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	AL11964511	**10/24/2018**
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Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on record review and interview, the Facility failed to maintain the employment status of staff members within the employee roster listed in the AHCA background screening clearinghouse (Employee Roster), within ten-business days of termination of employment, for one (Staff D) of four employees sampled.

Findings included:

A review of the Background Screening Employee Roster, conducted on , revealed that Staff D was listed as a current employee of the Facility. Staff D was hired on . Staff D was not on the Facility's current staff schedule.

During a request for Staff D's employee record, conducted on at 02:30pm, Staff B did not produce Staff D's employee record and stated that Staff D never worked at the Facility.

During an interview with Staff B, conducted on at 04:56pm, Staff B acknowledged and confirmed that the Facility's Background Screening Employee Roster was not up-to-date. Staff B did not provide a termination date for Staff D. Staff B stated that Staff D never worked for the Facility.

Unclassified

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0000 - Initial Comments

Assisted Living Facility

A Complaint Survey (CCR#: 2018013748) was conducted in conjunction with a Revisit to an 08/30/18 Monitoring Survey at Freshwater at Hudson Assisted Living Facility on 10/24/18. Freshwater at Hudson Assisted Living Facility had deficient practice identified at the time of the survey.

(License#: 9047)

0008 - Admissions - Health Assessment - 429.26( ) FS; 58A-5.0181(2) FAC

Based on record review and interview, the Facility failed to ensure that required complete documentation of a -to- health assessment was obtained for three Residents (#5, #8, and #9) of four sampled residents admitted to the Facility.

Findings Included:

A record review for Resident #5, conducted , revealed that Resident #5 had an assessment dated , which did not include a list of Resident #5's medications prescribed at the time of the assessment. Resident #5 was admitted in to the Facility on .

A record review for Resident #8, conducted on , revealed that Resident #8 had a health assessment dated with no type of medical history or diagnoses, /behavioral status, type of diet, or type of assistance needed with medications noted on the documentation of the assessment. There was a note to refer to the attached medical consult and the attached H&P (history and physical) but these items were not attached to the health assessment. Resident #8 was admitted in to the Facility on .

A record review for Resident #9, conducted on , revealed that Resident #9 had a health assessment with no date of the examination noted, no medications listed or attached, and no data for the health care provider who conducted the examination, including the Physician's signature, license number, address, and telephone number. Resident #9 was admitted in to the Facility on .

During an interview with Staff B, conducted on at 04:00pm, Staff B acknowledged and confirmed the missing required information for Residents #5, #8, and #9.

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Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observations, interviews, and record reviews, the Facility failed to provide care and services appropriate to the needs of residents accepted for admission; failed to provide oversight to residents' changes in condition; failed to document changes in resident's condition in the residents' record; and failed to notify residents' Physicians and Responsible Parties in changes in condition.

Findings Included:

A review of a Fire Rescue Report regarding Resident #1, conducted on , revealed that Resident #1 was sent to the local Hospital's Emergency Room on Monday, for , , malaise, and with drooping to the right. Resident #1's was rapid at and all other vital signs were normal.

A review of Resident #1's Hospital Emergency Room Report from Monday, , conducted on , revealed that the symptoms Resident #1 experienced waxed and waned over the weekend (and) and Resident #1 was last normal on Friday, . Resident #1's chief complaint was decreased responsiveness, falling, and . The Emergency Room Report noted a small to Resident #1's forehead and that Narcan was administered with no change in Resident #1's mental status.

During an interview with Staff B, conducted on at 01:40pm, Staff B was unable to explain why Resident #1's medications were not documented from through . At 02:45pm, Staff B stated that when the staff presented at work on Monday, , Resident #1 had lost balance and kept falling and ate little. Resident #1 was also very sleepy and had over the weekend. Staff B did not work over the weekend. Staff B stated that Resident #1's was drooping and their was displaced. Staff B said they sent Resident #1 to the hospital.

During an interview with Staff C, conducted on at 02:20pm, Staff C stated that Resident #1 kept falling, did not want to wake up, and exhibited these symptoms for two days indicating Saturday, and Sunday, .

A review of Resident #1's record, conducted on , revealed that the Facility failed to document changes in Resident #1's condition in the resident record. There was no documentation of any

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notifications to Resident #1's Physician and Responsible Party regarding the changes in condition Resident #1 sustained. A review of Resident #1's Medication Observation Records (MORs) revealed that Resident #1 did not have any medication documented as given from through , which included two medications (2mg and Saphris 5mg). There was no documentation that Resident #1's Mental Health Care Provider was notified regarding Resident #1 not receiving these medications.

