STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964511	R 12/17/2018
NAME OF PROVIDER OR SUPPLIER **FRESH WATER AT HUDSON**	STREET ADDRESS, CITY, STATE, ZIP CODE **14108 OLD DIXIE HIGHWAY** **HUDSON, FL 34667**	

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

0000 - Initial Comments

Assisted Living Facility

A Revisit to a 10/24/18 Complaint Survey (CCR#: 2018013748) was conducted in conjunction with a Revisit to a Monitoring Survey was conducted at Freshwater at Hudson Assisted Living Facility on 12/17/18. Freshwater at Hudson had deficient practice identified at the time of the survey.

(License#: 9047)

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

Based on observation, record review and interview, the Facility failed to provide appropriate supervision to meet the needs of residents residing in the Facility, which included an awareness of residents' health and safety, notifications to residents' Physicians and Responsible Parties, and maintaining residents' record with health care changes for four Residents (#2, #3, #5, and #9) of eleven sampled residents.

Findings Included:

Observations of Resident #2 conducted during survey on , revealed that the resident constantly crying and asking for money.

A review of Resident #2's record, conducted on , revealed that the resident health assessment form dated indicated that the resident had attention seeking behaviors but there were no care and services provided or arranged to meet the resident's need on page five of the form. Resident #2's Observation Log had no documented behaviors of repeatedly crying and asking for money. There was documented evidence that the Resident #2's Physician and Responsible Party notified of the resident's behavior. Resident #2's Medication Observation Record listed the prescribed medication , 25 take 1ml (25mg) Injection every two weeks for the resident's diagnosis of , . There was no documentation that Resident #2 received this medication. There was no documentation in Resident #2's record of how the Facility arranged for this medication to be given to the resident. There was no documented evidence that the Facility attempted to inquire if the , injection had been given to Resident #2.

During an interview with Staff A, conducted on at 11:00am, Staff A stated that Resident #2 had been crying repeatedly all weekend and stated "no" when asked if the Facility notified the resident's Physician and Responsible Party. Staff A stated that the doctor comes in and gives that medication

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(referring to the , injection) and stated that "they don't leave anything when they give it."

A review of incident reports for Residents #3, #5, and #9, conducted on , revealed incident reports for these three residents. Resident #3's incident report stated that the resident on with no time noted on the incident report. There was no documentation on the incident report that Resident #3's Responsible Party notified. There was no documentation regarding the notification of the Resident #3's Physician regarding who and time and date of the notification. Resident #5's incident report stated that the resident on at 11:30am. There was no documentation that Resident #5's Responsible Party notified of the . Resident #9's incident report dated stated that the resident threatened to shoot Resident #5 in the with a bee-bee gun. Another incident report for Resident #9 dated stated that the resident threatened Resident #5 and staff. There was no documentation on the incident report that Resident #9 Physician and Responsible Party notified of the two incidents. There was no incident reports for these two incidents for Resident #5.

A review of Resident #3's record, conducted on , revealed no documentation regarding the resident's regarding an investigation of the cause and intervention/prevention measures implemented to prevent the resident from falling. There were no documented notifications to Resident #3's Physician or Responsible Party.

A review of Resident #5's record, conducted on , revealed no documentation regarding the resident's regarding an investigation of the cause and intervention/prevention measures implemented to prevent the resident from falling. There were no documented notifications to Resident #5's Physician or Responsible Party. There was no documentation in Resident #5's record regarding the threats of bodily harm made by Resident #9 or notifications made to the resident's Physician or Responsible Party. There were no documented efforts to keep Resident #5 safe from Resident #9.

A review of Resident #9's record, conducted on , revealed no documentation regarding the two incidents of threatening bodily injury to both Resident #5 and staff. There was no documentation of Resident #9's behavior upon the resident's return after the first incident leading up to the resident's second incident in which the Facility and discharged the resident. There was no documented efforts of interventions implemented to keep Resident #9 from harming Resident #5 and staff.

