Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911412	A. BUILDING: _____ B. WING _____	R 10/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVEWELL AT COURTYARD PLAZA	15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments A revisit to a complaint investigation (# 2019014679) was conducted at Livewell at Courtyard Plaza on and concluded on . Deficiencies were identified at the time of the survey.	{A 000}		
{A 025} SS=D	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel	{A 025}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{A 025}	Continued From page 1 independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility continued to fail to provide care and services appropriate to meet the needs of two out of 35 sampled residents (Resident # 27 and # 35). Findings included: 1) A review of the facility's hospital list revealed Resident # 27 went to the hospital on and had not returned to the facility. On at approximately 12:30 PM, the Administrator stated that Resident # 27 was currently at the In-Hospice Unit at the hospital because the resident's had opened. On at 2:33 PM, an interview with Resident # 27's hospice nurse revealed that Resident # 27 was admitted to hospice on and during her initial nursing	{A 025}		

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{A 025}	Continued From page 2 assessment, she noticed a small [illegible] and described it as a "very small black dot". The nurse also stated that the resident had a [illegible] in the left area. On at 3:42 PM, Staff L stated that the hospice nurse had told her that the resident had breakage of the skin and provided care. Staff L was only aware of one of the [illegible] and stated that it was the responsibility of the Director of Nursing (DON) to review the hospice records. Staff L stated that she had no knowledge of the [illegible] in the [illegible] area. A review of Resident # 27's records revealed no documentation that the resident was receiving care prior to being admitted to hospice or any progress notes on the Resident's [illegible] before being admitted to hospice. 2) A review of Resident # 35's records revealed a progress note dated [illegible] stating "Resident left facility without signing out or notifying anyone. Police called". Further review revealed a hospital discharge summary document that stated it was unsafe to discharge the resident without proper supervision. On at 12:30 PM, the Administrator stated that Resident # 35 had just been brought to the facility by his friend. On at 12:38 PM, Resident # 35 stated "I just left. I told Staff O to release me and they didn't do anything. My doctor told me that I was going to be released. Staff L told me that someone had told her I was going to be released on the 11th. I left on at nighttime. I left from my room, out the window and jumped the fence	{A 025}		

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{A 025}	Continued From page 3 and the wall. I went straight home". A review of the facility's rounds document showed Resident # 35 was observed in the courtyard at 9 pm and observed in his bed sleeping at 11 pm on . A few minutes later, the same facility's rounds document was reviewed again and found that Staff N's documentation for at 11:00 PM, where the resident had been observed sleeping in his bed, had been erased. On at 2:13 PM, Staff L stated that she had erased Staff N's observation at 11:00 PM for Resident #5 because it was not true. She stated, "The resident was not here at 11:00 PM". On at 2:14 PM, Staff N stated that she did not see the resident in his room when she went on at 10 PM. She stated she had returned to his room at 10:30 PM, but the resident was still not in the room. She also stated she did not turn on the light to check but informed the night shift before she left. Staff N then stated that she did not tell anyone else because the resident was not the type to elope. She also stated that she kept calling the facility on her way home and asked them to check the TV room. Class III Uncorrected	{A 025}		
{A 027} SS=G	58A-5.0182(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making and	{A 027}		

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{A 027}	Continued From page 4 remind residents about scheduled for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a health care provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to assist one out of 35 sampled residents with arrangement for healthcare services for (Resident # 27). Resident # 27 had an and and no documentation of care services provided prior to the resident's enrollment in hospice services. Findings Included: A review of the facility's hospital list revealed Resident # 27 went to the hospital on and had not returned to the facility at the time of the inspection. On at approximately 12:30 PM, the Administrator stated that Resident # 27 was currently on the Hospice Unit at the hospital because the resident's had opened. A review of Resident # 27's health assessment dated showed she was diagnosed with , and Gait (disturbance). The health assessment also stated	{A 027}		

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{A 027}	Continued From page 5	{A 027}		

that the resident required total assistance with ambulation and used a wheelchair, required assistance with bathing, [illegible], self-care (grooming), toileting, transferring, and could eat independently. A physician's examination conducted at the facility on showed that the resident had "significant decline in function, non-ambulatory, increasing , rapid decline". The physician's note stated that the resident was referred for hospice evaluation. There was no documentation of how the resident's inability to ambulate was addressed by facility staff between [illegible] and [illegible]. There was no documentation of an updated health assessment, and no notes regarding the resident receiving any or increased assistance with activities such as toileting, changing of the adult briefs, or repositioning.

