RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Shady Acres Assisted Living Facility
670 County Road 782
Webster, FL 33597

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 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 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,

for
Kristie J. Mennella
Field Office Manager

KJM/amw
Enclosure

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964944	09/11/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Shady Acres Assisted Living Facility	**670 County Road 782 Webster, FL 33597**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0026 - 58a-5.0182(2) Fac - Resident Care - Social & Leisure Activities S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D
St - A - 0167 - 58a-5.025 Fac - Resident Contracts S-S= B
St - A - Z815 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses S-S= C

Specific Tag Findings:

0000-Initial Comments

On unannounced biennial licensure survey was conducted at Shady Acres Assisted Living Facility in Webster, Florida. Discernible deficiencies were identified as a result of this survey. The facility was not in compliance at this time.

0026-Resident Care - Social & Leisure Activities 58A-5.0182(2) FAC
Based on observations and interviews the facility failed to provide an activites program that meets the residents, needs, abilities and intrest for 12 of 12 residents in the facility (resident #1-#12).

Findings:

On at approximately 9:00 AM it was observed that the activities calendar hanging in the living dated for 2014. The calender contained start times of 8am 2pm and 7pm but no ending times. It was observed at 8am every day there is scheduled exercises. At 7pm every day there is scheduled social hour. At 2pm every day there is scheduled alternative activity for each day of the week. The listed activities repeat every week.

On at approximately 10:45 PM an interview was conducted with resident #2. When he was asked if he gets to participate in making choices regarding activities, resident #2 stated, "what activities? All I do is watch TV and relax." He was asked if the staff offer him games, arts & crafts, or anything besides TV and relaxing. He said, "no, not really."

On at approximately 11:20 AM an interview was conducted with resident #4. During the interview resident #4 was asked what kind of activities does she participate in at the facility. Resident #4 stated she did not know of any activities being done. She said she is not asked to do exercises in the morning or arts & crafts in the afternoon and she knows nothing about any entertainment.

On at approximately 11:56 AM an interview was conducted with resident #6. He was asked if he participates in facility activities. He stated, "what activities?" When he was asked what type of activities does he want to to do, he said play kick ball, baseball or horse shoes would be good.

Class III

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0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observations and interviews the facility failed to honor resident rights by failing to provide a decent living environment, to be treat each resident with personal dignity, individuality, and privacy for 4 of 12 residents (resident #1,#2, #4 and #6) . The facility also failed to post all required contact numbers in a common area accessible to all residents, for 12 of 12 residents living in the facility.

Findings:

On at approximately 9:10 AM during a tour of the facility it was observed that there were video cameras in the for residents #1, #4, #5, #6 and #10. The video cameras were connected to a receiver and monitor which was sitting on the medication cart by the kitchen in the main building. It was observed that resident #1 and #4 had dust and cobwebs on their ceiling fans. Resident #4's thick layer of dust under her bed and under her nate's bed (resident #4). It was observed in the dining area residents all ate at long plastic folding picnic tables. It was observed that the number and the Agency Consumer Hotline number was not posted in the facility.

On at approximately 10:15 AM an interview was conducted with resident #1. She stated that she did not like the video camera in her she knows that they have used it because she has seen the residents on the monitor located on the medication cart. She did not know if that was permissible or not.

On at approximately 11:20 AM an interview was conducted with resident #4. During the interview she was asked if she wanted a video camera in her she stated she did not want a camera in her did not know it was camera. She did not want anyone seeing her without her clothes on. It was also observed that under resident #4 and resident #5 bed there was a layer of dust. There was also dust on the ceiling fan blades. When this was pointed out to resident #4 she stated the staff could do a better job cleaning.

On at approximately 2:20 PM during an interview with staff member B she stated that the camera and monitor system was working up-until 3 months ago. She said the Administrator is trying to get it repaired.

