STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942983	05/18/2016
NAME OF PROVIDER OR SUPPLIER **AIDEN SPRINGS**	STREET ADDRESS, CITY, STATE, ZIP CODE **5520 HOWELL BRANCH ROAD** **WINTER PARK, FL 32792**	

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

0000 Initial Comments

Complaint Investigation #2016002615 was conducted on / / . Aiden Springs had deficencies at the time of the visit.

0026 Resident Care - Social & Leisure Activities

Based on observation and resident interviews, the facility failed to provide the ongoing activities for all the residents as scheduled on the facility's monthly activity calendar.

Findings:

Observation on at 11 AM revealed no live organ music player from time 11:15 AM-11:45 AM at the facility to play music for the residents as was scheduled on the activities calendar.

On at 1 PM, resident #1, #2, #21, and #22 stated activities had not been offered to them in a long time. They stated they have not seen the music live show in some weeks now. The residents also stated that there is never any activities done with them. These residents stated they do not get together for any meetings to plan activity suggestions, and that most of the time everyone stays in their because there is nothing to do.

During interview on at 2 PM, the administrator stated that the live music organ group should have come to the facility but offered no follow up response after this statement.

Class III

0030 Resident Care - Rights & Facility Procedures

Based on observation and resident interviews, the facility failed to treat residence with consideration and respect with due recognition of personal dignity, individuality, and need for privacy for 8 of 24 sampled residents.

Findings:

Observation on / at 8:40 AM found resident #12 asking for a new roll of toilet tissue for him and , resident #11 from staff B, holding the empty roll of toilet tissue in his hand. Resident #12 stated that it was needed quickly for his , resident #11.

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Staff B responded with an answer, wait a few minutes and I will get it for you. At / at 9:10 AM, thirty minutes later, staff B gave resident #12.

On at 12 PM, residents #1, #2, #21, and #22 said toilet tissue has to be requested. The residents stated that one roll is to last for one week. The residents also stated that you are questioned why are you using up the toilet tissue before the week is completed.

On / at 11 AM, Resident #8 revealed that once in a while he ran out of toilet paper. He had to ask for them and had to wait for a few days to get it.

On / at 11:25 AM, Resident #14's not have toilet tissue on the holder. The administrator observed the same and stated that residents would come and ask staff for toilet tissue. He didn't put it out because some residents like to hoard it.

Class III

0052 Medication - Assistance with Self-Admin

Based on observation and interview, the facility failed to ensure staff A followed the correct procedure when providing assistance with self-administration of medication for 1 of 1 sampled resident (#1).

Findings:

Observation on at 8:20 AM of a Medication Pass by staff A to resident #1. Staff A prepared, verified, and compared medications assigned for resident #1 from the medication cart and Medication Observation Record (MORs). Staff A handed the medication in the Dixie cup to resident #1 without saying anything. Staff A did not in presence of the resident read the label of the medication and observe the resident take the medication..

Medications given in the Dixie cup were: 25 mg of 1 capsule, 40 mg 1 tablet at bedtime, , , 5 mg 1 tablet and monitor & record daily, 10 mg 1 capsule, 100 mg 1 capsule with food, / 10-325 mg 1 tablet every 8 hours. Over the counter medications 5 mg, E 100 IU, 600+D3, , and 500 mg.

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Further Observation of resident #1 taking all her medications in the Dixie cup provided by staff A and dumping it on a napkin at the kitchen table to count her medications and look at the color.

Interview on at 8:25 AM with resident #1 asking why did she dump her medications on the napkin. She responded stated she wanted to make sure that she gets all of her medications. Resident #1 was asked staff A read the label or tell her the name of medications being taken. Resident #1 answered no.

During an interview on at 8:30 AM with staff A, she stated she did not give the 40 mg to resident #1, because it is not due until bedtime at night. Staff A was informed it is unknown if the 40 mg was given to resident #1 this morning, because resident #1 was not told the name of medications taken or the labels read to her.

During interview on at 3 PM with the Administrator who was informed him that the observation of the medication pass was not successfully conducted by unlicensed staff A. It was explained to the Administrator that staff A did not let resident #1 know the name of the medications or read the label to resident #1.

