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 |
|---|---|---|---|
| | AL11967569 | A. BUILDING: _____ B. WING _____ | 10/14/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ADDINGTON PLACE OF TITUSVILLE | 497 N WASHINGTON AVE TITUSVILLE, FL 32796 |

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| A 000 | Initial Comments<br><br>A Complaint Investigation 2020016897 was conducted at Addington Place of Titusville on . A deficiency was identified at the time of the investigation. | A 000 | | |
| A 025 SS=D | 429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision<br><br>429.26<br>(7) The facility shall 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 must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition.<br><br>59A-36.007<br>An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.<br>(1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:<br>(a) Monitoring of the quantity and quality of resident diets in accordance with rule | A 025 | | |

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| A 025 | Continued From page 1<br><br>59A-36.012, F.A.C.<br>(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.<br>(c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.<br>(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.<br>(e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.<br>(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.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to investigate and implement interventions to supervise and maintain the safety of 2 of 6 sampled residents (#1 and #2) following allegations of . . . . . .<br><br>Findings:<br><br>At 9:45 a.m. on . . . . resident #1 was seen sitting in a chair. Her , were closed and when aroused by the DON, she replied "hi" when greeted. Additional questions did not elicit any verbal response from her.<br><br>Resident #2 was seen sitting at a dining room table and when greeted, he replied "hello." He | A 025 | | |

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| A 025 | Continued From page 2<br><br>talked incessantly and most things he said were random and nonsensical.<br><br>Both residents ambulated independently around the unit ad lib.<br><br>At 11:05 a.m. on , caregiver A said resident #1 always thinks resident #2 is her husband and that on approximately , resident #1 tried to sleep with resident #2 and when staff tried to keep her out of the room, resident #1 became agitated and at times combative. Caregiver A said that caregiver B told her that resident #1 was sitting on the floor outside of resident #2's room earlier that night and resident #1 said resident #2 tried to have with her. Caregiver A said the incident was reported to nurse C, who said if occurred then it would have been consensual. Caregiver A said the residents spent a lot of time together, usually sitting outside and said she'd never seen inappropriate behavior between them.<br><br>At 11:19 a.m. on , caregiver B said she could not remember the date and said that the time was approximately 7:30 p.m. when she saw resident #1 on the floor and scooting herself out of resident #2's room. Resident #1 then said that resident #2 poked her in her butt and said her butt hurt. Resident #1 was fully clothed at the time and was picking at her pants in the area of her butt. The caregiver said she and caregiver A took resident #1 to the bathroom, looked at the resident's butt and did not see any injuries. Afterwards, resident #1 continued to want to go into resident #2's room so staff continuously redirected her. The caregiver said she'd never seen the residents touch each other before and said resident #1 follows resident #2 around. She reported the incident to the med tech but could | A 025 | | |

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| A 025 | Continued From page 3<br>not remember their name.<br><br>At 11:28 a.m. on . . . . . , nurse C said caregiver B told her, she believed on either or . . . . . , that resident #1 was scooting on her butt outside resident #2's room and that caregiver B told her that resident #1 had been sitting on resident #2's , . The nurse said she spoke to resident #1, who said nothing happened then giggled. The nurse said it was not reported to her that resident #1 alleged that resident #2 penetrated her anally and she, herself, never saw any inappropriate behavior between the residents. She instructed the caregivers to keep resident #1 out of resident #2's room and said staff continually reoriented resident #1 that resident #2 was not her husband but it did not help much.<br><br>Review of resident #1's record revealed her diagnoses included . . . . . . The record did not contain any documentation to reflect the alleged incident reported by staff.<br><br>Review of resident #2's record revealed his diagnoses included 's . His record too did not contain documentation about the allegation.<br><br>At 12:47 p.m. on during an interview with both the administrator and DON, they said residents #1 and #2 were friends and hung out with each other and resident #1 believed that resident #2 was her husband. The DON said she received a text from caregiver D at 4 a.m. on telling her that resident #1 had been in resident #2's room. The DON said she did not think much more about it because that was normal for memory care residents. She then said, while reading the text message on her phone, | A 025 | | |

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| A 025 | Continued From page 4<br><br>that at 8:39 a.m. on [redacted] she received a text from caregiver E telling her that there was a rumor going around that residents #1 and #2 had [redacted] on the evening of [redacted] and resident #1 was sliding on her belly on the floor saying that her butt hurt. The DON immediately forwarded the message to the administrator. The administrator then said after she received the message, she decided she would investigate the matter further on the next day. The DON then said she interviewed caregiver B on [redacted], who said resident #1 was scooting on her butt in #2's room and said, "he put it in my butt, and it hurts." The DON said caregiver B said she never saw the residents in any [redacted] activity and said both residents were fully clothed at the time. Both the DON and administrator said they did not believe anything inappropriate occurred between the residents, said neither of them informed either resident's family and health care provider to determine whether an exam needed to be conducted and the administrator said the only intervention implemented to keep the residents safe following the allegations was that she told the staff to redirect resident #1 out of resident #2's room. Neither could provide the surveyor with any documentation to indicate an investigation of the allegation was conducted.<br><br>Following resident #1's allegation of [redacted], the facility's nurse did not conduct an assessment on the resident but rather, unlicensed staff conducted one. In addition, the facility did not document the allegations or investigation, did not notify the resident's family, did not notify a health care provider for further instructions and did not implement interventions to ensure the safety of the residents was maintained. | A 025 | | |

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| A 025 | Continued From page 5<br>Class III | A 025 | | |