On at approximately 5:30 PM during an exit interview with the Administrator she stated, she did not know that cameras were not allowed in residents' and she would remove them. She said she did not know that the above stated numbers were required to be posted. She agreed that staff needs to do a better job cleaning and that the folding picnic tables were inappropriate for residents to eat at.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observation and interviews, the facility failed to keep medication in a secure place within the residents some other secure place that is out of sight of other residents in 1 of 1 residents (Resident #10).

Findings:

On at 9:45 AM during the entrance tour with staff, a resident #10 was observed in an unoccupied, unsecured It was also observed in the same unsecured medication inhaler which was not marked with a residents name lying on the floor of the .

On at 5:00 PM an interview was conducted with the administrator. She confirmed that the medication

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inhaler was not suppose to be left in the [redacted] and that it should have the resident's name on it.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on observation, record review and interview, the facility failed to store properly labeled medication in 1 of 1 residents (Resident #2).

Findings:

On [redacted] at 12:00 PM during the medication observation of resident #2. It was observed that his nasal spray did not have a prescription label or his name on the bottle or box.

On [redacted] at 12:00 PM an interview with staff member B confirmed that the nasal spray was not properly labeled. Staff member B further stated that this is how the medication arrived from the hospital.

On [redacted] at 12:00 PM a record review of the MOR and physicians orders stated [redacted] 42mcg/Inh Nasal Spray 2 sprays nasal 3 x daily".

Class III

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on observations and interviews the facility failed to have the three day emergency water supply for 12 of 12 residents in the facility (residents #1-#12).

Findings:

On [redacted] at approximately 1:00 PM during the food service dining review staff was asked to show where the 3 day emergency water supply was stored. She stated that they have used up the three day water supply and they have not replaced it.

On [redacted] at approximately 5:30 PM the Administrator was asked why the facility did not have a three day emergency water supply. She said they used it up and she has not had a chance to restock it yet.

Class III

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC

Based on observations and interviews the facility failed to maintain the interior walls in good repair in the common areas for 12 of 12 residents living in the facility (residents #1-12) and failed to maintain the an interior wall in the [redacted] 1 of 12 residents in the facility (resident #10).

Findings;

On [redacted] at approximately 9:10 AM during a tour of the facility it was observed that the facility had several

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interior walls that needed repair. In the main building living was observed that the corner-bead was damaged and missing joint It was observed there were two tennis-ball size holes in the wall. The walls were observed from waist high down to be severely scuffed up and in need of painting. The paint on the walls in was bubbling and peeling off the wall. It was observed in resident #10 wall was damaged at the foot of the bed.

On at approximately 5:30 PM an interview was conducted with the Administrator regarding the damage observed to the facility interior walls. The Administrator stated that the damage was caused by residents in wheelchairs and she has plans on fixing them. She was asked when was the damage first observed and she stated a couple months ago.

Class III

0167-Resident Contracts 58A-5.025 FAC
Based on record review and interview the facility failed to have a completed contract that included the daily, weekly or monthly rate for 1 of 2 residents (resident #7).

Findings:

On at 3:00 PM a record review was conducted on resident #7 contract. The review revealed resident #7's contract did not include the daily, weekly or monthly rate.

On at 5:00 PM in interview was conducted with the administrator in reference to resident #7's contract. She confirmed that the contract in the resident record was missing a daily, weekly, or monthly rate and was incomplete.

Class

Z815-Background Screening; Prohibited Offenses 408.809, 435.02(2), 435.06
Based on record reviews and interviews the facility failed to have a level II background screening for 1 of 3 staff members (Staff B).

Findings:

On a record review was conducted on direct care Staff B's employee record. It was observed her last background screening was completed and she did not have a current level II background in her records.

On at approximately 5:30 PM during an exit interview with the Administrator she was asked if she knew staff B was suppose to have a new background screening and she stated yes, she just hadn't gotten it done yet.

A review of the Agency's Background screening website confirmed a new level II background screening is required for Staff B.

Unclassified