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
	AL11968805	A. BUILDING: _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE BONITA SPRINGS	11400 LONGFELLOW LN BONITA SPRINGS, FL 34135

(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 An unannounced complaint survey for #2019009991, #2019010324, #2019010284 and #2019004848 was conducted through at American House Bonita Springs, an assisted living facility in Bonita Springs, Florida. Complaint #2019009991 and #2019010324 were substantiated at tag A0030 Resident Rights, A0077 Administration and A0165 Risk Management at class 1s. Compliant #2019010284 and #2019004848 were unsubstantiated. The following is description of the deficiencies.	A 000		
A 025	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,	A 025		

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A 025	Continued From page 1 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 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 staff interview, the facility failed to provide supervision/oversite to prevent the continuing aggression and physical violence to 8 (Residents #2, #4, #5, #6, #7, #8, #9, and #10) of all Memory Care Unit residents from [redacted] to [redacted]. Continued exposure to physical and [redacted] placed the residents of the memory care unit in imminent danger. The findings included: 1. Record review of Resident #1's chart revealed	A 025		

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A 025	Continued From page 2 he was admitted on [redacted] with [redacted], memory and [redacted] and sundowns noted on the Health Assessment 1823 Form. He was discharged on [redacted]. Resident #1 was documented as physically punching, hitting, or shoving residents, family, facility or hospice staff on [redacted], twice on [redacted], [redacted], twice on [redacted], [redacted], and [redacted]. Resident #1's progress notes from admission to discharge were reviewed and the following instances of [redacted] misbehavior, physical assaults and threats to residents, families, and staff were documented: 5:08 p.m., Medication Technician (MT) Staff B note: "[Resident #1] punched [Resident #4] in his side no I didn't witness it but the other residents did and also [Resident #1] says to me he hit the guy fast in his side with a closed fist." 7:23 p.m., MT Staff B note: "he [Resident #1] was sleeping on the couch and I tap him and ask him to get up and let's get in his bed and he told me don't f in touch him and he don't have no bed in here and he can sleep on the couch and he also got in [female staff's] [redacted] with his fist balled up. [Former Director of Memory Care Staff E] is not here at the moment for me to tell her about it but I did let her know earlier when he punched [Resident #4] in the side." [redacted] 4:44 p.m., former Director of Memory Care Staff E note: "Spoke with Resident [#1's] daughter [name] reg [regarding] resident behavior including hitting another resident...Will monitor resident behavior and contact daughter as she will schedule if needed a visit with psychiatrist [name] at VA [veteran's administration (VA)]."	A 025		

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A 025	Continued From page 3	A 025		

. . . 11:05 a.m., Resident Assistant ( ) Staff D note: "resident [#1] walking up to [female] medtech from behind trying to rub her bottom. This writer and medtech let him know he can't touch staff or other residents. resident [#1] replied its his. And tried to walk into [Resident #5's] room. staff redirects him resident [#1] continues to go to her room."

1:13 p.m., Staff D note: "resident [#1] has been trying to go into female residents' rooms all shift. he is attracted to [Resident #5's] room. resident [#1] constantly pushing her [Resident #5's] door saying to let him in. [Resident #5] opened room door and tried to kick resident [#1]. [Resident #1] yelled profanity and for her to stop hitting him. Staff tried to redirect resident [#1] multiple times resident [#1] continues to go to [Resident #5's] room.

. . . 10:00 p.m., former Director of Memory Care Staff E note: "Spoke with Resident's [#1] daughter [name] informed of .... as well as informed of resident's [#1's] inappropriate behavior. Daughter informed this writer [Resident #5] looks a lot like resident's [#1's] wife. Will monitor resident's behavior and let daughter know..."

1:53 p.m., Staff D note: "resident [#1] keeps touching female staff and female residents on bottom and grabbing by the trying to kiss them. Staff let resident [#1] know he can't do that. female residents yelling for him to go away. [Resident #1] tried to take [Resident #2] in his room to lay in bed together. staff redirected them. [Resident #1] became upset grabbing [Resident #2] by the stating she is his and she can get in bed. staff had to lock rooms due to resident [#1] keeps going in female residents' rooms."

