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
	AL11969271	A. BUILDING: _____ B. WING _____	11/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE SENIOR LIVING	2100 10TH AVE VERO BEACH, FL 32960

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A 000	Initial Comments An unannounced licensure complaint survey, Complaint #2019016898 was conducted on through at Renaissance Senior Living. The facility was not found to be in compliance during this visit.	A 000		
A 165 SS=G	429.23(&) FS; 59A-36.016 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; 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	A 165		

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A 165	Continued From page 1 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 determine whether it potentially involved conduct by a health care professional who is subject to	A 165		

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A 165	Continued From page 2 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 agency may adopt rules necessary to administer this section. 59A-36.016 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 observation, record review and interview, the facility failed to report to the Department of Children and Families (DCF) when knowing or suspecting that 1 out of 1 resident (resident #1) was physically and	A 165		

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A 165	Continued From page 3	A 165		

by a facility staff member (staff A). The facility also failed to require its staff to report events of resident , neglect or directly to DCF which potentially placed the residents at risk for harm.

The findings are:

In an interview with the DCF investigator on at 8:35am, she stated that during her investigation to determine if Resident #1 was in the facility on , she viewed a video kept by the facility Administrator which displayed staff A roughly removing Resident #1's pants while changing his clothes; Staff A stomping on the resident's while the resident sat on the side of the bed and having the resident lie on the floor while Staff A removed the bedsheets from the resident's bed. She stated that this video recording was arranged by the resident's family members so the family may monitor the resident's care while he was in his bedroom. She stated, that the video intermittently recorded approximately 10 seconds of footage along with periods of no recordings of approximately 1 minute in between, which made it difficult to see the continuity of Staff A's actions, yet it was obvious and visible that staff A of resident #1 with the recorded footage provided.

In an interview with the Administrator on at 10:55am, he stated that the facility underwent an event of resident on which involved Resident #1 and Staff A. He stated that Resident #1's daughter called Nurse A on at or about 10:30pm to notify her that after viewing the resident's bedroom video dated from at 7:26pm to at 7:43pm, it was evident that staff A physically and verbally

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A 165	Continued From page 4	A 165		

abused the resident by roughly removing the resident's pants. Staff A was observed stomping on the resident's [illegible] while the resident sat on the side of the bed and by having the resident lie on the floor while Staff A removed the bedsheets from the resident's bed. He stated that Nurse A notified him of Resident #1's daughter's description of Staff A's actions towards Resident #1 on [illegible] at or about 10:45pm and that he ordered for Nurse A to immediately perform a nursing assessment on resident #1. He stated that on when he learned of this event, Staff A was in process of leaving the facility since her shift ended at 11:00pm. He stated that Nurse A reported to him after performing her nursing assessment on , that the only remarkable finding was that the resident had minimal [illegible] on his right ankle and [illegible]. He stated that the resident was placed on hourly checks by the staff from [illegible] at 11:00pm until the resident was discharged to the inpatient hospice unit on . He stated that when he arrived to the facility in the morning of , he performed a nursing assessment himself, which had similar findings as Nurse A's assessment, and he asked the physician to order [illegible] ankle and [illegible]. He stated that he viewed the video which was provided by the resident's daughter on [illegible] and it accurately represented what was described to him by nurse A. He stated that the hospice nurse also evaluated Resident #1 during the afternoon on [illegible] and found that he had [illegible] with [illegible] grimacing and his right was [illegible] and with [illegible]. He stated that the hospice nurse additionally asked for physician order of , and [illegible] due to increased [illegible] behaviors. He stated that all the ordered for Resident #1 resulted in negative findings for [illegible] and that the resident was placed on

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A 165	Continued From page 5 additional medication by hospice, and the resident was discharged to the inpatient hospice unit on . In an interview with the Administrator on at 11:05am, he stated that he called the local police department in the morning of to report Staff A's actions towards Resident #; a Police Officer arrived onsite shortly thereafter. He stated that the Police Officer also viewed the video that captured Staff A being towards Resident #1 and this police officer submitted this case for a police detective investigation. He stated that the Police Officer told him that the police department will contact DCF and that he felt that he nor any other staff member needed to contact DCF at that time to report to DCF this resident event. He stated that he was certain that no other staff member contacted DCF for this event. He stated that on , Resident #1's wife notified the facility that the resident , in the hospice unit on . In an observation of the video on at 12:50pm, the recorded video was time stamped on at the following times. At 7:26pm, Resident #1 was side lying and resting on his bed. At 7:28pm, Staff A was abruptly pulling off the resident's pants while he was side lying on the bed and the resident said "stop it"; at 7:30pm, Staff A stomped down on the resident's left while the resident was sitting on the side of the bed and said "no, no, no. At 7:31pm, the resident was side lying on the floor without any pants or shorts, approximately 4 away from the bed while staff A was taking the bedsheets from the be. At 7:33pm, Staff B entered the bedroom and staff was verbally protesting how the resident's from his movement was	A 165		

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A 165	Continued From page 6 everywhere. At 7:34pm, Staff B assisted the resident to sit on the chair next to his bed and Staff A was verbally complaining how the resident put himself on the floor and will not stand up. At 7:35pm, Staff A and B were assisting the resident with . At 7:36pm, the resident was fully dressed and standing next to the bed with Staff A and B; and at 7:43pm, the resident was sitting on the chair next to his bed. In an interview with the Director of Nursing on at 1:10pm, she stated that Staff B resigned from the facility on . She stated that the facility staff members are required to report any knowledge or suspicion of resident or neglect to their supervising nurse and this supervisor was then required to report this to the Administrator. She stated that Staff B having found Resident #1 on the floor on while Staff A protested about the resident's behavior may be interpreted as a suspected act of or neglect. She stated that Staff B did not report Resident #1 being found on the floor on to any supervisor and the reason how Nurse A found out about Staff A's actions towards Resident #1 was because the resident's family had a video camera inside the resident's room and the family member reviewed the video recording which indicated that staff A physically and , the resident, and then reported this to nurse A. In an interview with the Police Department Detective on at 1:25pm, he stated that Resident #1's autopsy was scheduled with the medical examiner for tomorrow, and that he intended to participate in this autopsy with the medical examiner. Review of Resident #1's Nursing notes dated on	A 165		