On at 2:33 PM, an interview with Resident # 27's hospice nurse revealed that during an initial nursing assessment on , the nurse noticed a small [illegible] and described it as a "very small black dot". The nurse also stated that the resident had a [illegible], on the left area. The nurse stated she was unsure if the resident was receiving any care. Further review of the hospice assessment showed that on [illegible], the resident was identified as and wearing adult briefs.

Further review of Resident # 27's record and facility records showed no documentation that Resident # 27 had received any [illegible] care prior to being admitted to hospice care on .

A review of Resident # 27's hospice records showed she was admitted to hospice on [illegible] and diagnosed with and

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{A 027}	Continued From page 6 . . . . . An Interdisciplinary Plan of Care Revision form dated showed a note stating, ' . . on L (left) . . . . ' and ' pressure injury on '. A review of the hospice records showed other documentation of the . A review of the facility record showed no documentation of any , and described only that the resident was receiving hospice services. On . . . . . at 3:42 PM, Staff L stated that the hospice nurse had told her that the resident had breakage of the skin and provided . . . . care. Staff L stated she was only aware of one of the . . . . . on the left . . . . . area and that it was the responsibility of the Director of Nursing (DON) to review the hospice records. Staff L also stated that she had no knowledge of the in the . . . . area. On . . . . . at 4:15 PM, an interview with the ARNP (Advanced Registered Nurse Practitioner) revealed that her first assessment was completed on after being notified by the hospice nurse that one of the . . . . were not improving. The ARNP stated "I went to the ALF on for the first time. She had an . . . injury on the up to 2 by 2cm and 100% and with moderate . . . . We put treatment and then on , I went to the facility again to see if the . . . care was working and the new treatment I put. The started to debride. At that time, the . . . . was 2 by 2 by 5. She spends all day in her wheelchair and her . . . . care plan is 2 times a week or PRN (as needed) and reposition her every 15 minutes when she is in the wheelchair and every 2 hours if she is laying down in bed. She has a in the left . . . . . which was 1 by 1, but by the second visit on . . , it was no longer there".	{A 027}		

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{A 027}	Continued From page 7 She also stated that if Resident # 27 had an prior to being admitted to hospice, she should have been receiving care. Class II Uncorrected	{A 027}		
A 032 SS=D	58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(i) Resident Care - Elopement Standards 58A-5.0182 (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 58A-5.0181(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 58A-5.0191(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times.	A 032		

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A 032	Continued From page 8 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and 429.41(1)(l), F.S. 429.41(1)(a)3 & 3(l),FS 3. Resident elopement requirements.-Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills which shall	A 032		

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A 032	Continued From page 9 include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the drills are conducted in a manner consistent with the facility's resident elopement policies and procedures. (l) The establishment of specific policies and procedures on resident elopement. Facilities shall conduct a minimum of two resident elopement drills each year. All administrators and direct care staff shall participate in the drills. Facilities shall document the drills. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to follow its policies and procedures regarding elopement when one out of 35 sampled residents was missing from the facility (Resident # 35). The resident was missing for at least three hours before the police were contacted. Findings included: A review of the online Adverse Incident Reporting System (AIRS) revealed a report was filed on regarding Resident # 35 eloping from the facility on . Further review of the report revealed that "Resident left the facility at approximately 11:15 pm without following policy and did not sign out. Nursing assistant observed upon rounding the resident had left the facility without signing out. This resident placed a chair near his window, opened window and pushed the screen out where he jumped from the first floor and fence". A review of the facility's Resident Elopement Policy and Procedure stated, 'Any staff member who is unable to locate a resident after checking the temporary absence log verify the general	A 032		

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A 032	Continued From page 10	A 032		

whereabouts of the resident, must immediately notify the Administrator or Designee, irrespective of the time of day". Further review of the policy and procedure stated 'The preliminary inside search efforts should last no longer than 10 - 15 minutes and expand to outside which should last no more than minutes. If the resident is not found and expanded the search to side streets and main roads lasting no more than 10 - 15 minutes if the resident is not found law enforcement is to be called'.