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A 025	Continued From page 4	A 025		

4:20 p.m., former Director of Memory Care Staff E note: Spoke with daughter [name] reg [regarding] resident's [#1's] behavior daughter informed this writer she will notify [name] psychiatrist at VA ... She will also notify pcp [primary care physician]."

5:51 p.m., former Director of Memory Care Staff E note documented she spoke with Resident #1's daughter regarding Residents #1's behaviors. The daughter agreed to contact the psychiatrist regarding resident behavior and sleeping disturbance.

2:11 p.m., former Director of Memory Care Staff E note documented she called Resident #1's daughter again regarding Resident #1's behavior with female residents, and not eating or sleeping.

1:26 p.m., Staff D documented Resident #1's behavior of following female residents into their rooms and trying to pull on their doors. Reports the female residents are upset he won't leave them alone.

10:23 a.m., Staff D documented Resident #1 behaviors towards female staff and female residents.

10:45 a.m., former Director of Memory Care Staff E documented being informed by staff of Resident #1's behaviors towards female residents and female staff. FDMC Staff E contacted the daughter to come for a visit.

1:45 p.m., Staff D documented Resident #1 was , inappropriate with Resident #6 and trying to touch her. "Resident #6

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A 025	Continued From page 5 in corner of her room in chair crying and stated he won't leave me alone. Resident #1 standing over her stating he doesn't know what's wrong with her he just wants her to sit on his . ." 1:16 p.m., Staff D documented Resident #1 continued to be . . . . , inappropriate to female residents and female staff. . . . . 9:23 a.m., . . Staff D documented Resident #1 in appropriate . . behavior with female residents and going into women's rooms. The female residents continue to yell for help while the resident was disrobing and asking for "right now." 6:00 a.m., Staff D documented Resident #1 found in only his underwear on and had his "private area" out and was trying to talk a female resident into touching his "private area." . . . . 1:20 p.m., Staff D documented Resident #1's continued . . . . misconduct toward female staff. . . . . 11:51 a.m., MT Staff F documented Resident #1 hit female Resident #7's when she tried to get Resident #1 out of her room. . . . . 11:54 a.m., MT Staff F documented Resident #1 hit another female resident's and she screamed at him. . . . . . 1:56 p.m., Staff D documented Resident #9 was yelling for help when Resident #1 had female Resident #9 physically by the , would not release her and threatened to hit her.	A 025		

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A 025	Continued From page 6 . . . . . 6:59 p.m., MT Staff B documented Resident #1 hit his roommate Resident #8. 8:24 p.m., Medical Doctor (MD) documented Resident #1 was seen as staff reported Resident #1 had " a family member and a resident." . . . . . 9:41 p.m., MT Staff B documented Resident #1 has tried to get into bed with his roommate Resident #8. Resident #8 was heard saying "man what the hell are you doing." Resident #8 is really scared, asking for protection so was removed from the room. 11:23 p.m., former Director of Memory Care Staff E documented she spoke to Resident #1's daughter about his aggressive behavior toward his roommate. . . . . . 4:53 p.m., Senior Health and Wellness Director (SHWD) note: documented the psych RNP made medication changes. . . . . . 10:44 a.m., . Staff D documented Resident #1's attempt to hit his roommate Resident #8's . . . ., then his continued physical aggression and verbal threats. 10:51 a.m., Staff D documented Resident #1's continued physical aggression and shoving of the roommate Resident #8. 11:36 a.m., former Director of Memory Care Staff E documented Resident #1 was aggressive with her and attempting to hit her. 11:36 p.m., 3:43 p.m., former Director of Memory Care Staff E documented continuing discussions with Resident #1's daughter	A 025		

