STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967456	03/17/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Silver Creek Assisted Living St Cloud	**2910 Old Canoe Creek Road Saint Cloud, FL 34772**	
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= G
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0079 - 58a-5.019(4) Fac - Staffing Standards - Levels S-S= D
St - A - 0160 - 58a-5.024(1) Fac - Records - Facility 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
..... and ..... complaint inspection CCR2013013019 was conducted.

The facility had deficiencies found during the visit.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on resident record review and interview the facility failed to ensure 1 of 3 sampled residents (#3) records contained a health assessment completed 60 days before admission or 30 days after.

Findings:

Resident record review at approximately 2 PM for resident #3 revealed she was admitted to the facility on ..... and ..... Continued reviewed revealed a health assessment dated ..... A new health assessment report was not available for the admission on ..... and ..... The health assessment dated ..... did not address the resident's needs regarding diet, toileting and transferring.

In an interview with the administrator on ..... at approximately 2:30 PM, who confirmed the findings and stated she was not aware that new health assessments were needed after the resident moved back in.

Class III

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

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on interview and record review the facility failed to ensure it provided appropriate supervision to the needs of residents accepted for admission to the facility and failed to maintain a written record, updated as needed, of any significant changes as defined in subsection 58A-5.013 for 3 of 3 sampled residents (1 & 2) and failed to provide care and services appropriate to the needs of 1 of 3 sampled residents (#3) regarding physician's orders.

Findings:

1. In an interview on at approximately 10 AM with staff B who stated another resident used to get a bit scared of resident #1 but she was like that, nervous. "Resident #1 hit me, she liked to hit". She had

In an interview on at approximately 10:45 AM staff C who stated resident #1 hit resident #2 while I was trying to stop her. Resident #1 took the remote and hit resident #2 with it in the head. Before that, in her #1 slapped resident #2. "I put resident #1 in the kept resident #2 with me. I called the police because I could not handle both of them. The police took a report. I called the families and the administrator. The ambulance came right after and took resident #2 to the hospital". Resident #1 "was aggressive with anybody verbally; this time was the first time I saw her hit someone". Resident #2 sustained a red eye. She did not return from the hospital and resident #1 was discharged 2 days later.

Resident #1 had a health assessment dated assessments dated and that listed diagnoses of , was She needed supervision with activities of daily living (ADLs). The facility notes documented the following:

(year not indicated) She continued to go into other's

3/3 Wanders all over the place

doesn't stay still

she calmed down

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

doesn't want a

has negative attitude, not pleasant with other residents, argued with

was upset because another resident ate with fingers

10/1 Screamed at a resident who came out of pants down

10/2 Becoming bossy -in everyone business. She is the kitchen police.

11/7 up all night

The move out notice dated indicated the reason for discharge was that she had engaged in a behavior that repeatedly and substantially interfered with rights, health, safety of other residents and behavior that poses a danger to self or others.

Continued record review revealed no notations regarding the incident with resident #2.

In an interview with the director on at approximately 2:30 PM, who stated resident #2 was in the facility for a few days before the incident, therefore she had no paperwork for her, there were no notes regarding the altercation and the residents condition which required transfer to the emergency She moved in and moved out

Review on at approximately 6 PM of the Osceola County Sheriff's Report dated revealed that an altercation between 2 residents had taken place at the assisted living facility. The report indicated that a disturbance between 2 residents. They were arguing. Resident #1 was sleeping and resident #2 crawled in her bed. Resident #1 pushed resident #2 off her bed and told her to go back to sleep. Resident # 2 began throwing things around the turned over a large cabinet with resident's #1 things in it. They escalated to a physical altercation which led to resident #2 being hit in the eye. The caregiver separated them. "I observed the eye which appeared to be a minor injury". The writer indicated when he arrived the residents were separated and the emergency medical transport arrived for the eye injury, due to resident #2 insisting. Both have diminished capacity. The staff stated the resident would be moving out.

Review on at approximately 4PM of the emergency records indicated

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967456	03/17/2014
NAME OF PROVIDER OR SUPPLIER **Silver Creek Assisted Living St Cloud**	STREET ADDRESS, CITY, STATE, ZIP CODE **2910 Old Canoe Creek Road Saint Cloud, FL 34772**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

resident #2 was assaulted by another resident and sustained possible eye globe . She was referred to an eye .

Admission hospital records revealed she as admitted on . and discharged . She sustained eye and left eye globe. The physical exam indicated . without behaviors. The resident stated "she hit me". She underwent repair of left globe, removal of iris, . treatment of . and removal of lens. The resident was discharged to an assisted living facility.

2. Observations during the medication pass on at approximately 9AM for resident #3 noted a prescription label dated . that indicated ER 25 mg one twice daily. The Medication Observation Record listed ER 25 mg one daily and was marked as given from 3/1 to .

