STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11922334	04/30/2014
NAME OF PROVIDER OR SUPPLIER **Spring Haven Retirement Community**	STREET ADDRESS, CITY, STATE, ZIP CODE **1225 Havendale Blvd Nw Winter Haven, FL 33881**	
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= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

An unannounced complaint survey, CCR# 2014002648, was conducted on .

The Spring Haven Retirement Community, assisted living facility, had deficiencies at the time of the visit.

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

Based on record reviews and interviews, the facility failed to document notification to the health care provider of a resident's injury and also failed ensure that medical care was provided in a timely manner for 1 (Resident #1) of 4 residents sampled for record review.

Findings include:

Review of Resident #1's resident observation logs revealed the following on these dates: On at 12:00pm, the resident in the hallway. She complained of knee pain. The staff helped her up and she still could hardly stand on her own. They called the resident's daughters to let them know about the . Her daughter requested that staff call her back after the resident ate lunch. On at 8:00 p.m., the resident had her right leg . She ate a little and took her meds. On at 7:00am, the resident was complaining about her right knee and she said she was in very great pain. Staff could barely move her. On at 11:41pm, the resident was being sent out by family to the hospital. Resident was in pain in her right leg and could not bear any weight. The resident's daughters were very concerned that resident had injured her knee. On at 8:15pm, the resident was reported to be admitted to the hospital. Her daughter had called to let the facility know that the resident would be staying overnight at the hospital. On , the resident returned to facility. Resident was not mobile. She was wheelchair bound. There were no log notes about contacting the resident ' s doctor about her knee. There was also no fax to her doctor about the in her records. Resident #1 did not receive medical care until almost 24 hours after her .
Review of the facility internal report for Resident #1 for the same on at 12:00pm reported that the resident was found on the floor in the hallway. She was examined and asked was she hurting anywhere; she replied it was her knees. They picked her up and she was fine. There was no note that the physician had been called.
Interview with the resident care coordinator (RCC) and wellness director (WD) on at approximately 4:35pm revealed that they were unsure of exactly why her care was delayed. The RCC stated that in their health care committee meeting, they probably discussed her and asked the doctor for a physical ( ) evaluation which is their protocol. The (resident's) daughters are very active and in there every day. The only

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11922334	04/30/2014
NAME OF PROVIDER OR SUPPLIER **Spring Haven Retirement Community**	STREET ADDRESS, CITY, STATE, ZIP CODE **1225 Havendale Blvd Nw Winter Haven, FL 33881**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

reason they may have waited to send her out was at the request of the daughter.

Class III

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

Based on record reviews and interviews, the facility failed to provide appropriate notice of temporary relocation for treatment of an and neglected to ensure that medical services would be provided at an appropriate facility for 1 (Resident #3) of 4 residents sampled for record review.

Findings include:

The facility had the resident (#3) taken to the hospital when he was diagnosed with an and then refused to take him back when he was not admitted.
Interview with the resident care coordinator (RCC) and the wellness director (WD) on at approximately 10:45am revealed that Resident #3 went out to hospital for ( ). He was returned to facility and was there for 2 days. Then the hospital notified them that he was -Resistant positive (+) in his is defined as a that is resistant to many . They couldn't do isolation so they sent him back to the hospital. The hospital wanted to discharge him, but they refused to take him back because of the +. The facility's regional nurse had told them to send him back to the hospital. The hospital was upset that he was sent back.
In a later interview with the WD and RCC on at approximately 4:35pm, the WD stated that Resident #3's doctor did not have direct rehab admit privileges. They sent him to the hospital because the regional nurse told them to send him. They both stated that their concern was he shared a he had a breathing issue. He did not always cover his mouth. It was not indicated anywhere (on hospital forms) that he was suspected or tested for . They were called from the hospital and they asked them for a fax number to send his results. The results were +. The doctor was contacted and she gave verbal orders. They contacted the regional nurse and she called back the next day. She told them to send him to the hospital. He (resident) was not thrilled and neither was his son. The hospital wanted to send him back. They stated they were going to call the agency that investigates . They confirmed that the hospital did not ask for him to be sent to back to the hospital (they acknowledged that he really had no symptoms to be sent back to the hospital).
Review of Resident #3's facility records revealed that he was admitted to the facility on . His lab results for his dated was positive for moderate growth of . His doctor gave verbal orders for Resident #3 to the WD on for 100mg ( ) by mouth 2 times a day for 10 days; culture in 14 days; and isolation precautions.
Review of Resident #3's resident observation logs revealed the following:
On / at 1:30pm (WD and RCC indicated in their interview that it is believed that this log note was actually for), a fax was sent over from the hospital and it stated the resident was positive for . They were having the resident stay in his prevent the spread of . On at 4pm, the resident had a new order for 100mg ( ) by mouth 2 times a day for 10 days. The resident was moved from ( ) 116 to 106 for isolation due to . On / at 2:35pm, the resident was sent to hospital at approximately 1:25pm via ambulance. The log note dated / at 5pm indicated that the resident was sent back to Winter Haven Hospital due to . The staff was advised that they could not provide safety precautions or isolation due to licensure that the facility holds. They spoke with the resident's son and advised him of this decision.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11922334	04/30/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Spring Haven Retirement Community	**1225 Havendale Blvd Nw Winter Haven, FL 33881**	

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

Review of Resident #3's hospital records titled "Primary"revealed that he was seen at the emergency department (ED) on . The resident presented with the problem of " abnormal diagnostic test. " He was sent by the facility due to + in his . The communications section of form indicated that the facility was contacted and a facility staff member explained that the resident was in the hospital 3 days ago and was sent back to the facility. Yesterday the hospital called and told them that his culture was positive for . He was started on by his physician. Then they found out from their regional manager that the patient could not stay at the facility, so they sent him back to the Emergency department (ED). The form also reported that the patient did not meet the criteria to stay at the hospital. The hospital staff called the facility multiple times but they refused to take him back. It reported that because it was growing quite late the hospital would shelter the resident for the night as he had "no where safe to go."

Interview with Resident #3's son on at approximately 7:50pm revealed that Resident #3 went to the hospital for and returned with , 2 or 3 days. He had gotten at the hospital. They (facility staff) stated that there was nothing they could do for him. He had isolation in his . The regional nurse was made aware of the situation. They called an ambulance and had him taken to the hospital. He was not allowed to return. He was in the emergency 5 to 6 hours waiting for someone to deem him " abandoned " in order to admit him to the hospital. His family incurred bills for the ambulance and the hospital. The son stated that they (facility staff) could have done a cab or he could have taken his father to the hospital. They made no effort to contact him (resident's son) and just sent him there. They did not tell his son that he came back from the hospital and then they sent him out again and told him after the fact that he was sent and he did not understand why.

Interview on with resident assistants, Staff A at approximately 3:45pm and Staff B at approximately 4:00pm revealed that Resident #3 had been moved to a (private) by himself. They used gown, mask, and gloves which was appropriate for isolation. He also stayed in his . Staff B stated that Resident #3 was "OK" with it, but they had to explain it to him.

The facility did not provide an appropriate transfer to a medical facility for Resident #3. The resident was already in isolation at the facility. There was no documentation of any attempts to find the resident an appropriate placement during the treatment of his . As noted in the above mentioned resident observation log dated / , the resident's son was not notified until after the resident had been transported to the hospital by ambulance; therefore, the resident's family was also not permitted to find the resident temporary placement during his treatment.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Spring Haven Retirement Community
1225 Havendale Blvd Nw
Winter Haven, FL 33881

Dear Administrator:

Re: **CCR# 2014002648**

This letter reports the findings of a complaint survey that was 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,

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