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A 025	Continued From page 7 regarding medication dosing. . . . . . 6:10 a.m., Staff D documented Resident #1 being found in bed with male Resident #10. Staff made multiple attempts to remove Resident #1 from Resident #10 bed and room. . . . . . 6:10 a.m., Staff D documented Resident #1 was combative and declined to sleep. Resident #1 was found in male Resident #4's room asleep in recliner. When awoken to redirect became combative and threatening again. 9:25 a.m., Staff D documented Resident #1 became agitated and jumped up off sofa and hit a female resident in her and grabbed her by both . . . . 11:24 a.m., former Director of Memory Care Staff E documented Resident #1's daughter informed of resident hitting and grabbing of a female resident. The FDMC Staff E agreed for the daughter to pick the resident up for the day. 7:21 p.m., MT Staff C documented Resident #1 was verbally threatening to "slap the hell out of me." . . . . 7:28 p.m., MT Staff B documented Resident #1 was in found in female Resident #7's room. The female resident was yelling for help and yelling at Resident #1. 2:32 p.m., MT Staff B documented Resident #1 was is yelling, screaming and getting in everyone's yelling. 6:52 p.m., MT Staff B documented	A 025		

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A 025	Continued From page 8 Resident #1 was found in a female resident bed. The female was telling him to get out and was scared and shaking. . . . . 7:20 p.m., Licensed Practical Nurse (LPN) Staff G documented Resident #1 was nude laying in female resident's bed. The daughter was called to talk him out of the room. 9:10 a.m., MT Staff B documented Resident #1 was yelling at another resident and Resident #8, roommate, is saying he scared and Resident #1 is a bully. Resident #8 was requesting staff to call the police. 9:48 a.m., Staff D documented Resident #1 was kicking and punching the doors of female residents who refused to let him in their room. Resident #1 was making fists and punching towards staff. 1:21 p.m., Staff D documented Resident #1 continued to be physically aggressive to hospice staff, facility staff and other residents then began making . . . . remarks to the female residents. 1:46 p.m., Staff D documented Resident #1 grabbed a female resident by the and then turned the aggression on the staff and could not be re-directed. . . . . 6:57 a.m., Staff D documented Resident #1 had his roommate (Resident #8) by the . . . , punching him while Resident #8 was lying in bed. Staff separated, but Resident #1 continued to be aggressive so was "sent to 'A' side to be separated." 1:50 p.m., Staff D documented	A 025		

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A 025	Continued From page 9 Resident #1 continued his aggression but directed toward female Resident #2 and then staff, when they attempted to intervene. 2:05 p.m., SHWD documented contacted the daughter to discuss the aggression. The daughter agreed to a psych nurse consult for medication changes. 9:47 a.m., MT Staff B documented she intervened in aggression from Resident #1 towards his roommate Resident #8 and separated them. 9:53 a.m., MT Staff B documented Resident #1 was pursuing female Resident #5, who was yelling at him to stay out of her room. Staff had to intervene. 4:18 p.m., MT Staff B documented Resident #1 was again physically threatening his roommate, Resident #8 and running to the female residents who are yelling at him to leave them alone. 8:06 p.m., LPN Staff F documented Resident #1 had punched a staff member. 8:48 p.m., MT Staff C documented Resident #1 was combative with other residents and redirecting was not working. 6:17 p.m., MT Staff B documented Resident #1 was trying to move the couch going to all the room doors shaking the handles. 5:15 p.m., HWD documented Resident #1 was having aggressive behavior with staff and other residents. The Psych ARNP was told Resident #1 was having more aggressive	A 025		

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A 025	Continued From page 10 behavior around 5pm. Medications adjusted. . . . . . 3:31 p.m., MT Staff C documented Resident #1's continued aggressive by grabbing other resident's arms and making a closed fist at them. Residents are continuously afraid of Resident #1. . . . . 4:50 p.m., HWD documented Resident #1 hit another resident on the ⌄ and redirecting Resident #1 was not working. The daughter was called and asked to come get him. 5:00 p.m., HWD documented Resident #1 continued agitation and inability to redirect. this morning. The psych nurse was contacted adjusted medications. . . 10:38 a.m., MT Staff C documented Resident #1 hit another resident in the cheek when she "wouldn't let him in her room." . . . . 11:00 a.m., HWD documented Administration met to discuss care of Resident #1 and his physical aggression. "Decision was made to give family a 45-day notice and [Resident #1] could only come . . with a 24hr [24 hour] private caregiver." 10:14 p.m., HWD documented "daughter decided to move resident out of facility as she is unable to provide 24-hour private duty." 2. On at 1:30 p.m., during an interview the HWD said she was fairly new to the facility and hadn't been aware Resident #1 had been having these behaviors since he arrived at the facility. On at 1:33 p.m., during an interview the	A 025		

