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 _____	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 complaint investigation, complaint number 2021000674, and a COVID-19 focused control survey was conducted on through through , and at Noble Senior Living at Brooksville. Deficiencies were identified at the time of the survey.	A 000		
A 008 SS=G	429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner ' s form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident ' s admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner ' s direct observation of the patient at the time of examination and must include the patient ' s medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident ' s admission to or continued residency in the facility. The medical examination form, reflecting the resident ' s	A 008		

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A 008	Continued From page 1 condition on the date the examination is performed, becomes a permanent part of the facility ' s record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or , , nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident	A 008		

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A 008	Continued From page 2	A 008		

which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of require such assistance.

59A-36.006
(2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care provider as specified in either paragraph (a) or (b) of this subsection.
(a) A medical examination completed within 60 calendar days before the individual's admission to a facility pursuant to section 429.26(4), F.S. The examination must address the following:
1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations,
2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living,
3. Any nursing or services required by the individual,
4. Any special diet required by the individual,
5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication,
6. Whether the individual has signs or symptoms of or any other communicable , which are likely to be transmitted to other residents or staff,

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A 008	Continued From page 3 7. A statement on the day of the examination that, in the opinion of the examining health care provider, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care provider. The medical examination may be conducted by a health care provider licensed under chapter 458, 459 or 464, F.S. (b) A medical examination completed after the resident's admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09170. Faxed or electronic copies of the completed form are acceptable. The form must be completed as instructed. 1. Items on the form that have been omitted by the health care provider during the examination may be obtained by the facility either orally or in writing from the health care provider. 2. Omitted information must be documented in the resident's record. Information received orally must include the name of the health care provider, the name of the facility staff recording the information, and the date the information was provided. 3. Electronic documentation may be used in place of completing the section on AHCA Form 1823 referencing Services Offered or Arranged by the Facility for the Resident. The electronic documentation must include all of the elements described in this section of AHCA Form 1823. (c) Any information required by paragraph (a), that is not contained in the medical examination	A 008		

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A 008	Continued From page 4 report conducted before the individual's admission to the facility must be obtained by the administrator using AHCA Form 1823 within 30 days after admission. (d) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of section 429.26, F.S. and this rule. (f) Any orders issued by the health care provider conducting the medical examination for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility may be attached to the health assessment. A health care provider may attach a DH Form 1896, Florida . . . . . Form, for residents who do not wish . . . . . to be administered in the case of or . (g) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular	A 008		

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A 008	Continued From page 5 admission. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the resident health assessments for assisted living facilities, AHCA (Agency for Health Care Administration) Form 1823, were accurate and complete for 5 of 17 residents sampled, resident numbers 2, 4, 13, 28, and 40, failed to ensure a medical examination was completed by a health care provider within 60 calendar days prior to admission for 1 of 17 residents, resident number 2, and failed to ensure the appropriateness of residents admission for 1 of 17 residents sampled for admissions, resident number 18. Findings: Review of Resident #4's health assessment (AHCA Form 1823) revealed on Page 4 - no date is documented of when the medical examination was conducted. Review of Resident #40 health assessment (AHCA Form 1823), revealed dated , on Page 2, Section 1-A - Activities of Daily Living (ADLs) was documented with an "A" for Needs Assistance for preparing meals, shopping, making phone calls, handling personal affairs and handling financial affairs. Required comments were not documented to provide the extent and type of assistance needed. Review of Resident #2's Move-In Record revealed an admission date of . Review of the resident's health assessment (AHCA Form 1823) revealed the form	A 008		

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A 008	Continued From page 6 documented the medical examination was conducted , 204 days prior to the resident's admission. On Page 5, Section 3 - Services offered or arranged by the facility for the resident was blank. Review of Resident #28's health assessment (AHCA Form 1823), dated revealed under Section A. Ability to Perform Self-Care Tasks: preparing meals, shopping, handling financial affairs was documented as "A" - Needs Assistance. The comments column documented "facility" and does not document the assistance necessary. Review of Resident #13's health assessment (AHCA Form 1823) revealed on Page 4 no date is documented of when the medical examination was conducted. On Page 2, Section 1-A - Activities of Daily Living (ADLs), indicated that Resident #13 required assistance with all ADLs. Required comments were not documented to provide the extent and type of assistance needed. On Page 5, Section 3 - Services offered or arranged by the facility for the resident was blank. On , at 10:30 AM, during an interview, the Acting Director confirmed the residents' health assessments were not accurate and up to date. On , at approximately 1:40 PM, an interview was conducted with the Physician Assistant from an outside practice who provided health care for the residents. He stated it was true that the residents did need new health assessments. On at 9:00 AM, an interview was conducted with the Acting Director. She stated she had a resident admitted on around	A 008		

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A 008	Continued From page 7 2:00 AM from the hospital. [Resident #18's name] was re-admitted into the facility with a ... or possibly ... The resident was not on hospice. The Acting Director stated she was working on getting the resident placed in a nursing facility but had not received confirmation yet. She said, "I know we are not supposed to admit a resident with a ... who is not on hospice. I was not made aware of this admission until this morning. The only staff here to receive the resident was a Med Tech and there were two resident aides working as well. Her paperwork from the hospital also stated she had a possible ... on her ... heals. No one has assessed her since her re-admission." A request was made for the 1823 and any additional documentation related to Resident #18. No additional documentation was provided. An observation of Resident #18 was conducted on at 12:15 PM. The resident was observed sitting in wheelchair in her room. There was no seat cushion in her wheelchair. Staff attempted to assist the resident ... into her bed for an observation of the ... She was observed to be a total assist to transfer to her bed. She would not bear ... and relied on staff to get her into bed. An observation of the ... revealed an open area on her ..., approximately 5 centimeters in diameter. The area of injury was reddened with ... drainage. The ... was not dated and was soiled and not intact. The ... heels were covered with ... that were dated . Class II	A 008		