In an interview with the director on . at approximately 2 PM, she stated the resident's daughter told the staff the medication was not taken daily only. The director stated she did not have a script to validate the order. She called the resident's daughter, who brought in a physician's order sheet dated . from Keystone Health and Rehab. The sheet indicated ER 25 mg give 1/2 tablet (12.5 mg) 2 times per day and . 0.1mg take one tablet 2 times a day. The director stated she did not have the . either. She called the residents daughter again, who stated she did not think her mother needed the medication and would bring it later.

A telephone call was placed to the director on . at approximately 1:30 PM and informed her of the findings in regards to resident #2. She verbalized understanding.

Class II

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observations and interview the facility failed to ensure the unlicensed staff that assisted 2 of 2 sampled residents (#2 and 4) with self-administration of medications followed the correct procedure.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967456	03/17/2014
NAME OF PROVIDER OR SUPPLIER **Silver Creek Assisted Living St Cloud**	STREET ADDRESS, CITY, STATE, ZIP CODE **2910 Old Canoe Creek Road Saint Cloud, FL 34772**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Findings:

During the medication pass on [redacted] at approximately 9 AM staff #A retrieved the medications from the locked medication cart. She poured the medication in a soufflé cup and handed it to resident #3. She told the resident take your medications with water. She observed the resident take the medication and signed the Medication Observation Record (MOR). She returned the medication to the unlocked medication cart. She did not read the label to the resident.

Continued observations of the medication pass at approximately 9:45 AM noted staff A retrieved the medications from the locked medication cart. She told resident #4 "I'm going to give you your first med". She poured the medication in a scuffle cup and handed it to the resident. She told resident "take your medications with water". She observed the resident take the medication and signed the MOR. She returned the medication to the unlocked medication cart. She proceeded to give the resident all her medications one by one. This is your second medication, this is your third, fourth, fifth, sixth, seventh and eighth. She did not read the medication labels to the resident.

In an interview on [redacted] at approximately 4:30 PM, the director offered no comment when informed about the above noted observations.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observations and interview the facility failed to ensure medications were kept in a locked cabinet, locked cart or other locked storage receptacle, [redacted], or area at all times, out of sight of other residents, for 2 of 2 sampled residents (#3 & #4).

Findings:

Observations during the facility tour at approximately 8:50 AM noted that resident #3 had a shared [redacted]. On top of the resident's night table there was a bottle of [redacted] tears. The surveyor informed staff #A about the observations. She stated the resident's daughter brought the medication in. Staff #A placed the medication on the night stand again. The surveyor informed her of the regulatory requirement. The eye drops were an over the counter

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967456	03/17/2014
NAME OF PROVIDER OR SUPPLIER **Silver Creek Assisted Living St Cloud**	STREET ADDRESS, CITY, STATE, ZIP CODE **2910 Old Canoe Creek Road Saint Cloud, FL 34772**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

product and did not have the resident's name on the medication.

During the medication pass, in the dining area, on [redacted] at approximately 9 AM staff #A retrieved the medications from the locked medication cart. She poured the medication in a soufflé cup and handed it to resident #3. She did not lock the medication cart. There were other residents who also sat in the dining area.

Continued observations of the medication pass at approximately 9:45 AM noted staff A retrieved the medications from the locked medication cart. She retrieved the medications and poured the medication in a scuffle cup and handed it to the resident #4. She did not lock the medication cart. There were other residents who also sat in the dining area, one resident sat next to resident #4 and next to the medication cart.

The facility's medication policy indicated that centrally stored medications must be kept locked at all times. The policy did not address the house rules regarding medications kept in the residents; [redacted]

Observations at approximately 12 PM noted the bottle of over the counter eye drops on top of the medication carts located by the dining area, where the facility residents ate lunch.

Class III

0078-Staffing Standards - Staff 58A-5.019(2) FAC
Based on personnel record review and interview the facility failed to ensure verification of freedom from communicable [redacted] including [redacted] for 1 of 3 sampled records (#C); and freedom from [redacted] yearly after hire for 1 of 3 sampled staff (#A) and failed to ensure the freedom from [redacted] was obtained from a healthcare provider for 2 of 3 sampled staff (B & C).

Findings:

Personnel record review at approximately 3:15 PM revealed:

1. Staff C had no evidence to confirm freedom from communicable [redacted] including [redacted] upon hire in [redacted] Continued review revealed a [redacted] assessment dated [redacted] that was signed by a Registered Nurse, not a healthcare provider (doctor, Advanced Registered Nurse

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Practitioner (ARNP), physician assistant (PA).

2. Staff B had a test result dated that was signed by a Registered Nurse (RN).

3. Staff A had a chest x ray report dated that indicated no active Continued review revealed no evidence she obtained a healthcare provider's statement that indicated freedom from on and

In an interview with the director on at approximately 4 PM, who stated she did not know an RN could not do the test.

Class III

0079-Staffing Standards - Levels 58A-5.019(4) FAC
Based on observations, staff schedule review and interviews the facility failed to maintain the required minimum staff hours per week.

Findings:

During the facility entrance on at approximately 8:45 AM staff #A stated the census was 9 residents.

In an interview with the director on at approximately 10:30 AM, who stated the staff schedule never changes. She provided the staff schedules from 2013 to 2014.