The Administrator responded stated staff A is uncomfortable about her language barrier and she get nervous.

Class III

0093 Food Service - Dietary Standards

Based on observation, record review and interview, the facility failed to follow and serve daily posted meals accurately signed by the registered dietician, did not note the substitution in advance, failed to post therapeutic menus, and failed to have enough orange juice and milk on hand in the facility.

Findings:

Observation on at 8:15 AM found residents were only served a bowl of cereal, Cheerios or hot oatmeal, 1 biscuit, and cup of water for breakfast.

The Menu posted and approved by registered dietician for at 8:20 AM was 1/2 cup orange juice, 1/2 cup cereal or hot cereal, 1/2 banana, 1 English muffin/bagel, 1 cup of milk and coffee, tea, margarine, jelly.

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On / / at 9:30 AM, staff B opened the refrigerator and revealed only five 8 ounce (oz.)containers of milk and thirteen 4 oz. containers of orange juice on hand in the entire facility for a census of residents of 22.

On at 9:30 AM, staff B confirmed that she did not update the menu with the substitutions.

Record review for resident #1 and #2 revealed a required therapeutic diet restriction noted on the AHCA 1823 Health Assessment form.

On / / at 9:30 AM, a therapeutic diet was not posted in the kitchen or anywhere in the facility.

During an interview with residents #1, #2, #8, #12, #21 and #22, they stated that they are served the same thing every day and the menu posted is never followed. The residents also stated that they keep their own snacks and food inside their , in case they get hungry. The residents all agreed that the portion size could be larger.

The residents also stated that the facility is always out of milk, mostly they drink water for their 3 meals a day. They stated they are offered cookies and coffee break at 2 PM for a snack every day.

On at 12 PM, the lunch meal served to the residents was grilled cheese sandwiches, tomato soup, chips and pudding.

A review of the posted menu in the dining lunch menus for Wednesday, / , was to be 4 oz. of BBQ chicken, 1/2 cup baked beans, 1/2 cup garden salad, 1/2 cup fruit cocktail, coffee, tea; margarine, and dressing. A substituted menu was not posted.

On at 1 PM, the facility cook, staff B confirmed that she had used the supper menus for lunch because she did not have time to thaw chicken. She confirmed that she did not post the substitutions before or when the meal was served.

On / at 5:10 PM, the dinner meal provided to the residents was 1 thin 4 oz. pork chop cutlet, mashed potatoes, green beans, and water.

The Menu posted and approved by the registered dietician for dinner for was 1 cup tomato soup, 2 oz. grilled cheese sandwich on white bread, 1/2 cup of potato chips, 1/2 cup pudding, and 1 cup milk, iced tea.

On / at 5:30 PM, the administrator was informed that all three meals, breakfast, lunch, and dinner,

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were observed during the visit, and none of the meals followed the posted menu approved by the registered dietician, and none recorded the substitution.

Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observation and interview, the facility failed to ensure a safe living environment, maintained free of hazards, and failed to ensure all existing architectural and structural systems were maintained in good working order, affecting 3 of 22 sampled residents (#1, 2 & 20).

Findings:

Observation on / / at 9 AM found the Florida Sun the facility leaking water from the ceiling upon entrance in and out of the . The carpet was soaked and an orange industrial fan was drying the carpet.

Observation on / / at 11 AM found the couch, in the common area near the dining the television, with a peeling material on it.

On at 12 PM, resident #1's a cracked ceiling and a dirty air conditioning vent.

On / / at 12 PM, resident #1 stated that she was uncomfortable with the cracked ceiling and that she reported it to staff.

On / / at 1 PM, in unoccupied had a black/brown substance on the near the toilet and shower areas.

On / / at 1:30 PM, resident #2 and #20's a black/brown substance on the near the toilet and shower areas. There were also some cracks and holes in the . Both residents stated that the black/brown substance has been in the some months now. They reported it to staff.

On at 2:30 PM, the food pantry near the kitchen had a can of applesauce with black/brown substance on the top of the can.