A review of Resident # 35's health assessment dated and showed he was diagnosed with , Left Parietal , and Intraparenchymal . The health assessment also stated that Resident # 35 had memory and 'remembered few details of his life'. In addition, the assessment showed Resident # 35 needed to be in a safe and structured environment. He was independent in all of his Activities of Daily Living (ADL) and required assistance with self-administration of medication.

On at 12:30 PM, the Administrator stated that Resident # 35 had just been brought to the facility by his friend.

On at 12:38 PM, Resident # 35 stated "I just left. I told Staff O to release me and they didn't do anything. My doctor told me that I was going to be released. Staff L told me that someone had told her I was going to be released on the 11th. I left on at nighttime. I left from my room, out the window and jumped the fence and the wall. I went straight home".

On at 1:15 PM, an interview with a

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A 032	Continued From page 11 police officer revealed that the Administrator contacted the police on at 1:11 AM and stated a resident was missing. A review of the facility's rounds document showed Resident # 35 was observed in the courtyard at 9 pm and observed in his bed sleeping at 11 pm on . A few minutes later, the document was reviewed again and found that Staff N's documentation for at 11:00 PM had been erased. On at 2:13 PM, Staff L stated that she had erased Staff N's observation at 11:00 PM for Resident #35 because it was not true. She stated, "The resident was not here at 11:00 PM". On at 2:14 PM, Staff N stated that she did not see the resident in his room when she went on at 10 PM. She stated she had returned to his room at 10:30 PM, but the resident was still not in the room. She also stated she did not turn on the light to check but informed the night shift before she had left. Staff N then stated that she did not tell anyone else because the resident was not the type to elope. She also stated that she kept calling the facility on her way home and asked them to check the TV room. On at 3:33 pm, the Administrator stated that she received a call at approximately 11:47 pm and the police were contacted at 1:11 AM. The Administrator also stated that Staff L and herself wanted to arrive to the facility first and search for the resident before contacting the police. Class II	A 032		

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{A 162}	Continued From page 12	{A 162}		
{A 162} SS=D	58A-5.024(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name; 2. ; 3. Race; 4. Date of birth; 5. Place of birth, if known; 6. Social security number; 7. Medicaid and/or Medicare number, or name of other health insurance ; 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in Rule 58A-5.0181, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider ' s order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 58A-5.020, F.A.C., if applicable. (e) The resident care record described in paragraph 58A-5.0182(1)(e), F.A.C. (f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually.	{A 162}		

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{A 162}	Continued From page 13 (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 58A-5.0181, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 58A-5.0185, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 58A-5.025, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , ( ), CF-ES 1006, , , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy,	{A 162}		

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	AL11911412	A. BUILDING: _____ B. WING _____	R 10/25/2019

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{A 162}	Continued From page 14 guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 58A-5.0181, F.A.C. (o) The resident's [illegible], DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement; 2. The resident demographic data required in this paragraph; 3. The health assessment described in Rule 58A-5.0181, F.A.C.; 4. The resident's contract described in Rule 58A-5.025, F.A.C.; and 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029,	{A 162}		

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{A 162}	Continued From page 15 58A-5.030 and 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to verify all information was completed and updated after a significant change on the resident's health assessment for two out of 35 sampled residents (Resident # 27 and # 34) . Findings Included: Review of Resident # 27's records showed a health assessment dated [redacted] with diagnoses of [redacted], and Gait. Further review of Resident # 27's records revealed a hospice document stating she was admitted to hospice on [redacted] under the diagnosis of [redacted] and [redacted]. There was no documentation of an updated health assessment that stated Resident # 27 was nonambulatory, and receiving hospice services. A review of Resident # 34's health assessment dated [redacted]/8 did not indicate anything about what kind of diet the resident needed. On [redacted] at 2:20 PM, the Administrator acknowledged Resident's # 27's and # 34's health assessment was incomplete and not updated. Class III Uncorrected	{A 162}		
A 163 SS=D	429.49 FS Records - Resident, Penalties for Alteration Resident records; penalties for alteration.-	A 163		