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A 025	Continued From page 11 SHWD said in regard to Resident #1's behaviors, they would contact Resident #1's daughter, he would see his doctor and medication changes were made. On at 12:19 p.m., during an interview the SHWD said she was speechless when the progress notes were reviewed the day before. SHWD said she accepts fault for this as she should have been reading all of memory care notes. SHWD said she hadn't been doing so as there was a Licensed Practical Nurse who was the Memory Care Director (MCD) and SHWD assumed the MCD was monitoring it and it was her responsibility. On at 1:43 p.m., during an interview with the Executive Director, he admitted he hadn't been aware of all the documented incidents involving other residents in Resident #1's progress notes and admitted nothing was put in place to protect the other residents in the Memory Care Unit. Class I	A 025		
A 030	58A-5.0182(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 58A-5.0182 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule	A 030		

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A 030	Continued From page 12 58A-5.0181, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; . . . . , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- . . . . or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 58A-5.0181, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident . . . . . , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. . . . . control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery	A 030		

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A 030	Continued From page 13 of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . . . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity,	A 030		

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A 030	Continued From page 14 individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident ' s representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate	A 030		

Agency for Health Care Administration

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and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care . , , ..., and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.

(k) At least 45 days ' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally . . , ..., the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.

(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

(2) The administrator of a facility shall ensure that a written notice of the rights, . . . , ..., and

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prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident ' s access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and Rights Florida.

429.27(1)(a), FS
Property and personal affairs of residents.-
(1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs.
(b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or

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A 030	Continued From page 17 dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review, and staff interview, the facility failed to ensure the residents of the Memory Care Unit were provided the right to live in a safe and decent living environment free from [redacted] and neglect for 9 (Residents #1, #2, #4, #5, #6, #7, #8, #9, and #10) of all Memory Care Unit residents from [redacted] to [redacted]. Failed to report and respond to abnormal behavioral issues, including aggression and inappropriate activity. Failure to ensure staff do not video record residents/resident body parts. Continued exposure to physical and [redacted] placed the residents of the memory care unit in imminent danger. The findings included: 1. Record review of Resident #1's chart revealed he was admitted on [redacted] and discharged on [redacted]. Resident #1's progress notes from admission to discharge were reviewed and the following instances of misbehavior, assault and threats to residents and staff were documented: [redacted] 5:08 p.m., Medication Technician (MT) Staff B documented Resident #1 punched Resident #4 in his side. "Resident #1 says to me he hit the guy fast in his side with a closed fist."	A 030		

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A 030	Continued From page 18 7:23 p.m., MT Staff B documented Resident #1 was sleeping in the common area and got aggressive when staff tried to direct him to his room. 4:44 p.m., former Director of Memory Care Staff E documented her discussion with Resident #1's daughter regarding the resident's behavior including hitting another resident. But determined the facility would "monitor resident behavior and contact daughter as she will schedule if needed a visit with psychiatrist [name] at VA [veteran's administration (VA)]." 11:05 a.m., Resident Assistant ( ) Staff D documented Resident # , inappropriate behavior towards female staff and female residents including going in Resident #5's room. 1:13 p.m., Staff D documented Resident #1's continued attempts to get into female residents' rooms all shift including female Resident #5's room. 10:00 p.m., former Director of Memory Care Staff E documented her conversation with Resident #1's daughter regarding the inappropriate and physically aggressive behaviors. "Daughter informed this writer [Resident #5] looks a lot like resident's [#1's] wife. Will monitor resident's behavior and let daughter know..." 1:53 p.m., Staff D documented Resident #1 continued behaviors of grabbing female residents and staff and trying to kiss them and get into their beds including female Resident #2. "Staff had to lock rooms due to resident [#1] keeps going in female residents'	A 030		

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A 030	Continued From page 19	A 030		

rooms."