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A 025	Continued From page 8	A 025		
A 025 SS=K	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (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. 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.	A 025		

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A 025	Continued From page 9 (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 interview, observation, and record review, the facility failed to provide care and services appropriate to meet the needs of residents accepted for admission to the facility for 15 of 27 residents sampled, resident numbers 2, 3, 4, 5, 6, 7, 10, 11, 12, 15, 17, 18, 20, 26, and 27. Findings: On [redacted], at approximately 9:40 AM, an interview was conducted with the Hernando County Sheriff Deputy while reviewing a Computer Aided Dispatch ( ) query. He stated in the last 30 days ([redacted] -) the Sheriff's Office had received 81 calls from the facility, of those 81 calls, 17 involved which required transport to the hospital. He expressed concern about a lack of staff and security for the residents. He stated	A 025		

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A 025	Continued From page 10 the 81 calls in the 30-day period reviewed did not include the 911 hang ups which required officers to call [illegible] to verify the emergency. He stated there were a number of times he called the facility following those 911 hang up calls and "the phone just rang and rang and rang - no one answered." He also referenced a resident who had received service from the local fire rescue which involved a man whose [illegible] mask was embedded in the skin behind his [illegible]. He further explained the paramedics were very distressed and had to cut it out which caused considerable [illegible] and [illegible] to the resident. He added, "Just another example of neglect, and lack of supervision." Review of Resident #3's Resident Health Assessment for Assisted Living Facilities, AHCA (Agency for Health Care Administration) Form 1823, dated [illegible], showed diagnoses of [illegible], and [illegible]. The admission date was documented as [illegible]. Under the comments section was documented the resident's physical or sensory limitations as wheelchair, Spanish speaking, and [illegible]. Nursing/Treatment/[illegible] Service Requirements included hospice care. Review of the Hospice Certification of [illegible] Illness assessment, dated [illegible], revealed Resident #3's start of care began [illegible]. The primary diagnosis listed was [illegible]'s [illegible]. Review of a witness statement written by Staff P, Resident Care Aide, in regard to Resident #3 dated [illegible], stated, "I [Staff P's name], went	A 025		

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A 025	Continued From page 11	A 025		

to check my residents at 9:30 AM and went into [Resident #3's name] room and witnessed another male resident [identified as Resident #2] putting his penis in her and holding her . I immediately told him to stop and to go to his room. He went to his room. I reported it to the supervisor. Then at around 11:30 AM went to check [Resident #3's name] the same male resident [Resident #2] was laying (sic) in bed with her. I asked him to get out and he told me no, then I ran and got the supervisor [Staff C's name] and we took him out of her room."

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 . She described Resident #2 as a very tall fully ambulatory male, who resided on the same floor as Resident #3. She further stated the staff in charge of the day shift on the day of the incident was Staff D. 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. No known interventions except to redirect Resident #2 to his room were put in place between the time of the first incident and the second incident which occurred two hours later.

An interview with Resident #5 was conducted on at 11:00 AM. Resident #5 stated,

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A 025	Continued From page 12 "Staffing has become a real concern as well. There isn't enough staff to clean the facility or do the laundry. The hallways are always full of laundry, trash, and food trays. This is causing an increase in bugs. There are roaches everywhere. At night there is no staff on the 3rd floor. If you need something, it doesn't do any good to call. No one will answer the phone. The staff that are still here are very rude. They treat the residents like an inconvenience." An interview was conducted with Resident #6 on . . . . . at 11:15 AM. He stated he . on Friday, , at around 9 PM. He was in his room and . against a chair and hurt his right side. He remained on the floor in his room for hours. He yelled for help for over two hours. He used his cell phone to call the facility for help. He called the main number 25 times, and no one answered. He finally managed to get himself off the floor and into his bed. In the morning when staff came to bring breakfast, he reported the . An observation of Resident #6 was conducted on . . . . . at 11:15 AM. His right, medial side revealed a deep purple that covered his medial side from his upper ribcage to his pant line. On at 8:50 AM, an interview was conducted with the Fire Chief of the City of Brooksville Fire Rescue. He stated he had recently talked to the City Manager about concerns related to the number of calls they were receiving from the facility for non-emergency issues. He stated they have received many calls in the past several months for resident . . . When they get there it is found the resident is not hurt, they just need assistance getting into bed, and what they are hearing from the residents	A 025		

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A 025	Continued From page 13 is there is not enough staff or that they cannot get assistance from staff to get them into bed. He further stated this is concerning because these kinds of calls are taking them away from actual emergency calls which they are unable to respond to because of being tied up on non-emergent routine issues which the facility should be able to address. On at 10:30 AM, an interview was conducted with Staff C, Med. Tech. When asked if she thought there was sufficient staff to meet the needs of the residents, she stated, "No, I do not! We have barely enough facility staff, thank goodness for the agency staff otherwise we would be in real trouble. There has been a significant change since the new owners took over and it is not for the better." When asked if she thought there was sufficient staffing to meet the needs of the residents on all shifts, she responded, "No, I do not. Some days we have enough staff and other days not." She further stated, "There is no resident call system, that is why I try to check on them as frequently as possible." On at 11:35 AM, an interview was conducted with Staff J, Resident Care Aide. When asked if she thought there was sufficient staff to meet the needs of the residents on all shifts, she responded, "No, I do not. Some days we have enough staff and other days not." She further stated, "The new owners have not addressed the concerns as to how residents can call for help, they either have to yell or call the facility to get staffs' attention. There is no working phone on the third floor. There are also two phones on the first floor, one on second floor which residents can use but, most need assistance to place a call." When asked if she thought the residents receive proper care to meet	A 025		

