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
	AL11910431	A. BUILDING: _____ B. WING _____	R 01/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOBLE SENIOR LIVING AT BROOKSVILLE	307 HOWELL AVENUE BROOKSVILLE, FL 34601

(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 licensure re-visit was conducted on [illegible] through [illegible], through [illegible], and [illegible], at Noble Senior Living at Brooksville. Deficiencies were identified at the time of the survey.	{A 000}		
{A 165}	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. [illegible]; 2. or , damage; 3. Permanent [illegible]; 4. 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	{A 165}		

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{A 165}	Continued From page 1	{A 165}		

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, through the agency ' s online portal, or if the portal is offline, by electronic 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, through the agency ' s online portal, or if the portal is offline, by electronic 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.

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{A 165}	Continued From page 2 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. This Statute or Rule is not met as evidenced by: Based on interview, observation and record review, the facility failed: 1) to file adverse	{A 165}		

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{A 165}	Continued From page 3 incident reports with Agency for Health Care Administration (AHCA) for 3 incidents involving 5 of 27 residents sampled, residents numbers 2, 3, 5, 16; and 18; 2) report to Department of Children and Families (DCF) 2 of 4 incidents, resident numbers 9 and 18; and 3) report to Department of Children and Families (DCF) 1 of 1 neglect incident, resident number 11. Findings: 1. On , at 11:10 AM, an interview was conducted with the Acting Director regarding the alleged incident involving Resident #2 and Resident # 3. She described Resident #3 as a frail, small framed , female resident on hospice with , Spanish speaking only. She described Resident #2 as a very tall , male, fully ambulatory and who resided on the same floor. She further stated the staff in charge of the day shift on the day of the incident was Staff D, Med Tech. She stated the alleged first assault occurred on , at 9:30 AM, when Resident #2 was found standing over the bed of Resident #3 with his penis in Resident #3's . A second incident between Resident #2 and Resident #3 occurred two hours later at 11:30 AM, when Resident #2 was found naked in bed with Resident #3. The Acting Director stated she was contacted by Staff C by text on at 4:06 PM. She stated Law Enforcement was contacted the next day on , at 10:45 AM, as well as the Department of Children & Families. On at 10:30 AM, an interview was conducted with Staff C, Med Tech. Staff C stated, "I was here that day, me, [Staff D's name], and three agency staff, no nurses was (sic) on that day." Staff C stated the incident occurred	{A 165}		

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{A 165}	Continued From page 4	{A 165}		

between Resident #2 and Resident #3 at 9:30 AM , when Resident #2 was found in Resident #3's room performing oral with Resident #3. Resident #2 was redirected to his room. Then about two hours later at approximately 11:30 AM, while lunch was being delivered to the residents in their rooms, Resident #2 was again found in Resident #3's room, in her bed naked with her. Staff C stated she tried reaching the Acting Director on , at 1:00 PM, but could not reach her. She then stated she tried reaching the Business Manager who then informed the Acting Director. Staff C stated Resident #3 receives hospice care and is non-verbal and bed bound. Staff C stated Resident #2 seemed like a threat, offered no remorse, as though he did nothing wrong.

An interview with Resident #5 was conducted on at 2:15 PM. The resident was questioned about an incident which occurred on between him and Resident #16. Resident #5 stated he was in the hallway outside of his room around 9:00 PM. He was angry from an earlier incident with the business office personnel, concerning not receiving his money. [Resident #16's name] approached him yelling at him, and he pushed him to get him to away. He to the floor. The sheriff was notified, and he gave them a statement. He said he didn't punch him, just pushed him.

On , at 9:30 AM, an interview was conducted with the Acting Director, who advised there had been an adverse incident the night before ( ) which she described as a battery between Resident #5 and Resident #16. She further stated that law enforcement was called, and Resident #16 was taken to the hospital for evaluation.

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{A 165}	Continued From page 5 On . . . . . , at approximately 2:00 PM, an interview was conducted with the Acting Director. She stated that due to the change in administration at the facility, she was unable to file adverse incident reports with AHCA concerning recent incidents that had occurred at the facility. She stated she did not have access to the AHCA reporting system. She further stated she had begun the registration process with AHCA to obtain access to the reporting system, but her corporate office advised her not to follow through with the paperwork because they didn't want any more adverse incidents showing up on the facility's record. On at 4:54 PM, a telephonic interview was conducted with Staff K, third shift Resident Care Aide. When asked if she had any first-knowledge of Resident #2, she stated that one day late in (she did not have an exact date) she had found Resident #2 in Resident #18's room naked. She was summoned to the room by the screams of Resident #18. When asked if she had documented the incident she stated, "As a Resident Care Aide, I cannot document anything I must report any observations or incidents to a Med Tech and we do not have Med Techs always on the overnight shift. In those cases, I report any concerns to the Med Tech on the first shift. I remember reporting that incident to [Staff F's name] and I don't know if he reported it." The facility was not able to provide a policy for reporting adverse incidents to AHCA. 2) A case of . . . . . was documented on . at 5:46 PM. Resident #10	{A 165}		

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{A 165}	Continued From page 6	{A 165}		

was caught performing oral on Resident #9, who is intellectually . This incident occurred on , but was not reported until one month later, by Resident #9's roommate, Resident #11. Resident #9's mother stated she was made aware that her mentally son had been , assaulted by another resident identified as Resident #10. Resident #9's mother further stated she had been informed of the incident by Resident #11 (her son's roommate) that he had witnessed Resident #10 performing oral on her son (Resident #9), "who has a mental and has the mental capacity of a ."

On at 4:54 PM, a telephonic interview was conducted with Staff K, third shift Resident Care Aide. When asked if she had any first-knowledge of Resident #2, she stated that one day late in (she did not have an exact date) she had found [Resident #2's name] in [Resident #18's name] room naked. She was summoned to the room by the screams of [Resident #18's name]. When asked if she had documented the incident she stated, "As a Resident Care Aide, I cannot document anything I must report any observations or incidents to a Med Tech and we do not have Med Techs always on the overnight shift. In those cases, I report any concerns to the Med Tech on the first shift. I remember reporting that incident to [Staff F's name] and I don't know if he reported it."

A review of the facility policy, titled "Preventing , Neglect, ," read, "The Executive Director or designee, in consultation with the Director of Operations, should report known or suspected , neglect or , and all allegations of , neglect or , to the Department of Children and

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{A 165}	Continued From page 7 Families Services Central . . . . Hotline." 3) A review on . . . . . of the Hernando County Sheriff's Report (Incident # 2021-01174) dated . . . . revealed Brooksville Fire Rescue personnel found [Resident #11's name] to have a medical . . . mask embedded in the skin behind his which caused significant and required medical care. [Resident #11's name] had not removed his mask in a very long period of time. An observation of Resident #11 was conducted on at 11:00 am. The resident was observed to be alert with . . . . . He had bandages on his , , . Gauze bandages and steri-strips applied. A review of the facility policy, titled "Preventing . . , Neglect, , ," read, "The Executive Director or designee, in consultation with the Director of Operations, should report known or suspected . . . . , neglect or , and all allegations of , neglect or , ... to the Department of Children and Families Services Central Hotline." Class III	{A 165}		