RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Osprey Lodge
1761 Nightingale Lane
Tavares, FL 32778

RE: CCR #2014005329

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 26 and 2014 by representative(s) of this office.

Enclosed 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 this office at (386) 462-6201.

Sincerely,

Kristen J. Mennella
Field Office Manager

KJM/amw
Enclosure

Alachua Field Office
14101 N W Hwy 441, Suite 800
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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968349	09/11/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Osprey Lodge	1761 Nightingale Ln Tavares, FL 32778	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0028 - 58a-5.0182(4) Fac - Resident Care - Activities Of Daily Living S-S= D
St - A - 0032 - 58a-5.0182(8) Fac - Resident Care - Elopement Standards S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0165 - 429.23(1-4 & 6-10) Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Specific Tag Findings:

0000-Initial Comments

A complaint survey (CCR 2014005329) was conducted at Osprey Lodge, an Assisted Living Facility, on and Deficient practice was identified at the time of the survey.

0028-Resident Care - Activities of Daily Living 58A-5.0182(4) FAC
Based on observation, interview and record review the facility failed to offer assistance with Activities of Daily Living (ADLs) as necessary for 1 of 8 sampled residents (Resident #8).

The findings include:

1. On at 9:58 a.m. Resident # 8 was observed in the Pod #1 dining the table with his breakfast sitting in front of him. At 10:01 a.m. Staff B was observed walking past Resident #8 in the dining Staff B stated, "Wake Up [Resident #8], Wake up [Resident # 8]. Staff B then returned to the kitchen area and started cleaning up. At 10:36 a.m. Resident #8 was observed at the dining with the same breakfast meal infront of him. At 10: 38 a.m. Staff B was prompted by another staff member to assist Resident #8. Staff B walked over to Resident #8 and cleared his plate from the table.

2. On at 10:40 a.m. Staff B was interviewed. Staff B stated that she brought Resident #8 to the breakfast table at a quarter before 9:00 a.m. (8:45 a.m.). Staff B went on to say that she usually does not leave residents seated at the table but she is the only person working on Pod 1(of the memory care unit) at this time.

3. On at 12:46 p.m. Resident # 8's wife was interviewed. Resident #8's wife stated she comes into the facility to assist her husband with meals, because there are times when there is only one person assisting with residents with meals in the dining Resident #8's wife continued by stating that there are up to 15 residents on each pod (in the memory care unit), she added some residents, like her husband, need coaxing (prompting) while eating. Resident #8's wife stated , "I don't think that staffing in the dining the needs (of the residents)."

4. A record review of Resident #8's health assessment (AHCA 1823 form) signed on revealed Resident #8 needs assistance with all Activities of Daily Living including eating.

Class III

0032-Resident Care - Elopement Standards 58A-5.0182(8) FAC
Based on observation, record reviews and interview the facility failed to ensure residents identified at risk for elopement the facility failed to make a daily effort to ensure 1 of 4 sampled residents who were identified as an

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elopement risk had identification information on their persons which included the name of the resident and the name, address and telephone number of the facility (Resident #10).

The findings include :

1. On at 3:36 PM Resident # 10 was observed sitting outside. Resident #10 did not have any identification on him.

2. A review of the facility census record was revealed that resident #10 was at risk for elopement.

3. A review of resident # 10's record revealed in a resident observation log note dated resident eloped from the facility.

4. A review of the facilities elopement policy and procedures dated revealed the facilities policy states resident evaluated and identified as at risk for elopement per policy will wear an identification bracelet.

5. On at 5:37 PM an interview was conducted with the Administrator. The Administrator confirmed resident # 10 did to have identifying information on him. She confirmed that they don't know what happened to his identification bracelet. She further stated that she was unaware of the last time that Resident #10 had the identification on him.

Class III

0054-Medication - Records 58A-5.0185(5) FAC
Based on observation, interview and record review, the facility failed to ensure medication observation records were immediately updated after a medication pass for 1 of 3 residents sampled for medication review (Resident #11).

The findings include :

1. On at approximately 10:12 a.m. Staff A was observed signing the Medication Observation Record for Resident #11.

2. On at 10:27 a.m. Resident # 11 was observed to have an patch on her back. The patch was dated with the time of 9:00 a.m.

3. On at approximately 10:27 a.m. Resident #11 was interviewed. She stated "A staff member came in after breakfast and applied my patch." Resident #11 states she think the batch was put on shortly before 9:00 a.m.

Class III

0165-Risk Mgmt & QA; Adverse Incident Report 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC
Based on interview and record review, the facility failed to file an adverse incident report for 1 of 14 sampled residents for an event where a resident who was identified as a risk and suffered a broken hip and sent to a

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facility requiring a more acute level of care (Residents #3).

The findings include:

1. On at approximately 3:00 p.m. Resident #3's wife was interviewed. Resident #3's wife stated Resident #3 was diagnosed with a broken hip after his on She stated her husband was sent from the facility to a hospital. She went on to say her husband not resides in a Skilled Nursing Facility and not expected to return to this Assisted Living Facility.

2. On at approximately 7:00 p.m. an interview was conducted with the Administrator and the Director of Operations. Both stated they were unsure if an Adverse Incident Report had been filed for Resident #3 as the person responsible for reporting Adverse Incidents was no longer employed at the facility.

3. A review of Resident #3's health assessment (AHCA 1823 form) dated reveal resident #3 was identified as a risk and required special precautions for . A review of resident #3's Post Log revealed Resident #3 had a in the facility on and A review of Resident #3's incident log revealed after the on , Resident #3 was sent to the hospital on and diagnosed with a broken hip. Resident #3 was sent from the hospital.

4. A review of the Agency for Health Care Administration reporting systems revealed no Adverse Incident was submitted to the Agency after Resident #3 broke his hip and was transferred to a facility with a more acute level of care.

Class III