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

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A 025	Continued From page 14 their needs, she stated, "No, I don't. I think a lot gets put on the burner." An interview was conducted with the Acting Director on at 9:00 AM. She stated she had a resident (identified as Resident #18) admitted on around 2:00 AM from the hospital. Resident #18 was re-admitted into the facility with a or possibly . The resident was not on hospice. The Acting Director stated she was working on getting the resident placed in a nursing facility but had not received confirmation yet. She stated, "I know we are not supposed to admit a resident with a who is not on hospice. I was not made aware of this admission until this morning. The only staff here to receive the resident was a Med Tech and there were two resident aides working as well. Her paperwork from the hospital also stated she had a possible on her heals. No one has assessed her since her re-admission." An observation of Resident #18 was conducted on at 12:15 PM. The resident was observed sitting in wheelchair in her room. There was no seat cushion in her wheelchair. Staff attempted to assist resident into her bed for an observation of the . She was observed to be a total assist to transfer to her bed. She would not bear and relied on staff to get her into bed. An observation of the revealed an open area on her approximately 5 centimeters in diameter. The area of injury was reddened with drainage. The was not dated and was soiled and not intact. The heels were covered with that were dated .	A 025		

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A 025	Continued From page 15 There was no documentation of a facility assessment on re-admission. An interview was conducted with Resident #18 on [redacted] at 12:15 PM. The resident stated, "The staff are very kind to me. They could use some more help. There is not a lot of staff, but the girls do the best they can." An observation of Resident #11 was conducted on [redacted] at 11:00 AM. The resident was observed to be alert with [redacted]. He had bandages on both [redacted]. Review of the Hernando County Sheriff's Report incident #2021-01174, dated [redacted], revealed the Brooksville Fire Rescue was concerned [Resident #11's name] had not removed his mask in a very long period of time. During a medical call to the facility, Brooksville Fire Rescue personnel found [Resident #11's name] to have a medical mask embedded in the skin behind his [redacted] which caused significant [redacted] and required hospital care. Review of Resident #11's Resident Health Assessment for Assisted Living Facilities, AHCA Form 1823, dated [redacted] revealed he had diagnoses of [redacted], and [redacted]. The comment section noted he required daily observation for his wellbeing. An interview was conducted with Resident #12 on [redacted] at 11:45 AM. The resident stated she hasn't had a shower in three weeks because there wasn't enough staff to help. She also stated the bathroom in her room is not wheelchair accessible. She cannot get into her bathroom to use the toilet or brush her [redacted]. She must use	A 025		

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A 025	Continued From page 16 the public restroom down in the lobby. An observation of Resident #12 was conducted on at 11:45 AM. Resident #12 had a , and was observed sitting in her power wheelchair. She was wearing stained clothing, her skin had streaks of dirt, and she had an unpleasant odor. Review of Resident #12's Resident Health Assessment for Assisted Living Facilities, AHCA Form 1823, dated revealed the resident has a diagnosis of left, , and . The comments section notes the resident is a total assist with ambulation. On at 2:50 PM, an interview was conducted with Staff E, Med. Tech. She stated she works on the second floor as a Med Tech during the first shift and is responsible for the medications for 38 residents. She further stated, "Most residents are independent on the second floor, but we do have a few that require assistance with , bathing, and with no housekeeping with stripping beds, which I am doing right now due to a lack of staff. We do the best we can, but we are unable to give quality care at this time." An interview with Resident #10 was conducted on at 11:00 AM. Resident #10 stated there is not enough staff to care for the needs of the residents. There is no housekeeping to clean resident rooms or do the laundry. The resident was informed by staff that there was no one available to help clean his room. An observation of Resident #10 on at	A 025		

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A 025	Continued From page 17	A 025		

11:00 AM, showed his clothing was dirty with stains on his shirt and pants. There was an unpleasant odor in his room. There was a trash can full of garbage at the entrance of the room. The floors in the room were dirty and additional trash was observed around the room.

A review of the Hernando County Sheriff's Report incident #2020-35774, dated ..... read, "Upon arrival the Deputy made contact with [Staff O's name] a Med. Tech. at [the facility's name]. He stated [Resident #15's name] had not been seen in the facility since ..... at 4:45 PM. [Staff O's name] advised he was notified by other residents that she left the facility on ... but could not provide any more information." The Deputy noted he was familiar with [Resident #15's name] and had interacted with her earlier in the day. It was determined [Resident #15's name] had left the facility three times between and ..... On the first two occasions, [Resident #15's name] around downtown and ended up going to a local residence down the from the facility. A call was received from the residence advising that [Resident #15's name] was present at their house. The Deputy responded and found [Resident #15's name] on the roadway, who was visibly shaking due to the ... temperatures. Due to [Resident #15's name] continuing to willingly away from the facility, and the facility's inability to contain her, it was deemed likely she would suffer from neglect or injury. [Resident #15's name] was placed in protective custody and remanded to a local ... receiving facility.