Continued review of Resident #1's record revealed that on , the health care provider visited Resident #1 due to aggressive behavior and "yelling at staff and ." The health care provider noted "left message for Administrator to transfer." There was no documentation that the Facility transferred Resident #1 to any Acute Care or Facility or notified the Mental Health Care Provider of the concerns or order for transfer. Resident #1's record contained no documentation of any follow-up to the health care provider's request to transfer Resident #1. The health care provider also changed Resident #1's medication from 2mg twice every day to 5mg twice every day.

A review of internal reports for the facility, conducted on , revealed the following regarding resident :
On , Resident #2 had a to the ground outside and hit their and sustained a over the left . There was no documentation in Resident #2's resident record that the Facility notified Resident #2's health care provider regarding the and injury or documentation regarding any intervention or prevention measures that the Facility implemented to reduce reoccurrence for Resident #2.

On , Resident #2 had a and sustained a scratch. There was no documentation in Resident #2's resident record that the Facility notified Resident #2's Responsible Party and health care provider. Resident #2's record also did not have any documentation regarding any intervention or prevention measures that the Facility implemented to reduce Resident #2's reoccurrence.

On , Resident #2 had water spilled on their by Resident #11 and Resident #2 pushed Resident #11 down. The Police and 911 were notified by the Facility. There was not documentation in either Resident #2 or Resident #11's resident records that their Responsible Parties and health care providers were notified by the Facility. There was no documentation in either Resident #2 nor Resident #11's resident records for interventions that the Facility put in place to prevent reoccurrence.

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0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observations, record reviews, and interview, the Facility failed to read medication labels aloud while assisting with self-administration of medication and failed to notify the Physician of missed or refused medications for six Resident (#1, #2, #5, #9, #12, and #13) of six sampled residents who required assistance with self-administration of medications.

Findings Included:

During a medication pass observation with Resident #12, conducted on at 12:10pm, Staff B did not read Resident #12's medication labels for 10mg and 50mg tablets aloud to Resident #12. Resident #12 required assistance with self-administration of medication.

During a medication pass observation with Resident #2, conducted on at 12:15pm, Staff B did not read Resident #2's medication labels for 500mg, 500mg, 25mg, 50mg, 2mg, and 2mg tablets aloud to Resident #2. Resident #2 required assistance with self-administration of medication.

During a medication pass observation with Resident #13, conducted on at 12:20pm, Staff B did not read Resident #13's medication labels for 10mg and 800mg tablets aloud to Resident #13. Resident #13 required assistance with self-administration of medication.

A record review for Resident #1, conducted on , revealed that Resident #1 had no evidence of medications documented as given from through . Resident #1 was admitted to the Facility on . There was no documented evidence in Resident #1's record that the Facility notified Resident #1's health care provider regarding the missed medications. The missed medications included Resident #1's prescribed 81mg, Benzotropine 0.5mg, 3.125mg, Delayed Release 500mg, 40mg 2mg, 500mg, Saphris 5mg tablets and capsules and 1% Cream (See Photographic Evidence2).

A record review for Resident #5, conducted on , revealed that Resident #5 had refused the prescribed medication 25mg tablets from through and from through . Resident #5's record contained no evidence that the Facility notified Resident #5's health care provider regarding the medication refusals. Resident #5 had refused the prescribed medication Zolpiderm 10mg tablets from through , , and . (See Photographic Evidence5).

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A record review for Resident #9, conducted on , revealed that Resident #9's Medication Observation Record (MOR) had no evidence of medications documented as given from through . Resident #9 was admitted to the Facility . There was no documented evidence in Resident #9's record that the Facility notified Resident #9's health care provider regarding the missed medications. The missed medications included Resident #9's prescribed , 100mg and 20mg tablets.

During an interview with Staff B, conducted on at 01:40pm, Staff B ws unable to explain the reason Resident #1 missed prescribed dosages of medications from through . Staff B was unable to produce any documentation that the Facility notified Resident #1's health care provider regarding the missed dosages of medications. At 02:45pm, Staff B was unable to explain Resident #9's missed medication dosages and was unable to produce documentation that the Facility notified Resident #9's health care provider about the missed dosages of medication.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record review and interview, the Facility failed to maintain up-to-date Medication Observation Records (MORs) which included residents' , Physician and Physician's telephone number, and the month and year that the MORs reflected and also failed to update MORs each time medications were offered for six residents (#1, #2, #5, #8, #9, and #14) of nine sampled residents.

Findings Included:

A record review for Resident #1's MORs, conducted on , revealed that Resident #1's MORs did not include the Physician or the Physician's telephone number, did not include the MOR record date (the month and the year), and did not specify Resident #1's specifically to and . Resident #1 was admitted in to the Facility on and did not have any medication documented as given from through . These medications included , 81mg, Benzotropine 0.5mg, 3.125mg, , Delayed Release 500mg, , 40mg, , 2mg, 500mg, Saphris 5mg, and 1% , Cream. (See Photographic Evidence2)
The of Resident #1's MORs did not include a reason that these medications were not given. There was no documentation in Resident #1's record that the Facility notified the Physician that these medications were not given. There were no Physician orders to hold these medications in Resident #1's

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record.