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A 165	Continued From page 7 at 11:30pm, indicated that the resident had no , his right large was discolored and right was painful upon palpation. Review of the resident's diagnostic imaging conducted on indicated that the were negative for , or . Review of Resident #1's health assessment dated on indicated that he was diagnosed with . Review of this health assessment indicated that the resident received hospice care and needed assistance with all of his activities of daily living. In an interview with Resident #1's family member on at 2:00pm, she stated that she was allowed by the facility to place a camera inside the resident's room and that on , she discovered that Staff A physically and the resident by reviewing the video recording. She stated that she felt that this event affected the resident's physical function because he was able to walk independently before the event and not afterwards. She stated that the resident's right became and painful after a day of the event and the resident was not able to stand without assistance. In an interview with Staff C on 11- at 2:25pm, she stated that if and when she was presented with knowledge or suspicion of any resident being abused or neglected by any person, she would immediately report this to her supervising nurse and she will then provide a written account of this report. She stated there were no more steps for her to follow to report resident or neglect and that she did not know the DCF hotline telephone number.	A 165		

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A 165	Continued From page 8 In an interview with Staff D on 11- at 3:25pm, she stated that if and when she was presented with knowledge or suspicion of any resident being abused or neglected by any person, she would immediately report this to her supervisor or the administrator and she will then provide a written account of this report. She stated there were no more steps for her to follow to report resident . . . . . or neglect and that she did not remember the specific prevention training she received at the facility. She stated that she did not know the DCF hotline telephone number. In an interview with Staff E on 11- at 3:40pm, she stated that if and when she was presented with knowledge or suspicion of any resident being abused or neglected by any person, she would immediately report this to her supervising nurse. She stated there were no more steps for her to follow to report resident or neglect and that did not know the DCF . . . . . hotline telephone number. In an interview with Staff F on 11- at 6:30pm, she stated that if and when she was presented with knowledge or suspicion of any resident being abused or neglected by any person, she would immediately report this to her supervising nurse. She stated there were no more steps for her to follow to report resident or neglect and that she did not know the DCF . . . . . hotline telephone number. In an interview with Staff G on at 6:50pm, she stated that if and when she was presented with knowledge or suspicion of any resident being abused or neglected by any person, she would immediately report this to her supervising nurse. She stated there were no	A 165		

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A 165	Continued From page 9 more steps for her to follow to report resident or neglect and that she did not know the DCF hotline telephone number. In an interview with Nurse A on 11- at 7:15pm, she stated that Resident #1's family member called her on at around 10:30pm to report that Staff A was seen physically and verbally abusing the resident on video, earlier that evening. She stated that immediately after speaking with the resident's family member, she contacted the director of nursing and the administrator to notify them of this event. She stated that the administrator instructed her to perform a thorough nursing assessment of the resident and to contact the resident's physician, which she immediately did on . She stated that the resident presented to be in the same clinical condition as usual, with the exception of having minimal , to his right . She stated that the resident was placed on hourly checks on . Review of the undated facility prevention, neglect and , policies and procedures (undated) indicated that the facility had zero tolerance and every staff member is responsible for implementing these policies and procedures. Review of this document indicated that every staff member must know the DCF hotline telephone number and must report any knowledge or suspicion of resident , neglect or , to the administrator immediately. Further review of this document indicated that all staff members are mandatory reporters. In an interview with Staff H on 11- at 9:45am, she stated that if and when she was presented with knowledge or suspicion of any	A 165		

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A 165	Continued From page 10 resident being abused or neglected by any person, she would immediately report this to her supervising nurse and the chain command will reach to the Administrator. She stated that she will attempt to not get too involved after this report reached the Administrator. She stated there were no more steps for her to follow to report resident or neglect and that she was aware that there was a poster with the DCF hotline telephone number on it, but she did not readily know this number. She stated that she would seek to find this number to call if administration did not respond to her initial resident or neglect report within 24 hours. In an interview with the Administrator on at 11:25am, he stated that based on the facility prevention policies and procedures, each staff member has an individual choice of reporting knowledge or suspicion of resident or neglect to DCF, and that the staff must report this to their supervisor. He stated that during this event involving staff A and resident #1, no staff members had to report this directly to DCF as long as the staff reported this to their supervisor, the supervisor reported this event to him, he reported this to the police, and the police told him that they were going to contact DCF for this event. He stated that he felt that this indirect reporting method to DCF for resident or neglect events was compliant with facility rules and State regulations. In an interview with the Director of Clinical Support on at 11:30am, she stated that based on facility polices and procedures, any staff members not knowing the DCF hotline telephone number is potentially not in compliance with said policies and procedures.	A 165		

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A 165	Continued From page 11 In an interview with the Administrator on [redacted] at 11:40am, he stated that he did not report to DCF the event involving Staff A and resident #1 because he was in process of gathering information for the facility's investigation and the facility made sure that the resident was safe after this event on [redacted]. He stated that if he would have known that the police department personnel did not contact DCF on or by [redacted], he would have contacted DCF at that point in time to report this event. Class II	A 165		