An interview with Resident #17 was conducted on at 11:10 AM. Resident #17 stated he had not had clean bed sheets for two weeks. He was told by a Resident Aide, "There is not enough

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A 025	Continued From page 18 staff to wash the laundry and he would simply have to wait." An observation of Resident #17 was conducted on [redacted] at 11:10 AM. Resident #17 was observed sitting in a chair in his room. His clothes were stained and had an unpleasant odor. His hair was uncombed, and he was unshaven. His room had laundry piled in three corners. There was an overflowing trash container in the corner. An interview was conducted on [redacted] at 3:00 PM with Resident #4. Resident #4 stated there is very little staff to assist. He stated he can stand and pivot to get into his bed if there is someone there to steady him. With the lack of staffing, he must wait sometimes until 11:00 PM to 12:00 AM before anyone can help him into bed. He has had to spend the night in his chair many times because there was no staff to assist him into bed. There is very little staff to keep the laundry done so it piles up. An observation of Resident #4 on [redacted] at 3:00 PM showed the resident had stains on his shirt and crumbs of food visible on front of his clothing. He had food remains in his beard and he smelled of [redacted]. His room had two piles of laundry along one wall which smelled of feces and [redacted]. A review of Resident #4's Resident Health Assessment for Assisted Living Facilities, AHCA Form 1823, not dated, revealed diagnoses of [redacted], left [redacted], abnormal posture, [redacted], and [redacted] following [redacted] affecting right dominant side, aphasia, type 2 [redacted], & [redacted]. The comments	A 025		

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A 025	Continued From page 19 section noted he required assistance with ambulation, toileting and transferring. On at 4:54 PM, a telephonic interview was conducted with Staff K, third shift Resident Care Aide. She confirmed there is not sufficient staff on the third shift. She stated, "Most days it is just me and another Resident Care Aide to not only watch and be responsible for the residents on all three floors, but that they are also expected to do housekeeping and laundry as well. I am sick of covering for the place. When are they going to shut it down? You work for the State. Can't you shut it down, because that is what needs to happen. I and the other Resident Care Aide try our best to check on residents every two hours, but isn't always possible because we are spread too thin. We are only resident aides we cannot document anything. We have to report it to a Med. Tech. and if there is none on our shift we have to report it to a Med. Tech. when they come on first shift in the morning. I know the phones are unplugged from the wall during the second shift to keep the residents from calling 911 all the time. The only way we know the residents need help is if they call out to us. These residents do not receive the kind of care they deserve. I know I wouldn't want my loved one living here." 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	A 025		

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A 025	Continued From page 20 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." On , at approximately 9:15 AM, an observation of Resident #7 revealed the of his khaki colored pants were wet with . On at 9:55 AM, an interview was conducted with Staff S, Hospice Aide for Resident #27. The Hospice Aide stated, "I do not feel she is getting care. I would come one time a week. Her laundry is not getting washed. It piles up each week. I came in on Friday and found one of my other patients, [Resident #26's name] lying in ." On at 2:52 PM, an interview was conducted with Resident #20. He stated, "I have a . The nurse last checked my in . I have not seen her in or . I'm worried about it, it was last changed in . The facility could not produce any records of home health visits or consultations with outside medical services. Class I	A 025		
A 030 SS=K	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (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	A 030		

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A 030	Continued From page 21 Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, 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 59A-36.006, 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;	A 030		

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A 030	Continued From page 22 7. . . . . control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery 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,	A 030		

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A 030	Continued From page 23 free from . . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, 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	A 030		

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A 030	Continued From page 24 at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate 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 must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. 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,	A 030		

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A 030	Continued From page 25 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, [illegible], and 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 [illegible] Hotline operated by the Department of Children and Families, and, if applicable, [illegible], 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 [illegible] Hotline operated by the Department of Children and Families, and [illegible], Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using	A 030		

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(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 030	Continued From page 26 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 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 observation, interview, and record review, the facility failed to provide a safe, decent living environment, an environment free from pests; failed to ensure freedom from for 3 of 27 residents, resident numbers 3, 9, and 18; failed to ensure freedom from neglect for 13 of 27 residents, resident numbers 1, 4, 5, 6, 7, 9, 10, 11, 12, 14, 15, 17, and 18; and failed to develop and implement COVID-19 (Corona 2019) control procedures, which has the potential to affect all residents residing in the facility. Findings: 1) During the initial tour on at 9:30 AM, the following observations were noted: The facility hallways were observed to have piles of soiled laundry and trash throughout. There were torn curtains on the windows. There were spider webs visible on the windows as well as corners of the hallways. Two mattresses were found lying	A 030		

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NOBLE SENIOR LIVING AT BROOKSVILLE	307 HOWELL AVENUE BROOKSVILLE, FL 34601

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on the floor at the end of the third-floor hallway. Three pillows without pillowcases were found at the end of the second-floor hallway. Piles of soiled laundry, full bags of trash, as well as loose garbage were observed in the residents' rooms. There was an unpleasant odor throughout the facility.

An interview with Resident #5 was conducted on at 11:00 AM. Resident #5 stated, "Staffing has become a real concern as well. There isn't enough staff to clean the facility or do the laundry. The hallways are always full of laundry, trash, and food trays. This is causing an increase in bugs. There are roaches everywhere. At night there is no staff on the 3rd floor. If you need something, it doesn't do any good to call. No one will answer the phone. The staff that are still here are very rude. They treat the residents like an inconvenience."

An interview with Resident #6 was conducted on at 11:15 AM. Resident #6 stated, "The staff do not care about the residents. There is never enough staff to meet the needs of the residents. People have just started taking care of themselves and the people around them. Residents take their laundry down to the laundry room, take their own garbage out, and try to help each other. There are roaches in my room and in the hallways."

On , at 10:35 AM, an interview was conducted with Staff C, Medication Technician (Med Tech). When asked if the facility had a problem with roaches she stated, "Yes, it does. The facility does have a problem with roaches."