A record review for Resident #2's MORs, conducted on , revealed that Resident #2's MORs did not include the Physician or the Physician's telephone number on page three and had medications the Facility did not document as given to Resident #2. These medications included:
- 25mg not documented as given on at 12:00pm
- 200mg not documented as given on and at 08:00pm
- 2mg not documented as given on at 12:00pm
- 160-4.5gram Aerosol not documented as given on at 08:00am
- 0.4mg not documented as given on at 08:00am
- 0.1% Cream not documented as given on at 05:00pm

(See Photographic Evidence5)
The of Resident #2's MORs did not include a reason that these medications were not given. There was no documentation in Resident #2's record that the Facility notified the Physician that these medications were not given. There were no Physician orders to hold these medications in Resident #2's record.

A record review for Resident #5's MORs, conducted on , revealed that Resident #5's MORs did not include the Physician or the Physician's telephone number and had medications the Facility did not document as given to Resident #5. These medications included Resident #5's prescribed medications:
- 10mg not documented as given on at 08:00pm
- 10mg not documented as given on at 08:00pm
- 90mg not documented as given on and at 05:00pm
- 3.125mg not documented as given on , , and at 05:00pm
- 0.5mg not documented as given on at 08:00pm
- 325mg not documented as given on and at 08:00pm
- /Acetimenophen 5-325mg not documented as given on and at 08:00pm
- 25mg not documented as given on at 08:00pm
- 100mg not documented as given on and at 08:00pm
- Zolpiderm 10mg not documented as given on , , and at 08:00pm (See Photographic evidence5)

The of Resident #5's MORs did not include a reason that these medications were not given. There was no documentation in Resident #5's record that the Facility notified the Physician that these medications were not given. There were no Physician orders to hold these medications in Resident #5's

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record. The Facility did document some of these medication refused by the Resident on other dates and times not included with the aforementioned dates and times. There was no documentation in Resident #5's record that the Facility notified the Physician of Resident #5's medication refusals.

A record review for Resident #8's , MORs, conducted on , revealed that Resident #8's MORs had medications the Facility did not document as given to Resident #8. (See Photographic Evidence1)
These medications included Resident #8 prescribed medications:
- Benzotropine 0.5mg not documented as given on at 08:00pm
- Extended Release 500mg not documented as given on at 08:00pm
- 10mg not documented as given on and at 08:00pm
- 20mg (not documented as given on and at 08:00pm)

The of Resident #8's MORs did not include a reason that these medications were not given. There was no documentation in Resident #8's record that the Facility notified the Physician that these medications were not given. There were no Physician orders to hold these medications in Resident #8's record. Resident #8's MORs did not included the Physician or the Physician's telephone number.

A record review for Resident #9's and MORs, conducted on , revealed that Resident #9's MORs did not include the Physician or the Physician's telephone number, did not specify MOR record date (the month and the year), and did not include Resident #9's of and . Resident #9's prescribed medication 100mg was not documented as given on and at 08:00pm. Resident #9's prescribed medication 20mg was not documented as given on at 08:00pm. Resident #9 admitted in to the Facility on and did not have any medications documented as given from through . The of Resident #9's , MORs did not include a reason that these medications were not given. There was no documentation in Resident #9's record that the Facility notified the Physician that these medications were not given. There were no Physician orders to hold these medications in Resident #9's record. (See Photographic Evidence1)
Resident #9's MORs (See Photographic Evidence5) did not include the Physician or the Physician's telephone number, did not specify MOR record date (the month and the year), did not include Resident #9's of and . Resident #9's prescribed medication 20mg was not documented as given on at 08:00am and 0.25mg was not documented as given on at 08:00am and on at 12:00pm and on at 12:00pm. The of Resident #9's MORs did not include a reason that these medications were not given. There was no documentation in Resident #9's record that the Facility notified the Physician that these

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medications were not given. There were no Physician orders to hold these medications in Resident #9's record.

A record review for Resident #14's MORs, conducted on , revealed that Resident #14's MORs (See Photographic Evidence3) did not include the Physician or the Physician's telephone number on the page that included Resident #14's 'as needed' medications.

During interviews with Staff B, conducted on at 01:40pm, Staff B was unable to explain or show documentation for the reason Resident #1 did not receive medications from through . At 02:45pm, Staff B was unable to explain or provide documentation for the reason Resident #9 did not receive medications from through . At 04:00pm, Staff B acknowledged and confirmed that MORs for Residents #1, #2, #5, #8, #9, and #14 did not include all required data and the missing documentation for each residents' MORs.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on record review and interview, the Facility failed to obtain directions and parameters for use medication ordered by a health care provider "as needed" for two Residents (#13 and #14) of nine sampled resident who required assistance with self-administration of medications.