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A 163	Continued From page 16 (1) Any person who fraudulently alters, defaces, or falsifies any medical or other record of an assisted living facility, or causes or procures any such offense to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. (2) A conviction under subsection (1) is also grounds for restriction, suspension, or termination of license privileges. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain resident records without alteration or falsification for one out of 35 sampled residents (Resident # 35). Findings included: Record review on at 2:05 PM revealed a two-hours round checklist completed by Staff N for 'Section C - Third shift from 11 PM to 7 AM'. Staff N had documented Resident #5 was 'in bed/sleeping' on at 11:00 PM. A few minutes later, the document was reviewed again. During the review, it was revealed that Staff N's documentation for at 11:00 PM had been erased. On at 2:13 PM, Staff L stated that she had erased Staff N's observation for Resident #5 at 11:00 PM because it was not true. She stated, "The resident was not here at 11:00 PM". On at 2:14 PM, Staff N stated that she did not see the resident in his room when she went on at 10 PM. She stated she had returned to his room at 10:30 PM, but the resident was still not in the room. She also stated she did	A 163		

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A 163	Continued From page 17 not turn on the light to check but informed the night shift. Staff N then stated that she did not tell anyone special because the resident was not the type to have eloped. She also stated that she kept calling the facility on her way home and asked them to check the TV room. Class III	A 163		
{A 165} SS=D	429.23(&) FS; 58A-5.0241 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives;	{A 165}		

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{A 165}	Continued From page 18 6. Any condition that requires 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; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and	{A 165}		

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{A 165}	Continued From page 19 determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The Department of Elderly Affairs may adopt rules necessary to administer this section. 58A-5.0241 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1) above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility continued to fail to submit an adverse incident report within 15 days of the incidents to the state for two out of 35 sampled residents (Residents #	{A 165}		

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{A 165}	Continued From page 20 2 and # 3). Resident # 2 was sent to the hospital with a black , after being assaulted by Resident # 3. Resident # 3 had a history of aggressive behavior and local law enforcement was involved. Findings included: On . . . . at 11:35 am, an interview with Resident # 2 revealed that he was recently in the hospital because he was punched in the , . by a resident. Resident # 2 stated that he does not recall who the resident was and does not remember much of what happened. A review of the facility's records revealed an internal incident report dated at 2:30 PM stating that "Resident was struck by another resident (Resident # 3) while in the courtyard". In the section titled 'Action taken to prevent recurrence', it stated, "Resident sent to the hospital for evaluation for , . The police was contacted and visited. The aggressor was sent to the hospital crisis department for evaluation and medication management". A review of the facility's records revealed an internal incident report dated at 2:30 PM stating that "Resident struck and shoved another resident (Resident # 2) for blowing smoke into his . . . . Both residents were sitting in the courtyard. Contacted Miami-Dade police. In the section titled 'Action taken to prevent recurrence', it stated, Miami - Dade Police contacted and visited. Resident was sent to hospital crisis for evaluation and treatment'. On at 1:32 pm, the DON (Director of Nursing) stated the administrator was responsible for reporting/filing adverse incident reports and	{A 165}		

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{A 165}	Continued From page 21 that the administrator was aware of the altercation. On at 2:46 pm, the DON stated "In front of the cops I let him know that in no circumstances this is allowed. I told him that verbal communication is the most effective way to solve an issue and not take any action upon himself. After that, we sent him to Crisis for Evaluation. Informed the hospital of the incident and evaluation for behavior and possible adjustment to medications. Psych did not change anything for crisis. He does not have an assigned PCP. I'm unsure if he's had an , , . I would have to check." On during a revisit, a review of the state's Adverse Incident Reporting System revealed no reports were still not filed for the incident that occurred with Resident # 2 and # 3. On at 2:09 pm, the Administrator stated that the previous administrator was supposed to have done it before she left but that she'd complete them . Class III Uncorrected	{A 165}		