STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969247	**01/02/2019**
NAME OF PROVIDER OR SUPPLIER **SWEETWATER OAKS**	STREET ADDRESS, CITY, STATE, ZIP CODE **2820 PAN AMERICAN BLVD** **NORTH PORT, FL 34287**	

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

0000 - Initial Comments

An unannounced emergency power plan monitoring and complaint survey CRR# 2018016257 was conducted on at Sweetwater Oaks, an assisted living facility (license #13083) in North Port, Florida.

The complaint contained 1 allegation which was substantiated with deficiencies.

The following is description of the deficiencies.

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

Based on record review and interview the facility failed to ensure 2 (Residents #6 and #7) of 3 legal representatives were contacted of any significant change in their condition.

The findings included:

1. On review of Resident #7's medical record revealed a resident progress note dated . It was written by the facility Manager stating when she checked Resident #7 that morning she found him with to his knuckles and arm. She placed a call to the Advance Registered Nurse Practitioner (ARNP), who ordered home health to address the to Resident #7's right , left arm and his unsteady gait. Further review revealed no documentation Resident #7's Health Care Surrogate was notified of Resident #7's with injuries and the physician order for home health services.

On at around 1:15 p.m., in an interview with Resident #7's Health Care Surrogate (HCS) and Power of Attorney (POA), she said while Resident #7 was at the facility she had multiple complaints about his overall care. When Resident #7 was discharged on to another facility they informed her Resident #7 had a with injuries on and it might be related to the 0.5 mg the ARNP had ordered for him on . She called the facility and spoke with Owner #1 and explained to him she was filing a grievance because she was never told about Resident #7's with injuries on , home health services for and unsteady his unsteady gate. She also told him she was never informed the ARNP had ordered 0.5 mg. for , three times a day.

Review of Resident #7's 1823 Health Assessment form dated noted the ARNP had ordered , ( ) 0.5 mg, an , medication to be given 3 times a day. There was no documentation the HCS/POA was notified the ARNP had ordered , an , medication for

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Resident #7 on .

On , around 2:00 p.m., in an interview with Owner #1 he said Resident #7's HCS/POA had called him a week after Resident #7 was discharged from the facility to file a grievance about not being notified of the with injuries and not being informed the ARNP had order 0.5 mg three times a day without her knowledge.

On at around 3:30 p.m., in an interview with the facility Manager, after reviewing Resident #7's medical records, she confirmed he had a with injuries on and was ordered home health services for injuries and unsteady gate. She also confirmed the ARNP had ordered for , on . She said they have no documentation the HCS/POA was notified of Resident #7's significant change in condition on and .

2. On review of Resident #6's medical records revealed she was admitted to the facility on . A physician order, dated , for , 25 mg, an , , medication daily. On the , 25 mg was increased to twice daily.
Further review of Resident #6's medical records revealed no documentation why , 25 mg was started on and increased to twice daily on . The last documented resident progress note in the medical records is dated . There is no documentation the POA was notified Resident #6 was started on , , an , , , medication on with several increases.

On at 4:35 p.m., in an interview with the facility Manager said after reviewing Resident #6's medical records she was started on , 25 mg on for an increase in her behaviors. She said due to an increases in her behaviors the , 25 mg was increased to twice daily on and the resident is currently receiving , 75 mg daily as noted on the medication observation report. The Manager said Resident #6 was exhibiting increased , , behaviors why the mediation was started and increased several times. She confirmed the last resident progress note is dated and there is no documentation the POA was informed of Resident #6 significant change in condition related to her , , behaviors requiring the start and increases of the , , an , , medication.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on interview and record review the facility failed to ensure they have a system in place to ensure residents and/or a representative filing a complaint/grievance were documented, investigated and

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resolved in a timely manner.

The findings include:

On review of Resident #7's medical record revealed a resident progress note dated written by the facility Manager stating when she checked Resident #7 that morning she found him with to his knuckles and arm. She placed a call to the Advance Registered Nurse Practitioner (ARNP) who ordered home health to address the to Resident #7 right , left arm and his unsteady gait. Further review revealed no documentation Resident #7's Health Care Surrogate was not notified of Resident #7's with injuries and the physician order for home health services.

On at around 1:15 p.m., in an interview with Resident #7's Health Care Surrogate (HCS) and Power of Attorney (POA), she said while Resident #7 was at the facility she had multiple complaints about his overall care. When Resident #7 was discharged on to another facility they informed her Resident #7 had a with injuries on and it might be related to the 0.5 mg medication, an , mediation with a effect, ordered by the ARNP on . She said she called the facility and spoke with Owner #1 and explained to him she was filing a grievance because she was never told about Resident #7 with injuries on and was never informed the ARNP had ordered 0.5 mg on without her permission or knowledge. She said as of this time no one from the facility has addressed her grievances/complaints as to why she was not notified of the and why the ARNP ordered 0.5 mg.

Review of Resident #7's 1823 Health Assessment form dated noted the ARNP had ordered , ( ) 0.5 mg an , medication to be given 3 times a day.

