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
	AL11969551	A. BUILDING: _____ B. WING _____	03/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERFIELD OF TALLAHASSEE, LLC	208 E THARPE ST TALLAHASSEE, FL 32303

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A 000	Initial Comments An unannounced complaint survey (CN2020005345) was conducted at Canterfield of Tallahassee Assisted Living Facility on . At the time of survey deficiencies were identified.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(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. 59A-36.007 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 59A-36.012, 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.	A 025		

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A 025	Continued From page 1 (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 interview and record review the facility failed to maintain general awareness and whereabouts for 1 of 2 sampled residents (resident #2) resulting in injury ( ) caused by resident #1 The Findings included: On at 8:38 AM interview with the Executive Director (ED)who reported that resident #1 and resident #2 first altercation occurred on Saturday ( ) when the two residents got into an altercation and resident #1 bit resident #2 on the resident #2 had to be transferred out to hospital and received five stitches. ED reported at that time the facility reached out to the family and had the resident #1 and resident #2 separated. ED reported that resident #2 returned from hospital and one-to-one staff was assigned to resident #2. ED reported that second incident was on Sunday ( ), right after dinner when a staff member was assisting resident #1 to the restroom in resident's room. ED stated that as	A 025		

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A 025	Continued From page 2	A 025		

staff was assisting resident #1 to the restroom, resident #2 followed behind resident #1 and staff resident's room. ED reported that during this time a lot was going on, another family member was leaving goodie bag at front desk and another resident (#3) was also trying to in the room with resident #1 and #2. ED reported that another memory care resident informed staff in memory care that resident #1 and resident #2 was fighting. ED reported that he immediately sent another staff to resident's room, and when the staff member walked in, resident #1 was standing over resident #2 and resident #2 was crying and staff immediately took resident #2 to the nursing station because her , was . ED reported that staff E was the one-to-one staff with resident #2 that Sunday. ED reported that he was in the building when the incident occurred.

On at approximately 10:50 AM interview with director of nursing (DON) who reported that she worked all day Friday until Friday night, then came Saturday and worked. Stated that she left between PM and PM on Saturday night. Stated that before she left she informed all resident care aides that someone needs to be with resident #2 at all times and in no instance was the resident #1 and resident #2 to be together because the resident #1 might hurt resident #1 and if that happens the facility would receive a citation. Director of Nursing reported that when she was on duty, she made sure that resident #2 had one-to-one staff. DON reported that on Saturday from the time she came on duty until PM resident #2 was kept with her, helping with little duties around the facility. DON reported that at PM, staff member C arrived at the facility and was one-to-one with resident #2 until 7pm.

On at approximately 11:00AM interview

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A 025	Continued From page 3	A 025		

with staff C, resident aide who reported that she was with resident #2 on Saturday from 1pm to 7pm as one-to-one staff. Staff C reported that she was not trained with her duties as one-to-one staff but was informed by the Director of Nursing to keep resident #1 and resident #2 apart and try to deescalate the situation because resident #2 was very upset. Staff C reported that to her understanding one-to-one means keeping the person by your side, redirecting in any manner.

On at approximately 6:12PM via telephone, interview with employee E who reported that she was not aware of the incident that happened on Sunday because she does not work on Sunday. Employee C reported that all resident aides had been informed by the director of Nursing that resident #1 and resident #2 are not supposed to be together at all because resident #2 might get hurt and if she does that staff would be fired and the facility will receive a citation. Employee E reported that on shift, resident aides would sit two hours in resident 's room and rotate out in case resident #2 tried to go to resident #1 room.

On at approximately 6:34PM via telephone with staff member J who reported that she worked on duty Sunday from 3:00pm until around 6:15pm. Staff J reported that during shift change she and staff G was counting medication when staff G looked out the window and saw resident going into resident #1 room. Staff J reported that staff G ran out of the room to room and separated resident #1 and #2. Staff J reported that time she was on duty form 3:00pm to 6:15PM she worked from 3pm to around 6:15pm, resident #2 did not have one-to-one staff. Staff J reported that Executive Director was on-site because staff P, maintenance director had

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A 025	Continued From page 4 taken pictures of a water leak in a resident #3 room and sent to the ED. Staff J reported that when she left the facility ED and maintenance director was in resident #3 room tending to the water leak. On . . . . . at approximately 8:17PM received telephone call from Executive Director who reported that he was new in his position as Executive Director and there were much he needed to learn. Stated that after the survey exit, he relieved director of nursing from her position because she did not complete information in her duties in assigning a one-to-one staff with resident #1. ED reported that he gave the wrong information about staff E being one-to-one with resident #2 on Sunday . . . when resident #2 received injury. ED reported that he gave the wrong staff name (staff E), and at that time he present another name staff Q. ED reported that this name would not be on the schedule because name was omitted b ED. A record review conducted of incident report dated . . . . . which indicated, resident #1 shared apartment with resident #2, agitated and at this time. Resident #1 stated, "I bit her". Resident #2 discovered during routine care, resident right . . . . . , resident reported bit by husband with whom she shares apartment. There was no documentation provided of incident report for of incident reported of resident #1 hit resident #2 in the . . . A record review was conducted of resident #1 1823 health assessment which indicated his medical history and diagnoses: . . . . of , agitation. or behavioral status: alert, severe, ... Elopement risk. Nursing/Treatment/ . . .	A 025		

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A 025	Continued From page 5 service requirements: Big Bend Hospice Services A record review conducted of resident #2 which indicated her medical history and diagnoses: [illegible], overactive [illegible] or behavioral status: [illegible]. Nursing/Treatment/ [illegible] service requirements: medication administration monitoring. Elopement risk Class II	A 025		
A 165 SS=D	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;	A 165		

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A 165	Continued From page 6 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) . . , 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	A 165		

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A 165	Continued From page 7 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 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.	A 165		

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A 165	Continued From page 8 This Statute or Rule is not met as evidenced by: Based on interview and record review the facility failed to submit an initial adverse incident report within 1 business day after a resident to resident altercation resulting in injury for resident #2. The Findings included: On at 8:38 AM interview with the Executive Director (ED) who reported that resident #1 and resident #2 first altercation occurred on Saturday ( ) when the two residents got into an altercation and resident #1 bit resident #2 on the and resident #2 had to be transferred out to hospital and received five stitches. ED reported that second incident occurred on Sunday ( ), after dinner when resident #1 punched resident #2 in the , she receiving a , police had to be called to the facility and resident #2 had to be sent out to the hospital for treatment. ED reported that he had busy, and on Monday he tried to submit the form but was locked out of the Agency for healthcare administration portal to submit the adverse incident. ED reported that he did not know why he was able to submit the adverse incident report. Contact with made with agency for healthcare administration to find portal was up and running. Initial adverse incident submitted on at A record review conducted of incident report dated which indicated, resident #1 shared apartment with resident #2, agitated and at this time. Resident #1 stated, "I bit her". Resident #2 discovered during routine care, resident right , resident reported bit by husband with whom she shares apartment.	A 165		

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A 165	Continued From page 9 There was no documentation provided of incident report for of incident reported of resident #1 hit resident #2 in the . A record review conducted of Executive Director submission to agency which indicated that report was created but not submitted on at 9:54 AM. On at 10:39 AM, report submitted to agency. Class III	A 165		