On , at 11:36 AM, an interview was conducted with Staff L, Resident Care Aid. When

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A 030	Continued From page 28 asked if the facility has a problem with roaches she stated, "Yes, it does. Due to the residents eating in their rooms it has created more of a problem." An interview with Resident #7 was conducted on [redacted] at 1:00 PM. Resident #7 reported having a lot of roaches in her room. She bought a can of bug spray because they still had a bug problem. She stated she had roaches in her inhaler one morning when she went to use it. The resident stated there is a lack of housekeeping and supplies. She stated she has gone weeks without housekeeping. The floor in her bathroom is dirty and she can't clean it by herself. There is a lack of supplies which includes toilet paper, soap, and clean towels. Residents are helping each other with mopping floors and picking up garbage. She reports going without toilet paper for two to three weeks, and even now she must practically beg to get a roll of toilet paper. An interview with Resident #14 was conducted on [redacted] at 3:00 PM. Resident #14 stated her room is dirty. It hasn't been vacuumed in a couple of months. Her roommate asked to use the facility's vacuum so they could clean the room themselves, but this was not allowed. There is no staff to do her laundry. She reported she has seen an increase in the roaches in her room because of the dirty floor. An interview was conducted with Resident #1 on [redacted] at 9:30 AM. Resident #1 reported she was very upset that staff were not helping her get her room floor clean. The roaches were getting worse and she felt if she could get her floors clean that would help.	A 030		

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A 030	Continued From page 29 An observation during the interview with Resident #1 on at 9:30 AM showed there were two live roaches observed crawling on the wall. On at 9:40 AM, an interview was conducted with the Acting Director. She confirmed the facility has run out of clean towels. The resident aides don't have clean towels to give the residents showers. An interview was conducted with Resident #15 on at 1:45 PM. Resident #15 stated she had a lot of roaches in her room. She sees them crawling on the wall at night. She told staff, but they didn't do anything about it. On at 2:50 PM, an interview was conducted with Staff C, Med Tech, Second Floor. When asked if the facility has a bug problem, Staff C stated, "That has always been a problem now and again, but , now I have noticed more of a problem since COVID-19 because residents have been confined to their rooms and are eating in their rooms." During an observation of Resident #10 on at 11:00 AM, his clothing was dirty with stains on his shirt and pants. There was an unpleasant odor in his room. There was a trash can full of garbage at the entrance of the room. The floors in the room were dirty and additional loose trash was observed around the room. An interview was conducted with Resident #17 on at 11:10 AM. The resident stated his supplies get shipped directly to him for the use with the home health nurse. He doesn't like the fact that he has seen roaches crawling on his supplies. There is very little staff to assist with taking out the garbage.	A 030		

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A 030	Continued From page 30 During an observation of Resident #17 on [redacted] at 11:10 AM, the resident was dressed in clothes that were stained and had an unpleasant odor. His hair was uncombed, and he was unshaven. His room had laundry piled in three corners. There was an overflowing trash container in the corner. An interview was conducted with Resident #4 on [redacted] at 3:00 PM. Resident #4 stated, "No staff come in to get the laundry and so it piles up, which is why you see the roaches crawling everywhere." An observation on [redacted] at 3:00 PM was conducted during the interview with Resident #4 and showed the resident had stains on his shirt and crumbs of food visible on the front of his clothing. He had food remains in his beard and he smelled of [redacted]. His room had two piles of soiled laundry along one wall which smelled of feces and [redacted]. Live roaches were crawling on two of the walls in his room. During a telephonic interview on [redacted] at 4:54 PM with Staff K, Resident Care Aide, who works the third shift [11 PM to 7 AM], she stated she not only has the responsibility of watching the residents, but also is expected to do housekeeping and laundry. She stated that is not possible because there is only one additional Resident Care Aide with her, and they are responsible for all three floors. When asked if the facility had a bug problem she stated, "Oh my, yes! There are rooms that are running with roaches, it is disgusting!" Review of the facility census for [redacted] revealed a census of 102.	A 030		

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A 030	Continued From page 31 2) Review of Resident #3's Resident Health Assessment for Assisted Living Facilities, AHCA (Agency for Health Care Administration) Form 1823, dated [redacted], shows diagnoses of [redacted], and [redacted]. She was admitted on [redacted]. The comments section noted resident's physical or sensory limitations as wheelchair, Spanish speaking, and [redacted] Nursing/Treatment/[redacted] Service Requirements include hospice care. Review of Hospice Certification of Illness, dated [redacted], showed a start of care on [redacted]. Primary diagnosis was listed as [redacted]. Review of a witness statement written by Staff P, Resident Care Aide, in regard to Resident #3 dated [redacted], stated, "I [Staff P's name], went to check my residents at 9:30 AM and went into [Resident #3's name] room and witnessed another male resident [identified as Resident #2] putting his penis in her [redacted] and holding her [redacted]. I immediately told him to stop and to go to his room. He went to his room. I reported it to the supervisor. Then at around 11:30 AM went to check [Resident #3's name] and the same male resident [Resident #2] was laying (sic) in bed with her. I asked him to get out and he told me no, then I ran and got the supervisor [Staff C's name] and we took him out of her room." On [redacted] at 11:10 AM, an interview was conducted with the Acting Director regarding the alleged incident involving Resident #2 and	A 030		