During an interview with the Administrator, conducted on at 11:25am, the Administrator stated, "I don't have time for all of it; I am only here three days per week." At 12:30pm, the Administrator agreed that the Facility did not follow their incident reporting policy and procedure and stated, "We need to do

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more documentation."

Class III

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 and compare medication labels to Medication Observation Records (MORs) for three Residents (#5, #10, and #11) of three sampled who required assistance with self-administration of medications. The Facility failed to notify the Physician of refused medications for two Residents (#1 and #6) of two sampled residents who refused medications and required assistance with self-administration of medications.

Findings Included:

A review of Resident #1's MORs, conducted on , revealed that Resident #1 refused the prescribed medications , , 10mg and 10mg from through and , 40mg. There was no documented evidence found in Resident #1's record that the resident's Physician and Responsible Party notified of the medication refusals.

A review of Resident #6's MORs, conducted on , revealed that Resident #6 refused the prescribed medications , 1mg from through at 08:00pm and 12/5mg from through and from through at 08:00pm. There was no documented evidence found in Resident #6's record that the resident's Physician and Responsible Party notified of the medication refusals.

During a medication pass with Staff A for Resident #11, conducted on at 11:50am, Staff A did not compare the resident's medication label to the resident's MORs or read the medication label aloud to the resident.

During a medication pass with Staff A for Resident #5, conducted on at 11:55am, Staff A did not compare the resident's medication label to the resident's MORs or read the medication label aloud to the resident.

During a medication pass with Staff A for Resident #10, conducted on at 12:00pm, Staff A did not compare the resident medication label to the resident's MORs or read the medication label aloud to

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the resident.

During an interview with the Administrator, conducted on at 12:30pm, the Administrator acknowledged and confirmed that Medication Technicians were to read medication labels and compare medication labels to MORs while assisting residents with medications. The Administrator was unable to provide documentation that Resident #1 and #6's Physicians and Responsible Parties notified of their medication refusals.

Class III

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

Based on record review and interview, the Facility failed to maintain Medication Observation Records (MORs) which included residents' , Physician, and Physician's telephone number and failed to update the MORs each time medications offered for six Residents (#1, #2, #5, #6, #7, and #8) of six residents who need assistance with self-administration of medication.

Findings Included:

A review of Resident #1's MORs, conducted on , revealed that Resident #1's MORs did not include the resident's Physician or the Physician's telephone number as required. Resident #1's MORs continued to listed the medication 14mg/24-hour patch listed as a current medication. Resident #1's prescribed 14mg/24-hour patch was ordered on for fourteen days and should have been discontinued on .

A review of Resident #2's MORs, conducted on , revealed that Resident #1's MORs did not include the resident's Physician or the Physician's telephone number as required.

A review of Resident #5's MORs, conducted on , revealed that Resident #1's MORs did not include the resident's Physician or the Physician's telephone number as required.

A review of Resident #6's MORs, conducted on , revealed that Resident #1's MORs did not include the resident's Physician or the Physician's telephone number as required. Resident #6's MORs stated that the resident had no known . Resident #6's most recent health assessment form dated stated that the resident was to .

A review of Resident #7's MORs, conducted on , revealed that Resident #1's

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MORs did not include the resident's Physician or the Physician's telephone number as required. Resident #7's MORs stated that the resident had no known . . . . Resident #7's most recent health assessment form dated stated that the resident was . to . There was no documentation that Resident #7 received the prescribed medication . . . . . 20meq on at 12:00pm.

A review of Resident #8's MORs, conducted on , revealed that Resident #1's MORs did not include the resident's Physician or the Physician's telephone number as required. There was no documentation that Resident #8 received the prescribed medication 100mg on . . . . . at 05:00pm.

During an interview with the Administrator, conducted on at 11:15am, the Administrator acknowledged and confirmed that Residents #1, #2, #5, #6, #7, and #8 did not have their Physicians and Physicians' phone number on their MORs as required. The Administrator further acknowledged and confirmed that Residents #6 and #7 had incorrect listed on their MORs and that Residents #7 and #8 had missing documentation that all medications given to them.