. . . . 4:20 p.m., former Director of Memory Care Staff E documented she spoke with Resident #1's daughter regarding his behaviors. The daughter agreed to notify the VA psychiatrist and the primary care physician.

. . . . 5:51 p.m., former Director of Memory Care Staff E documented she spoke with Resident #1's daughter regarding Residents #1's behaviors. The daughter agreed to contact the psychiatrist regarding resident behavior and sleeping disturbance.

2:11 p.m., former Director of Memory Care Staff E documented she called Resident #1's daughter again regarding Resident #1's behavior with female residents, and not eating or sleeping.

1:26 p.m., Staff D documented Resident #1's behavior of following female residents into their rooms and trying to pull on their doors. Reports the female residents are upset he won't leave them alone.

10:23 a.m., Staff D documented Resident #1 . . . behaviors towards female staff and female residents.

10:45 a.m., former Director of Memory Care Staff E documented being informed by staff of Resident #1's behaviors towards female residents and female staff. FDMC Staff E contacted the daughter to come for a visit.

1:45 p.m., Staff D documented Resident #1 was . . . , inappropriate with Resident #6 and trying to touch her. "Resident #6

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A 030	Continued From page 20 in corner of her room in chair crying and stated he won't leave me alone. Resident #1 standing over her stating he doesn't know what's wrong with her he just wants her to sit on his . ." 1:16 p.m., Staff D documented Resident #1 continued to be . . . . , inappropriate to female residents and female staff. . . . . 9:23 a.m., . . Staff D documented Resident #1 in appropriate . . . behavior with female residents and going into women's rooms. The female residents continue to yell for help while the resident was disrobing and asking for "right now." 6:00 a.m., Staff D documented Resident #1 found in only his underwear on and had his "private area" out and was trying to talk a female resident into touching his "private area." . . . . 1:20 p.m., Staff D documented Resident #1's continued . . . . misconduct toward female staff. . . . . 11:51 a.m., MT Staff F documented Resident #1 hit female Resident #7's when she tried to get Resident #1 out of her room. . . . . 11:54 a.m., MT Staff F documented Resident #1 hit another female resident's and she screamed at him. . . . . . 1:56 p.m., Staff D documented Resident #9 was yelling for help when Resident #1 had female Resident #9 physically by the , would not release her and threatened to hit her.	A 030		

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A 030	Continued From page 21 . . . . . 6:59 p.m., MT Staff B documented Resident #1 hit his roommate Resident #8. 8:24 p.m., Medical Doctor (MD) documented Resident #1 was seen as staff reported Resident #1 had " a family member and a resident." . . . . . 9:41 p.m., MT Staff B documented Resident #1 has tried to get into bed with his roommate Resident #8. Resident #8 was heard saying "man what the hell are you doing." Resident #8 is really scared, asking for protection so was removed from the room. 11:23 p.m., former Director of Memory Care Staff E documented she spoke to Resident #1's daughter about his aggressive behavior toward his roommate. . . . . . 4:53 p.m., Senior Health and Wellness Director (SHWD) note: documented the psych RNP made medication changes. . . . . . 10:44 a.m., . . Staff D documented Resident #1's attempt to hit his roommate Resident #8's . . . ., then his continued physical aggression and verbal threats. 10:51 a.m., Staff D documented Resident #1's continued physical aggression and shoving of the roommate Resident #8. 11:36 a.m., former Director of Memory Care Staff E documented Resident #1 was aggressive with her and attempting to hit her. 11:36 p.m., 3:43 p.m., former Director of Memory Care Staff E documented continuing discussions with Resident #1's daughter	A 030		

