STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910478	10/28/2015
NAME OF PROVIDER OR SUPPLIER **INN AT THE FOUNTAINS**	STREET ADDRESS, CITY, STATE, ZIP CODE **1255 PASADENA AVENUE, S.** **SAINT PETERSBURG, FL 33707**	

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

0000 Initial Comments

Assisted Living Facility

A complaint survey, CCR# 2015011105, was conducted from to in conjunction with a change of ownership survey (CHOW) state licensure survey.

The Inn at the Fountains, assisted living facility, had deficiencies at the time of the visit.

0025 Resident Care - Supervision

Based on record review and interview, the facility failed to provide care and services appropriate for the needs of residents regarding daily observation by staff for the safety awareness of 1 (#1) of 3 residents sampled for supervision.

Findings include:

A record review of an internal facility report, dated showed that on at 11:52 am, Resident #1 was found unresponsive in the pool.

Multiple staff were interviewed on / and / from 2:00 pm to 3:30 pm about the sequence of events on the day of the incident.

During the interviews, Staff #B stated that on / at 11:30 am, that she observed Resident #1 going to the pool area alone.

Staff #C, stated that around 11:50 am on , she observed from the 11th floor window by the elevator, someone floating in the pool. She called on her radio to tell nursing there was someone in the pool.

Staff #E stated that on / " Staff #A, Staff #D and myself were the first responders and we pulled the resident out of the pool " . Staff # E stated that the resident was found to be fully clothed with shoes on and his walker was at the bottom of the pool. Staff # E stated that she started ( ) and another nurse was called to come down to assist. Staff #E stated that she asked Staff # H to go and get the automated external defibrillator ( ).

There were two firemen doing contract work at the facility and one of the firemen stated that they took over the until emergency medical services ( ) arrived. At 12:00 pm, the resident was

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transported by to the closest hospital.

A review of hospital records indicate that Resident #1 later on / / at 4:30 pm. at the hospital.

On / at 5:45 pm, facility nursing progress notes stated, Resident #1 was found out by the swimming pool in a lounge chair reportedly having been there for a couple of hours as stated by a resident that viewed him out of an apartment window. Resident was awake but unresponsive upon assessment. quickly arrived and transported to nearest hospital. His diagnosis was and possible heat .
A review of the report dated / at 5:48 pm. indicates that staff called 911 to report the resident had been there for more than two hours lying on a lounge chair by the pool with no shade. The resident was responsive to verbal stimuli but did not speak. His skin hot and red to touch. packs were applied to under arms and neck after removing patient from heat.
Assessment from the hospital stated possible heat and the plan was to admit for further observation and and .
Discharge summary from the hospital stated Resident #1 was seen due to altered mental state which seems to have been triggered by and underlying was evident.
Record review of Resident #1's medical record showed that he was admitted to the facility on .
He had diagnoses of , decreased hearing and of the back. Resident #1's latest health assessment dated showed the resident had diagnoses of , , related illness and was . He needed supervision with ambulation, dressing, self care ( ) toileting and transferring. He was independent in eating.

The primary care physician for Resident #1 on , at 1:48 pm, stated during a phone interview that the last time he had seen the resident was .
He stated that Resident #1 had a mild and left sided due to a in 2012. His function will not get better, it will either remain the same or get worse over time. He has a hearing , unsteady gait and was diagnosed with on his back in 2011. The primary care physician stated "if it was on a recent 1823 that Resident #1 required supervision with his ADLs then he should not have been at the pool without supervision, it would not be safe". The primary care physician also stated that he was not aware of the resident being at the pool on numerous occasions and getting . He was also not aware of the incident on , 2015 when Resident #1 was found unresponsive by the pool and transported to the emergency (ER) for a possible heat .
The Director of Nursing (DON) stated on at 11:00 am "all health assessments are reviewed either by her or the Licensed Practical Nurse (LPN)".
The facility failed to make sure the resident was supervised by the pool due to Resident #1's health assessment, dated , which stated supervision with ambulation and the primary care physician

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stated his gait was unsteady due to a prior .

Class I

0165 Risk Mgmt & QA: Adverse Incident Report

Based on record review and interview, the facility failed to submit an adverse incident report, or develop a plan of corrective action to prevent further incidents for an event that occurred on / of which the facility had control for1 (#1) out of 3 residents sampled for adverse incidents.

Findings include:

Resident #1 had two health assessments (1823) dated that stated his diagnoses were and unsteady gait and he was to have assistance with all activities of daily living (ADLs) to include ambulation, bathing, dressing, eating, self care ( ), toileting and transferring.
A record review of Resident#1's medical record showed he was found unresponsive while sitting by the pool alone for an extended period of time on / . Another resident had alerted the staff that the resident had been sitting outside in the sun for over two hours, the staff called 911, and came to transport the resident to the Emergency . He was sent to the hospital for possible heat and stayed there for 5 days. This was an event over which the facility could exercise control rather than as a result of the resident's condition.
The facility failed to submit a one day adverse incident report regarding the incident on / which required the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident.
Per the facility's policy on unusual occurrence (incident) reports, revised / / , the facility will complete a resident occurrence (incident) report on any incident which involves a resident. There was no unusual occurrence report found for Resident #1 dated / .
In an interview with the DON on at 11:15 am she stated that she had looked in the records for Resident #1 and she could not find the incident report for the event on / .
The facility did not implement an action plan after this incident even though the resident had a history of walking to and sitting by the pool alone and he was known to forget to come inside until staff could come and get him. The DON on at 11: 20 am stated that there was no plan put into place which would allow the resident to go to the pool with supervision.
The health assessment (1823) dated from his readmission stated he was to have supervision with all ADLs except eating which he was independent.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Inn at the Fountains
1255 Pasadena Avenue, S.
St. Petersburg, FL 33707

Dear Administrator:

This letter reports the findings of a complaint CCR# 2015011105, survey inspection conducted on 26 through 28, 2015, by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) by , 2015.

The inspection resulted in findings of non-compliance in the following areas:

St - A – 0025 – 58a-5.0182(1) Fac – Resident Care – Supervision Class I

St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report Class III

Directed Corrective Actions:

1. The Assisted Living Facility is required to immediately evaluate all assisted living residents to determine the level of supervision needed for each resident's access to the swimming pool currently located on the facility grounds. The Assisted Living Facility must develop and implement a policy on pool access for assisted living residents. Elements must include:

   a. Periodical assessment of assisted living residents for pool use.

   b. Identification of levels of supervision for each assisted living resident.

   c. Implementation of a system of supervision for each assisted living resident using the pool.

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11/4/15

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All staff are to be trained on this policy and documentation, including material and sign in sheets must be available to the Agency upon request.

2. The Facility is required to review ALL resident Health Assessment Forms (AHCA 1823) to ensure that the information contained within is complete and has been signed by the appropriately licensed healthcare provider.

3. The Assisted Living Facility is required to document that the Administrator has reviewed and instructed staff of Adverse Incident Reporting requirements.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call **Paul Brown**, Health Facility Evaluator Supervisor at 727-552-2000.

Sincerely,

Paul Brown

for Reid Caufman
Field Office Manager

PRC/PFB

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