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A 030	Continued From page 32 Resident # 3. She described Resident #3 as a frail, small framed , , female resident on hospice with . She described Resident #2 as a very tall fully ambulatory , male, who resided on the same floor as Resident #3. She further stated the staff in charge of the day shift on the day of the incident was Staff D. 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. No known interventions except to redirect Resident #2 to his room were put in place between the time of the first incident and the second incident which occurred two hours later. The Acting Director stated after she was notified, she immediately placed a call to the Regional Director of Operations who advised her to contact hospice which she did on at 5:16 PM. She did not come to the facility until the following day, . She stated law enforcement was contacted the next day on at 10:45 AM, as well as the Department of Children and Families. During a follow-up interview on , at 2:20 PM the Acting Director stated, she directed staff to keep a direct line of sight on Resident #2, he was moved to the third floor on Tuesday, . The psychologist completed an evaluation on at 4:00 PM. Resident #2 was later that same evening. On at 10:30 AM, an interview was conducted with Staff C, Med Tech. Staff C stated,	A 030		

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A 030	Continued From page 33 "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 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. She further stated she was not familiar with Resident #2. There were no special instructions, no history on this resident at all, as she could not find the resident's chart at the time of the incident. She stated she was never instructed by administration to contact law enforcement. She continued, "I don't know if or when law enforcement was contacted. I was unsure with the restrictions with COVID [Corona] and everything. I was waiting for the Administration to direct me to call Law Enforcement, but I wasn't advised to do so - so I didn't. Rounds are supposed to be made to each and every room and I do not think that has been happening. There is no way for the residents to call for assistance from the care staff that is why it is imperative for staff to faithfully make their rounds." On at 2:06 PM, an interview was conducted with Staff R, Medical Assistant,	A 030		

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A 030	Continued From page 34 Certified Nursing Assistant, with a private physician service. She stated on Tuesday, [redacted], following the incident between Resident #2, and Resident #3, she met Resident #3 for the first time. She described Resident #2 as very manipulative, and disobedient in his response to her requests for him to zip up his pants. She stated while she was talking with him, he began making [redacted] advances or suggestive remarks to her that she found very inappropriate. He ignored her multiple requests for him to button up his pants and to refrain from making remarks. By the time she finished speaking with him he exposed himself as he walked down the hallway from the nurses' station to the elevator. An interview was conducted with Resident #6 on [redacted] at 11:15 AM. He stated he [redacted] on Friday, [redacted], at around 9 PM. He was in his room and [redacted] against a chair and hurt his right side. He remained on the floor in his room for hours. He yelled for help for over two hours. He used his cell phone to call the facility for help. He called the main number 25 times, and no one answered. He finally managed to get himself off the floor and into his bed. In the morning when staff came to bring breakfast, he reported the [redacted]. An observation of Resident #6 was conducted on [redacted] at 11:15 AM. His right, medial side revealed a deep purple [redacted] that covered his medial side from his upper ribcage to his pant line. An interview was conducted with the Acting Director on [redacted] at 9:00 AM. She stated she had a resident (identified as Resident #18) admitted on [redacted] around 2:00 AM from the hospital. Resident #18 was re-admitted [redacted] into the facility with a [redacted] or possibly [redacted]	A 030		

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A 030	Continued From page 35 . The resident was not on hospice. The Acting Director stated she was working on getting the resident placed in a nursing facility but had not received confirmation yet. She stated, "I know we are not supposed to admit a resident with a , who is not on hospice. I was not made aware of this admission until this morning. The only staff here to receive the resident was a Med Tech and there were two resident aides working as well. Her paperwork from the hospital also stated she had a possible on her heals. No one has assessed her since her re-admission." An observation of Resident #18 was conducted on at 12:15 PM. The resident was observed sitting in wheelchair in her room. There was no seat cushion in her wheelchair. Staff attempted to assist resident into her bed for an observation of the . She was observed to be a total assist to transfer to her bed. She would not bear and relied on staff to get her into bed. An observation of the revealed an open area on her , approximately 5 centimeters in diameter. The area of injury was rendered with drainage. The was not dated and was soiled and not intact. The heels were covered with that were dated , from the hospital. There was no documentation of a facility assessment on re-admission. An observation of Resident #11 was conducted on at 11:00 AM. The resident was observed to be alert with . He had bandages on both . A review of the Hernando County Sheriff's Report	A 030		

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A 030	Continued From page 36 incident # 2021-01174, dated , revealed the Brooksville Fire Rescue was concerned [Resident #11's name] had not removed his mask in a very long period. During a medical call to the facility, 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 hospital care. An interview was conducted with Resident #12 on at 11:45 AM. The resident stated she hasn't had a shower in three weeks because there wasn't enough staff to help. She also stated the bathroom in her room is not wheelchair accessible. She cannot get into her bathroom to use the toilet or brush her . She must use the public restroom down in the lobby. Resident #12 stated staff are rude to her and the other residents. They yell at the residents and ignore their needs. She stated she previously lived on the first floor. An observation of Resident #12 was conducted on at 11:45 AM. Resident #12 had a , and was observed sitting in her power wheelchair. She was wearing stained clothing, her skin had streaks of dirt, and she had an unpleasant odor. A review of the Hernando County Sheriff's Report incident #2021-01174, dated , reported Fire Rescue Personnel observing residents laying in soiled sheets right in front of the facility staff. The sheets were observed to have been soiled and the resident not cleaned for hours if not a longer period. An interview was conducted with Resident #17 on at 11:10 AM. Resident #17 stated he	A 030		