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A 030	Continued From page 22 regarding medication dosing. . . . . . 6:10 a.m., Staff D documented Resident #1 being found in bed with male Resident #10. Staff made multiple attempts to remove Resident #1 from Resident #10 bed and room. . . . . . 6:10 a.m., Staff D documented Resident #1 was combative and declined to sleep. Resident #1 was found in male Resident #4's room asleep in recliner. When awoken to redirect became combative and threatening again. 9:25 a.m., Staff D documented Resident #1 became agitated and jumped up off sofa and hit a female resident in her and grabbed her by both . . . . 11:24 a.m., former Director of Memory Care Staff E documented Resident #1's daughter informed of resident hitting and grabbing of a female resident. The FDMC Staff E agreed for the daughter to pick the resident up for the day. 7:21 p.m., MT Staff C documented Resident #1 was verbally threatening to "slap the hell out of me." . . . . 7:28 p.m., MT Staff B documented Resident #1 was in found in female Resident #7's room. The female resident was yelling for help and yelling at Resident #1. 2:32 p.m., MT Staff B documented Resident #1 was is yelling, screaming and getting in everyone's yelling. 6:52 p.m., MT Staff B documented	A 030		

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A 030	Continued From page 23 Resident #1 was found in a female resident bed. The female was telling him to get out and was scared and shaking. . . . . 7:20 p.m., Licensed Practical Nurse (LPN) Staff G documented Resident #1 was nude laying in female resident's bed. The daughter was called to talk him out of the room. 9:10 a.m., MT Staff B documented Resident #1 was yelling at another resident and Resident #8, roommate, is saying he scared and Resident #1 is a bully. Resident #8 was requesting staff to call the police. 9:48 a.m., Staff D documented Resident #1 was kicking and punching the doors of female residents who refused to let him in their room. Resident #1 was making fists and punching towards staff. 1:21 p.m., Staff D documented Resident #1 continued to be physically aggressive to hospice staff, facility staff and other residents then began making . . . . remarks to the female residents. 1:46 p.m., Staff D documented Resident #1 grabbed a female resident by the and then turned the aggression on the staff and could not be re-directed. . . . . 6:57 a.m., Staff D documented Resident #1 had his roommate (Resident #8) by the . . . , punching him while Resident #8 was lying in bed. Staff separated, but Resident #1 continued to be aggressive so was "sent to 'A' side to be separated." 1:50 p.m., Staff D documented	A 030		

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A 030	Continued From page 24 Resident #1 continued his aggression but directed toward female Resident #2 and then staff, when they attempted to intervene. 2:05 p.m., SHWD documented contacted the daughter to discuss the aggression. The daughter agreed to a psych nurse consult for medication changes. 9:47 a.m., MT Staff B documented she intervened in aggression from Resident #1 towards his roommate Resident #8 and separated them. 9:53 a.m., MT Staff B documented Resident #1 was pursuing female Resident #5, who was yelling at him to stay out of her room. Staff had to intervene. 4:18 p.m., MT Staff B documented Resident #1 was again physically threatening his roommate, Resident #8 and running to the female residents who are yelling at him to leave them alone. 8:06 p.m., LPN Staff F documented Resident #1 had punched a staff member. 8:48 p.m., MT Staff C documented Resident #1 was combative with other residents and redirecting was not working. 6:17 p.m., MT Staff B documented Resident #1 was trying to move the couch going to all the room doors shaking the handles. 5:15 p.m., HWD documented Resident #1 was having aggressive behavior with staff and other residents. The Psych ARNP was told Resident #1 was having more aggressive	A 030		

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A 030	Continued From page 25 behavior around 5pm. Medications adjusted. 3:31 p.m., MT Staff C documented Resident #1's continued aggressive by grabbing other resident's arms and making a closed fist at them. Residents are continuously afraid of Resident #1. 4:50 p.m., HWD documented Resident #1 hit another resident on the and redirecting Resident #1 was not working. The daughter was called and asked to come get him. 5:00 p.m., HWD documented Resident #1 continued agitation and inability to redirect. this morning. The psych nurse was contacted adjusted medications. 10:38 a.m., MT Staff C documented Resident #1 hit another resident in the cheek when she "wouldn't let him in her room." 11:00 a.m., HWD documented Administration met to discuss care of Resident #1 and his physical aggression. "Decision was made to give family a 45 day notice and [Resident #1] could only come with a 24hr [24 hour] private caregiver." 10:14 p.m., HWD documented "daughter decided to move resident out of facility as she is unable to provide 24-hour private duty." On at 1:30 p.m., during an interview the HWD said she was fairly new to the facility and hadn't been aware Resident #1 had been having these behaviors since he arrived at the facility. On at 1:33 p.m., during an interview the SHWD said in regard to Resident #1's behaviors,	A 030		