Review of the facility's Grievance Policy in their admission packet said they follow the Florida Statue 429.28 in receiving and responding to resident complaints. All grievances are addressed by the facility Manager or Administrator and if any grievance/complaint is not resolved by the facility they will be forwarded to the Ombudsman for resolution.

On at around 2:00 p.m., in an interview with Owner #1, he said Resident #7's HCS/POA had called him a week after Resident #7 was discharged from the facility to file a grievance about not being notified of the with injuries and not being informed the ARNP had order 0.5 mg three times a day. He said he did not document the grievance/complaint, their investigation related to the grievance and the resolution to the grievances as per their Grievance Policy. He said he had told the facility Manager of Resident #7's HCS/POA grievances and thought she had addressed the grievance.

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On at around 3:30 p.m. in an interview with the facility Manager, she said she was unaware Resident #7's HCS/POA had filed grievances related to not being informed of his with injuries on and not being notified the ARNP had ordered without her consent and knowledge. She said she was unaware they are required to document each grievance/complaint and the facility does not have a system in place to ensure a resident and/or their representative filing a grievance/complaint were documented, investigated and resolved in a timely manner.

Class III

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

Based on staff interviews and record review the facility failed to ensure they maintained an up-to-date admission and discharge log with the names of all residents with their admission date for 8 Residents (#1, #2, #3, #4, #5, #6, #7, and #8) of 8 residents. The facility failed to document the date of discharge, the reason for discharge and where each resident was discharged to, for 2 Residents (#7 and #8) of 2 discharged from the facility.

The findings included:

On review of the facility's record noted they do not have a log which documents when a resident is admitted to the facility and where they were admitted from for Residents #1, #2, #3, #4, #5, #6, #7, and #8. Resident #7 was discharged from the facility on and Resident #8 was discharged from the facility . Review of Resident #7 and #8's medical records and facility records revealed the facility did not document the date and the facility/place Residents #7 and #8 were discharged to as required.

On at 12:15 p.m., in an interview with facility Owner #1 and facility Manager, they said they were unaware they were required to maintain documentation/log which documented the date a resident is admitted to the facility and where they were admitted from and document when a resident is discharged from the facility and where they were discharge to. They said they did not document or log when and where each resident was admitted from for Residents #1 through #8 and did not document or log when Residents #7 and #8 were discharged and where they were discharge to as required.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on staff and resident interviews and record review the facility failed to ensure they had the

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required materials to implement their Emergency Power Plan (EPP) and notifying in writing each resident or their legal representative for 6 Residents (#1, #2, #3, #4, #5, and #6) of 6 residents of their Comprehensive Emergency Management Plan (CEMP) and EPP.

The findings included:

On a review of the facility's EPP, approved and implemented on , stated they would use portable air conditioning (A/C) units to cool the resident's rooms and living area. Two generators would be used to power the A/C units and the third generator will be wired into the electrical panel to power all the 110 volts outlets. The third generator would power the lights, refrigerator and ceiling fans. Each generator will be tested once a month and the facility will store the gas at the facility. The facility will store 96 hours of fuel on-site in gas containers outside in a shed. The policy continues to state, they would provide training procedure to the staff to ensure they know how to implement the emergency power plan and train the staff to empty fuel out of the generators to avoid crystallization and how to run the monthly generator tests.

On at around 9:30 a.m., during a facility tour with Owner #1 he said their EPP was approved and implemented on . During the tour of the facility all 3 generators were observed in their original packaging and there was no gas at the facility to test each generator or run the generators for the 96 hours as written in their EPP. Observation of the electrical panel noted it was not wired/updated as written in the EPP for the use of the third generator to power the 110 volts. Owner #1 said as written in their EPP they would place each portable A/C unit in each resident's room and living area. He said after searching the facility they do not have the required extension to power the A/C units and they would not be able to implement the EPP as written. Owner #1 also confirmed there was no gas at the facility to power the generators for testing or emergency use.

On at 11:30 a.m., in an interview with Resident #1, she said she has been living at the facility for over a year. She said she was never informed of the facility's CEMP or EPP and does not know what they would do in an emergency.

On at 11:55 a.m., in an interview with Resident #5, she said she has been living at the facility for several months. She said she was never informed of the facility's CEMP or EPP and does not know what they would do in an emergency.

On at 4:15 p.m., in an interview with Resident #5's son, he said he visits his mother weekly and is her legal representative. He said he was never informed of the facility's CEMP or EPP and was unaware they had generators and would use them to cool the facility in case of a power failure.

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On ... at 5:00 p.m., in an interview with the facility's Manager, she said none of the facility staff were trained on how to operate the generators or the A/C units as written in the EPP. She confirmed they do not have documentation that Residents #1, #2, #3, #4, #5 and #6 or their legal representatives were informed of the facility's CEMP and EPP. She further said was unaware they were required to inform the residents or their legal representatives of the facility's CEMP and EPP.

Class III