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A 030	Continued From page 37 had not had clean bed sheets for two weeks. He was told by a Resident Aide, "There is not enough staff to wash the laundry and he would simply have to wait." An observation of Resident #17 was conducted on [redacted] at 11:10 AM. Resident #17 was observed sitting in a chair in his room. His clothes were stained and had an unpleasant odor. His hair was uncombed, and he was unshaven. His room had laundry piled in three corners. There was an overflowing trash container in the corner. An interview was conducted on [redacted] at 3:00 PM with Resident #4. He stated there is very little staff to assist the residents. He stated he can stand and pivot to get into his bed if there is someone there to steady him. With the lack of staffing, he must wait sometimes until 11:00 PM to 12:00 AM before anyone can help him into bed. He has had to spend the night in his chair many times because there was no staff to assist him into bed. An observation of Resident #4 was conducted on [redacted] at 3:00 PM. Resident #4 was sitting in his power wheelchair in his room. He had stains on his shirt and crumbs of food visible on front of his clothing. He had food remains in his beard and he smelled of [redacted]. His room had two piles of laundry along one wall which smelled of feces and [redacted]. There were roaches crawling on two of the walls in his room. (Photographic evidence obtained.) On [redacted] 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	A 030		

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day late in [redacted] (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."

Review of the Hernando County Sheriff's open case report 2020-33396 revealed a [redacted] was documented on [redacted] at 5:46 PM. Allegations were made against [Resident #10's name], caught performing oral [redacted] on [Resident #9's name], who is mentally [redacted]. The incident allegedly occurred on [redacted] but was not reported until one month later by [Resident #9's name, roommate, Resident #11's name]. An interview was conducted during the investigation with [Resident #9's name] mother. She stated she was made aware that her mentally [redacted] son had been [redacted] assaulted by another resident identified as [Resident #10's name]. [Resident #9's name] mother further stated she had been informed of the incident by her son's roommate. He had witnessed [Resident #10's name] performing oral [redacted] on her son, "who has a mental [redacted] and has the mental capacity of a [redacted]."

Review of the facility resident room roster dated [redacted] confirmed Resident #9 and Resident #10 continue to reside on the second floor.

During an interview with the Acting Director on

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NOBLE SENIOR LIVING AT BROOKSVILLE	307 HOWELL AVENUE BROOKSVILLE, FL 34601

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. . . . . at approximately 10:00 AM, she stated staff were advised to ensure distance is maintained between [Resident #9's name and Resident #10's name], and document any further interactions observed. She confirmed no documentation has occurred that this is being done.

3) On . . . . . at 9:30 AM, a tour of the facility was conducted. Observed were signs on 16 resident rooms warning that droplet precautions were required. Personal Protective Equipment (PPE) storage containers were placed outside of 11 of the 16 rooms. The containers had a supply of gloves, gowns, surgical masks, and aloe wipes. There were no N95 masks, , goggles or . . shields, bleach wipes, or -based sanitizer available for staff entering these rooms. Only four of the 16 residents were in their rooms at the time of observation.

During the tour it was also observed that multiple residents were walking throughout the inside of the facility, outside the facility, and in the smoking area of the facility with no masks on. -based sanitizer was available at the entrance of the facility, in the nursing stations, and on medication carts, but no other sanitizer was available for staff or residents to use. Restrooms were not stocked with soap and/or paper towels.

On . . . . . at 11:00 AM, during an interview, Staff Q, Agency Licensed Practical Nurse (LPN) stated that contact precautions were put into place in . . for residents who were positive for COVID-19. Residents have not been screened for signs and symptoms of COVID-19 and/or received any COVID-19 testing to remove the precautions. She stated the facility does not

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A 030	Continued From page 40 provide N95 masks for care of residents who are positive for COVID-19. She stated the housekeeping staff had quit in . . . . . , so regular cleaning and was not being completed. Due to the lack of staffing, screening of staff and residents is not completed. She herself has not been screened or tested for COVID-19 since early . On at 2:00 PM, an interview was conducted with the Acting Director. The Acting Director stated, the Administrator stated she was unable to provide a list of positive COVID-19 residents or staff, COVID-19 testing dates, COVID-19 policies and procedures, a list of PPE supplies, or staff training related to COVID-19. She stated residents who are suspected of having COVID-19 are not staying in their rooms. Residents walk around the facility and around the community. She stated there is no way to restrict the residents' activities. She was unaware of anyone contacting the Department of Health with information about positive COVID-19 residents and/or staff. The facility's COVID-19 screening procedures for staff, visitors, and residents was observed on , , , and . Staff were not observed to be screened for COVID-19 upon entrance to their shifts. Staff and delivery personnel were observed entering the facility through the front entrance without being screened for COVID-19. The Centers for . . . . . Control and Prevention has provided guidance for preventing the spread of COVID-19 in assisted living facilities (ALFs.) The CDC Internet website, updated on (accessed on . . . . .), states the following, "To prevent spread of COVID-19 in their facilities,	A 030		

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A 030	Continued From page 41 ALFs should take the following actions: Immediately notify the health department about any of the following: If COVID-19 is suspected or confirmed among residents or facility personnel; Designate one or more facility employees to actively screen all visitors and personnel, including essential consultant personnel, for the presence of and symptoms consistent with COVID-19 before starting each shift/when they enter the building; Personnel should wear a facemask (or cloth covering if facemasks are not available or only source control is required) at all times while they are in the facility; Encourage residents to wear a cloth covering (if tolerated) whenever they are around others, including when they leave their rooms and when they leave the facility (e.g., residents receiving ,); Provide access to -based sanitizer with at least 60% throughout the facility and keep sinks stocked with soap and paper towels; Ensure adequate cleaning and supplies are available. Provide EPA-registered disposable wipes so that commonly used surfaces can be wiped down." Class I	A 030		
A 054 SS=E	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for	A 054		