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A 030	Continued From page 26 they would contact Resident #1's daughter, he would see his doctor and medication changes were made. On at 12:19 p.m., during an interview the SHWD said she was speechless when the progress notes were reviewed the day before. SHWD said she accepts fault for this as she should have been reading all of memory care notes. SHWD said she hadn't been doing so as there was a Licensed Practical Nurse who was the Memory Care Director (MCD) and SHWD assumed the MCD was monitoring it and it was her responsibility. On at 1:43 p.m., during an interview with the Executive Director, he admitted he hadn't been aware of all the documented incidents involving other residents in Resident #1's progress notes and admitted nothing was put in place to protect the other residents in the Memory Care Unit. 2. On at 10:39 a.m., during an interview the Health and Wellness Director (HWD) explained that on she received a call from MT Staff B saying there had been an incident between Staff A and Resident #1. The HWD said she examined Resident #1 and found 4 red marks on Resident #1's . HWD said Resident #1 didn't say what happened, but his roommate, Resident #8, said your guy hit my guy. At this time, MT Staff A was told not to come to work while they investigate. HWD said over the next several days more appeared on Resident #1, including one to his arm that was clearly a palm print. The HWD said she notified the Department of Children and Families who sent out an investigator. During this time, Resident #1's daughter took him to the doctor.	A 030		

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A 030	Continued From page 27 Based on the doctor's examination, the doctor contacted Department of Children and Families also. The HWD said that sometime in the following week or so, Resident #1's daughter called the police and the police came to the facility to investigate. The HWD said during this time, MT Staff A showed her a video of Resident #1 that had been taken on MT Staff A's personal cell phone. The video showed Resident #1 in a female resident's bed. Resident #1 was only in his underwear and the female resident was fully clothed. The HWD said MT Staff A was subsequently terminated from his position due to violations of company policy. On at 11:00 a.m., during an interview the HWD said following this occurrence, they had staff meetings, provided in-services on transitioning residents, educated staff on policy on no cameras/videos of residents on personal phones. However, HWD was unable to provide any documentation that trainings had actually occurred. Class I .	A 030		
A 077	429.176 FS; 429.52( ),58A-5.019(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120	A 077		

Agency for Health Care Administration

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A 077	Continued From page 28 consecutive days without an administrator who has completed the core educational requirements. 429.52( ), FS (4) A new facility administrator must complete the required training and education, including the competency test, within 90 days after date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 58A-5.019 Staffing Standards. (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by Part II, Chapter 408, F.S., Part I, Chapter 429, F.S., Rule Chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least ; 2. If employed on or after , have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to Sections 408.809 and 429.174, F.S.; and 4. Complete the core training and core competency test requirements pursuant to Rule 58A-5.0191, F.A.C., no later than 90 days after becoming employed as a facility administrator. Individuals who have successfully completed	A 077		

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A 077	Continued From page 29	A 077		

these requirements before , are not required to take either the 40 hour core training or test unless specified elsewhere in this rule. Administrators who attended core training prior to , are not required to take the competency test unless specified elsewhere in this rule.
5. Satisfy the continuing education requirements pursuant to Rule 58A-5.0191, F.A.C.
Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department.
(b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraphs (1)(a)4. of this rule to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must:
1. Complete the core training and core competency test requirements pursuant to Rule 58A-5.0191, F.A.C.; and
2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility.
(c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to

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A 077	Continued From page 30 assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements of an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to . . . , , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not . . . . . , serve as an administrator of any other facility. (e) Pursuant to Section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, . , . . . , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No =Ref-04002. This Statute or Rule is not met as evidenced by: Based on record review, and staff interview, the Executive Director failed to ensure the provision of appropriate care to all residents in the Memory Care Unit. Failed to ensure resident supervision protected them from abnormal behavorial issues, including aggression and inappropriate . . . . activity. (Refer to A0025) Failure to ensure each resident's right to live in a safe environment free from . . and neglect. (Refer to A0030)	A 077		

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A 077	Continued From page 31	A 077		

Failure to protect the population of a memory care unit allowed for to continue for 8 months.