Review of the staff schedules revealed it listed the administrator "on call" 7 days a week (Only actual hours worked count towards total staff hours). The director worked AM to PM Monday to Friday, for a total of 40 hours. Continued review of the schedule for the week of 3 to 2014 revealed the total staff including the director was a total 192 staff hours. Based on a census of 9, the facility needed a total of 212.

In an interview with a resident family on at approximately 12 PM, the family member expressed concerns regarding staff shortage.

In separate interviews with staff B and C on at approximately 11:30 AM the staff also expressed concern with the work load for 1 staff that had to care for 9 residents, pass

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	AL11967456	03/17/2014
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medications, cook, answer the phone, provide assistance with activities of daily living and do housekeeping.

Class III

0160-Records - Facility 58A-5.024(1) FAC
Based on observations, record reviews and interview the facility failed to maintain an up-to-date admission and discharge log that listed 3 of 5 samples residents (# 1, #4, and #2); and failed to maintain an up-to-date record of major incidents occurring within the last 2 years for I of 3 sampled residents (#2).

Findings:

During the facility entrance on [redacted] at approximately 9 AM staff A stated the census was 9 residents.

Review of the facility's admission and discharge log at approximately 11 AM revealed that resident's #1, who was no longer at the facility did not have the move out date listed; resident #2, who moved in and out in [redacted] was not listed on the log and resident #4 who lived at the facility was not listed on the log.

In an interview with staff C on [redacted] at approximately 10:45 AM who stated resident #1 hit resident #2 while she was trying to stop her. Resident #1 took the remote and hit resident #2 with it in the head. Before that in her [redacted] resident #1 slapped resident #2. "I put resident #1 in the [redacted] I kept resident #2 with me". I called the police because I could not handle both of them. The police took a report. I called the families and the administrator. The ambulance came right after and took resident #2 to the hospital.

At approximately 11 AM the director was asked to provide the facility's incident reports. In an interview with the administrator on [redacted] at approximately 11:30 AM, who confirm the findings and stated she had overlooked the log. She stated there were no incident reports available.

Review on [redacted] at approximately 6 PM, the Osceola County Sheriff's Report dated [redacted] at approximately 6 AM indicated that an altercation between 2 residents had taken place at the ALF, a disturbance between 2 residents. They were arguing. Resident #1 was sleeping

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

and resident #2 crawled in her bed. Resident #1 pushed resident #2 off her bed and told her to go back to sleep. Resident #2 throwing things around the [redacted] turned over a large cabinet with the things of resident #1 .They escalated to a physical altercation which led to resident #2 being hit in the eye. The caregiver separated them. "I observed the eye which appeared to be a minor injury". The writer indicated when he arrived the residents were separated; and the EMT arrived for the eye injury, due to the insisting of resident #2. Both have diminished capacity. The staff stated the resident would be moving out.

Class III

0165-Risk Mgmt & QA; Adverse Incident Report 429.23 FS; 58A-5.0241 FAC
Based on record review and interview the facility failed to submit to the Agency the 1 and 15 day report after the police was called regarding a resident altercation for 2 of 3 sampled residents (#1 & #2).

Findings:

In an interview with staff C on [redacted] at approximately 10:45 AM who stated resident #1 hit resident #2 while she was trying to stop her. Resident #1 took the remote and hit resident #2 with it in the head. Before that in her [redacted] resident #1 slapped resident #2. "I put resident #1 in the [redacted] kept resident #2 with me". I called the police because I could not handle both of them. The police took a report. I called the families and the administrator. The ambulance came right after and took resident #2 to the hospital.

In an interview with the director on [redacted] at approximately 4 PM, who stated that an adverse incident report for the event with residents #1 and #2 was not filed.

Review on [redacted] at approximately 6 PM, of the Osceola County Sheriff's Report dated [redacted] at approximately 6 AM indicated that an altercation between 2 residents had taken place at the ALF, a disturbance between 2 residents. They were arguing. Resident #1 was sleeping and resident #2 crawled in her bed. Resident #1 pushed resident #2 off her bed and told her to go back to sleep. Resident #2 throwing things around the [redacted] turned over a large cabinet with the things of resident #1 .They escalated to a physical altercation which led to resident #2 being hit in the eye. The caregiver separated them. "I observed the eye which appeared to be a minor injury". The writer indicated when he arrived the residents were

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NAME OF PROVIDER OR SUPPLIER **Silver Creek Assisted Living St Cloud**	STREET ADDRESS, CITY, STATE, ZIP CODE **2910 Old Canoe Creek Road Saint Cloud, FL 34772**	
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separated, and the EMT arrived for the eye injury, due to the insisting of resident #2. Both have diminished capacity. The staff stated the resident would be moving out.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

Administrator
Silver Creek Assisted Living St Cloud
2910 Old Canoe Creek Road
Saint Cloud, FL 34772

Dear Administrator:

Re: CCR #2013013019

This letter reports the findings of a state licensure survey that was conducted on ... 10 and 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 after **2014,** 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 Lorraine Henry at

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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