Findings Included:

A review of Resident #1's Medication Observation Records (MORs) revealed that Resident #1 did not have any medication documented as given from through , which included two medications (2mg and Saphris 5mg). There was no documentation that Resident #1's Mental Health Care Provider was notified regarding Resident #1 not receiving these medications.

A review of withdrawal symptoms, conducted on , revealed when the medication discontinued after long-term used could produce withdrawal symptoms which included anger, hostility, irritability, fog (loss of mental clarity), , appetite changes, increased hear rate, , fatigue, agitation, and , . The severity of the withdrawal symptoms influenced by how abruptly the medication discontinued. Data obtained from www.4mind4life.com/ -withdrawal-symptoms

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A review of Saphris withdrawal symptoms, conducted on , revealed that when the medication Saphris discontinued after long-term use, could have withdrawal symptoms which included agitation, anger, , fog (loss of mental clarity), , , , , fatigue, , irritability, swings, tremors, and to the with the sudden discontinuation of use.
Data obtained from
https://mentalhealthdaily.com/2015/08/19/saphris- , -withdrawal-symptoms-list-of-possibilities

A record review of Resident #13's Medication Observation Records (MORs), conducted on , revealed that Resident #13 did not have any reason notated as to the reason to take the prescribed "as needed" medication 10mg.

A record review of Resident #14's MORs, conducted on , revealed that Resident #14 did not hae any reason notated as to the reason to take the prescribed "as needed" medications Liquid Suspension, 10 , , , and 20mg (See Photographic Evidence3).

During an interview with Staff B, conducted on , Staff B acknowledged and confirmed that Resident #13 and Resident #14's "as needed" medications did not include any parameters or reasons to take these medications and when.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on observation and interview, the Facility failed to designate a staff person in charge of the Facility in writing during the temporary absence of the Administrator.

Findings Included:

During the Entrance Conference with Staff B, conducted on at 10:35am, Staff B stated that the Administrator was absent from the Facility. Staff B stated that the Administrator had not been in the Facility since Friday ( ). Staff B attempted to contact the Administrator during the survey and while the Agency was in the Facility and the Administrator did not answer. Staff B left a voicemail message for the Administrator to call. Staff B did not know the length of time of the Administrator's absence from the Facility would be.

The Administrator did not arrive during the survey and there was no written designation of someone left

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in charge of the facility.

During the Exit Conference with Staff B, conducted on at 04:45pm, Staff B confirmed there had been no response from the Administrator.

Class III

0081 - Training - Staff In-Service - 58A-5.0191( ) FAC

Based on record review and interview, the facility failed to provide proof of in-service training, within 30 days of employment, in the subject of resident behavior and needs/providing assistance with the activities of daily living (ADL Training) for one (Staff A) of three employee records reviewed.

Findings included:

A review of direct care staff records conducted on showed that Staff A had a date of hire of . A review of Staff A's record showed no proof of ADL Training. Staff A was was noted on the facility's direct care staffing schedule.

Staff B was interviewed at 4:02 PM on and acknowledged that there was no proof of ADL Training in Staff A's record.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC

Based on record review and interview, the facility failed to provide proof of an initial training on providing assistance with self-administered medications and safe medication practices in an assisted living facility (Medication Assistance Training) for unlicensed personnel that assisted residents with self-administered medications for one (Staff A) of three employee records reviewed.

Findings included:

A review of employee records conducted on showed that Staff A had no proof of Medication Assistance Training in their record. A review of medication observation records (MORS) for Resident #14 showed that Staff A assisted the resident with medications on , , , and (photographic evidence obtained).

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A phone interview was conducted with Staff A on . . . . . at 3:45 PM and they stated that they assisted facility residents with self-administration of medication.

An interview was conducted with Staff B at 4:00 PM on and they acknowledged that there was no proof of Medication Assistance Training in Staff A's record.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record review and interview, the Facility failed to maintain satisfactory inspection reports from the Department of Health (DOH) Group and Food sanitation inspections.

Findings Included:

A review of the Facility's Group and Food sanitation inspection reports by the DOH, conducted on , revealed that the last satisfactory Group and Food Inspection Reports the Facility obtained was on . . . . . .

During an interview with Staff B, conducted on . . . . . at 03:30pm, Staff B acknowledged and confirmed that the Group and Food sanitation inspection reports were older than one year. Staff B stated that the Administrator "may have these saved on the computer and no, I don't have access to the [Administrator's] computer."

Class III