have any documentation for the required 1 hour in-service training for resident rights and the required 3 hour in-service training for activities of daily living.
In the phone interview with the administrator on at approximately 3:10pm, he stated he would send the certificates for the required in-service training that was not included in the fax received from the facility earlier on

The fax received on still did not include certificates for the required training.

Class III

0084-Training - Assis Self-Admin Meds & Med Mgmt 58A-5.0191(5) FAC

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Based on record reviews and interviews, the facility failed to ensure that staff who assisted residents with self-administration of medications received the minimum of 2 hours of annual update training for 3 (facility manager, Staff A, and Staff B) of 3 employees sampled.

Findings include:

Interview with the facility manager (FM) on at approximately 10:10am and later at 5:10pm revealed that the FM, Staff A, and Staff B mostly work with the residents by themselves during their shift.
In the interview with the FM on at approximately 5:40pm, she stated she would send the surveyor the staff training certificates requested by fax.
Review of the FM's employee records revealed that she had a validation certificate for medication administration assistance that was issued
Review of Staff A's employee records revealed that she had a validation certificate for medication administration assistance that was issued on
Review of Staff B's employee records revealed that she had a validation certificate for medication administration assistance that was issued
None of the employees sampled had a current annual update for assistance with self-administered medications.

Class III

0165-Risk Mgmt & QA; Adverse Incident Report 429.23 FS; 58A-5.0241 FAC

Based on record review and interviews, the facility did not report an adverse incident for 1 (Resident #5) of 5 residents sampled for record review.

Findings include:

Review of the facility's internal reports revealed that Resident #5 was pushed by Resident #1 on and had to be sent to the hospital.
Interview with the facility manager (FM) on at approximately 10:00am revealed that Resident #5 was pushed by Resident #1. Resident #5 received a cut to the back of her head and was sent to the hospital where she received stitches. The FM did not file an adverse incident report.
Interview with the FM on 01 at approximately 5:40pm revealed that she did not know anything about how or why the facility would report an adverse incident. She planned to ask the administrator.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2014

Administrator
Fresh Water at Hudson
14108 Old Dixie Highway
Hudson, FL 34667

Dear Administrator:

Re: **CCR# 2013011135**

This letter reports the findings of a complaint survey that were conducted on . 2014, by representative(s) 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 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(s). Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

Patricia Reid Caufman
FOV Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

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