The findings included:

Record review of Resident #1's chart revealed he lived in the Memory Care Unit for approximately 8 months. Resident #1's chart contained numerous progress notes documenting Resident #1 with physically aggressive and/or , inappropriate behavior toward other residents in the Memory Care Unit throughout his 8 month stay in the facility. He was documented as physically punching, hitting, or shoving residents, family, facility or hospice staff on , , , twice on , , , twice on , , , , , , and .

Documentation revealed administrative staff were aware of the behaviors as the Memory Care Director (MCD) documented behavioral issues on , , , , , , , , , and . The Senior Health and Wellness Director (SHWD) documented behaviors and behavioral medication changes on and . The Health and Wellness Director (HWD) documented behavioral issues on , and .

On at 1:33 p.m., in an interview the SHWD said in regard to Resident #1's behaviors they would contact Resident #1's daughter, he would see his doctor and medication changes were made.

On at 12:19 p.m., in an interview the SHWD said she was speechless when the progress notes were reviewed. SHWD said she

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A 077	Continued From page 32 accepts fault for this as she should have been reading all of the memory care notes. SHWD said she hadn't been doing so as there was a Licensed Practical Nurse (LPN) who was the MCD and the SHWD assumed the MCD was monitoring it as part of her responsibility. On at 1:43 p.m., in an interview the Executive Director admitted he hadn't been aware of all the documented incidents involving other residents in Resident #1's progress notes and admitted nothing was put in place to protect the other residents in the Memory Care Unit. Class I .	A 077		
A 165	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:	A 165		

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A 165	Continued From page 33 1. [illegible]; 2. [illegible] or [illegible] damage; 3. Permanent [illegible]; 4. [illegible] or [illegible] 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 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) [illegible], neglect, or [illegible] 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	A 165		

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A 165	Continued From page 34 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 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	A 165		

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A 165	Continued From page 35 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 staff interview, the facility failed to complete adverse incident reports and to report events to the Agency for Healthcare Administration (AHCA) as required by law. The findings included: On .. .. . at 10:39 a.m., in an interview the Health and Wellness Director (HWD) explained on she received a call from Medication Technician (MT) Staff B, saying there had been an incident between Resident Aide ( ) Staff A and Resident #1. The HWD said she examined Resident #1 and found 4 red marks on Resident #1's . The HWD said Resident #1 didn't say what happened, but his roommate Resident #8, said your guy hit my guy. At this time, Staff A was told not to come to work while they investigate. The HWD said over the next several days more . . . . . appeared on Resident #1, including one to his arm that was clearly a palm print. The HWD said she notified the Department of Children and Families who sent out an investigator. The HWD said that during this time, Resident #1's daughter took him to the doctor and based on the doctor's examination, the doctor contacted the Department of Children and Families also. The HWD said that sometime in the following week or so, Resident #1's daughter called the police and the police came to the facility to investigate. The HWD said during this time, Staff A showed her a video of Resident #1 that had been taken on Staff A's personal cell phone. The video showed Resident #1 in a female resident's bed. Resident #1 was only in	A 165		

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A 165	Continued From page 36 his underwear and the female resident was fully clothed. The HWD said Staff A was subsequently terminated from his position due to violations of company policy. A review of the adverse incidents filed during this time did not show any adverse incident reports had been filed regarding this investigation. On at 11:37 a.m., the Executive Director said they had discussed filing an adverse incident report but decided they contacted Department of Children and Families and didn't feel they needed to file an adverse incident. The Executive Director said he was aware an event reported to law enforcement or it's personnel for investigation is a reason to report an adverse incident to AHCA. Class III .	A 165		