Class III

0058 - Pharmacy & Dietary; Uncorrected Deficiencies - 429.42( ) FS; 58A-5.033(3)(a) FAC

Based on record review, observation, and interview the facility failed to correct deficiencies related to medications.

Findings Included:

During a Revisit to a complaint survey conducted on 12/17/18, the Facility failed to correct two of the three Class III deficiencies regarding medications. These two Class III deficiencies were cited again at the time of the survey.

During the Exit Conference with the Administrator, conducted on at 12:30pm, the Administrator acknowledged and confirmed that the Facility must employ or contract with consultant services of a licensed Pharmacist or a licensed Registered Nurse until such time the Agency determines that such consultation services are no longer required.

Class III

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0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on observation, record review, and interview, the Facility Administrator failed to supervise the Facility's operation and failed to provide management to staff to ensure the provision of appropriate care and services to all residents residing in the Facility.

Findings Included:

During a survey conducted on , the Facility had multiple uncorrected deficiencies. During the survey there were additional tags cited which included Resident Care - Supervision.

During an interview with the Administrator, conducted on at 11:25am, the Administrator stated, "I don't have time for all of it; I am only here three days per week; and, it's too far", referring to the Facility's proximity to the City in which the Administrator lives. Staff A maintained daily operation of the Facility with the Administrator available via telephone on most days.

Class III

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

Based on record review and interview, the facility failed to ensure that 1 of 3 sampled staff (A) received three hours of in-service training within 30 days of employment pertaining to resident behavior and needs.

Findings included:

During a review of staff training conducted on , it was revealed that Staff B with a hire date who provided direct care for residents, had a training certificate for a1 hour training in activities of daily living and behavioral needs..
The requirement is a three hour training.
In an interview with the administrator on at 11:00am, he stated that he did not know the training was for three hours.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(&) FS; 58A-5.0241 FAC

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Based on record review and interview, the Facility failed to have a risk management and quality assurance program to assess incident reports and develop corrective action plans and report an Adverse Incident to the Agency for Health Care Administration for two events in which police were called to remove one Resident (#9) from the Facility for threatening another resident and staff.

Findings Included:

A review of an incident report for Resident #9's record, conducted on , revealed that on at 11:00am the resident made threats of bodily harm to Resident #5. The incident report stated that Resident #9 "went to Walmart bought a pistol with bee-bees [and] threatened to shoot [Resident #5] in the the next day". The police came to the Facility and removed Resident #9 from the Facility. Another Incident Report dated at 06:30am stated that Resident #9 threatened Resident #5 again and threatened staff bodily harm. The police notified and removed Resident #9 from the Facility. There was no documentation found in Resident #9's record of the Facility's attempt to remove the bee-bee pistol the day of purchase. There were no documented notifications to Resident #9's Physician and Responsible Party for either incident. There was no documentation found in Resident #9's record regarding the resident's return to the Facility after the first incident regarding behaviors or demeanor upon the resident's return before the second incident. There was no documentation regarding intervention or prevention measures put in place regarding Resident #9's aggressive behavior.

A review of Resident #5's record, conducted on , revealed no incident reports or documentation in the resident's record regarding the threats made by Resident #9. There were no documented notifications to Resident #5's Physician or Responsible Party regarding Resident #9's threats of bodily harm to the resident. Resident #5's record had no documented safety measures implemented to keep the resident safe from Resident #9.

During an interview with the Administrator, conducted on at 11:15am, the Administrator stated that the Facility did not submit an Adverse Incident reports to the Agency for Health Care Administration for Resident #9's threat of bodily harm to Resident #5. The Administrator further confirmed that Resident #5's record had no documentation regarding notification made about either incident or safety measures , to keep Resident #5 safe from Resident #9. The Administration further confirmed that Resident #9's record had no documentation regarding return to the Facility, notifications made about either incident, behavior or demeanor from the resident return to the Facility from the first incident to the second incident, or intervention measures implemented for the resident.

Class III