On at 2:40 PM, staff C was shown the black/brown substance on top of the canned applesauce located in the food pantry and recommending it be discarded immediately, keeping it away from the all

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other foods stored in the food pantry. Staff C stated that the administrator was going to discard it but must have forgotten about it.

On at 2:45 PM, the duct vent located in front of the kitchen was very dirty and directly opposite from the duct vent was a hole approximately 1 and 1/2 inches by 3 inches.

On at 9:30 AM, the ceiling light fixture in the dining in front of the kitchen flickered and had a broken plastic cover. The cover could down on residents who normally congregated in the area. At 5:30 PM, the administrator confirmed the findings.

On at 3 PM, the administrator was informed of the physical plant findings needing repair. He acknowledged that repairs are needed and worked on them the best he could with the expensive cost to repair some of the items. He also stated that he would assess 9 and 15 for the black/brown substance. He stated he was not aware of this issue in those two . He stated that 's floor was repaired and painted.

Class II

0165 Risk Mgmt & QA: Adverse Incident Report

Based on facility record review and interview, the facility failed to file adverse incident report to Agency for Health Care Administration (AHCA) involving 2 of 2 sampled residents as required when law enforcement was called to the facility for an incident (#1 & 18).

Findings:

Facility's record review revealed an internal incident report filed after an altercation between residents #1 and #18 on at 9 PM which resulted the police being called by resident #1.

On at 12:30 PM, resident #1 stated that she just moved to the facility and no one told her that resident #18 was territorial and protective about a chair and television in the front common area across from resident #1's. She said resident #18 came out of her saw her sitting on the chair and started hitting her, her right arm. She said staff E partially observed the ending of the altercation and called the administrator immediately. Resident #1 stated that staff E broke up the altercation, and resident #1 called the police to the facility.

Record review for residents #1 and #18 revealed documentation of the incident and family notification but there was no documentation regarding the police coming to the facility after being called by resident

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#1.

On at 2 PM, resident #18 stated she did not remember the incident. She said she gets along with everyone.

On at 4 PM, the administrator was asked if an Adverse Incident Report was filed to AHCA as required when law enforcement is called to the facility. He confirmed that he just filed the internal incident report and spoke with both residents and their family members about the incident. The administrator stated he did not know until a later day that police were called to the facility about the incident.

On / at 5 PM via telephone conversation with staff E, she said she witnessed the altercation between resident #1 and #18 on and confirmed that she caught the end of the altercation between both residents and separated them. Staff E also stated that she immediately called the administrator to notify him, but did not get an answer and left a voicemail message.

Class

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Aiden Springs
5520 Howell Branch Road
Winter Park, FL 32792
Attention: Albert Green

Dear Mr. Green:

This letter reports the findings of a complaint investigation CCR#2016002615 conducted on , 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** .

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

A - 0152 - Physical Plant - Safe Living Environ/other Class II
The facility failed to ensure a safe living environment, was maintained free of hazards and failed to ensure all existing architectural and structural systems were maintained in good working order.

Directed Corrective Actions:

1. The Assisted Living facility is required to create a policy and procedure that contains a mechanism for residents, families and staff to report repairs and hazards to the administrator/owner. A log book should be part of this new policy and procedure. The log should be reviewed at least on a weekly basis by the administrator/owner to ensure they are aware of any concerns involving the physical plant and hazards in the facility **by** .

2. The staff must be trained on this new policy and procedure. The new procedure should be monitored to ensure it is being followed. The sign-in sheet for the training and the new policy and procedure must be available for review upon Agency request **by** .

3. All concerns listed in the statement of deficiencies must be corrected **by** .

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

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com

Aiden Springs
, 2016

Should you have any questions, please contact . Lorraine Henry, Orlando Field Office, at (407) 420-2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be

D7JR

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2727 Mahan Drive
Tallahassee, FL 32308
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RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Aiden Springs
5520 Howell Branch Road
Winter Park, FL 32792

RE: CCR #2016002615

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on , 2016, 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 -2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure
XG90

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