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A 054	Continued From page 42 use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain and immediately update the daily medication observation record each time the medication was offered or administered for 2 of 3 sampled residents who receive assistance with self-administration of medications or medication administration, resident numbers 20 and 21. Findings: A review of the paper Medication Observation Record (MOR) for Resident #20 revealed for the period of to the following physician ordered evening medications were not documented as having been provided or	A 054		

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A 054	Continued From page 43 refused: [illegible] SOD DR [illegible] delayed release] 250 MG [milligrams] capsule, [illegible] 300 MG tablet, [illegible] 3 MG tablet, and [illegible] 300 MG capsule. A review of Resident #21's facility record showed there was no paper MOR or electronic MOR for the period of [illegible] to [illegible] that documented the following physician ordered medications were provided or refused: tab 20 MG, [illegible] 10 MG, [illegible] 5 MG tab, [illegible] tab 25 MG, [illegible] 15 MG tablet, [illegible] tablets 10 MG, [illegible] 100 MG, and [illegible] 0.4 MG. During an interview conducted on [illegible] at 3:15 PM, Staff Y, Medication Technician, reported, "I use a paper medication administration sheet for [Resident #20's name] because he does not have an electronic one with all of his medications on it. Second shift does not record their medication assistance on the paper sheet. I do not know why. [Resident #21's name] does not have an electronic medication administration record with his medications on it and also does not have a paper one. I do not know why he does not have one." Class III	A 054		
A 079 SS=K	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and	A 079		

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Respite Care Residents Staff Hours/Week
0-5 168
[illegible] 212
16-25 253
26-35 294
36-45 335
46-55 375
56-65 416
66-75 457
76-85 498
86-95 539

For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week.
2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours.
3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.
4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night.
5. A staff member who has completed courses in First Aid and [illegible]
( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times.
a. Documentation of attendance at First Aid or

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A 079	Continued From page 45 courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with	A 079		

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A 079	Continued From page 46 the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs.	A 079		

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A 079	Continued From page 47 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to have enough qualified staff to provide resident supervision, to provide or arrange for resident services, and to provide for resident care for 18 of 27 residents sampled, resident numbers 1, 4, 5, 6, 7, 9, 10, 11, 12, 14, 15, 17, 18, 23, 24, 25, 26, and 27. Findings: An interview was conducted with Resident #1 on [redacted] at 2:00 PM. Resident #1 stated she had not had a shower in four or five days. Her laundry hasn't been completed by staff in a month. Resident #1 stated she was told that staff walked out one day, and they haven't been able to get sufficient staff since then. Resident #1 stated residents are mopping floors, vacuuming, and taking their own garbage out. She reported	A 079		

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A 079	Continued From page 48 she was very upset that staff were not helping her get her room floor clean. The roaches were getting worse and she felt if she could get her floors clean that would help. On , at approximately 9:40 AM, an interview was conducted with a Hernando County Sheriff's Deputy. The Sheriff's Deputy stated a resident (Resident #11) had received services from Brooksville Fire Rescue because the resident's mask had become embedded in the skin behind his . The mask had to be cut off, which caused considerable and , to the resident. An observation of Resident #11 was conducted on at 11:00 AM. The resident was observed to be alert with . He had bandages on both . A review was conducted of Resident #11's Resident Health Assessment for Assisted Living Facilities, AHCA Form 1823, dated . According to the assessment, Resident #11 has a diagnosis of , and . The comment section noted that the resident requires daily observation of his wellbeing. A review was conducted of the Hernando County Sheriff's Report (Incident #2021-01174) dated . The report described the incident involving Resident #11 who had not removed his mask for a long period of time. During a recent medical call to the facility, Brooksville Fire Rescue personnel found Resident #11 to have a medical mask embedded in the skin behind his which caused significant and required hospital care.	A 079		

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A 079	Continued From page 49 An interview was conducted with Resident #6 on at 11:15 AM. He stated he on Friday, , at around 9:00 PM. He was in his room and against a chair and hurt his right side. He remained on the floor in his room for hours. He yelled for help for over two hours. He used his cell phone to call the facility for help. He called the main number 25 times, and no one answered. He finally managed to get himself off the floor and into his bed. In the morning when staff came to bring breakfast, he reported the . He stated, there is never enough staff to meet the needs of the residents. People have just started taking care of themselves and the people around them. Residents take their laundry down to the laundry room, take their own garbage out, and try to help each other. An observation of Resident #6 was conducted on at 11:15 AM. His right, medial side revealed a deep purple that covered his medial side from his upper ribcage to his pant line. An interview with Resident #5 was conducted on at 11:00 AM. Resident #5 stated, staffing has become a real concern as well. There isn't enough staff to clean the facility or do the laundry. The resident stated the hallways are always full of laundry, trash, and food trays. At night there is no staff on the third floor, and no one answers the telephone if he needs something. The resident stated that the staff are very rude and treat the residents like an inconvenience. On , at 8:50 AM, an interview was conducted with the Fire Chief of the City of Brooksville Fire Rescue. He stated they have received many calls in the past several months	A 079		

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for resident . . . When emergency personnel arrive, it is found the resident is not hurt, they just need assistance getting . . . into bed. They are hearing from the residents that there are not enough staff or that they cannot get assistance from staff to get them into bed.

On , at 10:30 AM, an interview was conducted with Staff C, Med Tech. When asked if she thought there was sufficient staff to meet the needs of the residents, Staff C stated, "No, I do not! There has been a significant change since the new owners took over and it is not for the better." When asked if she thought there was sufficient staffing to meet the needs of the residents on all shifts, Staff C responded, "No, I do not." She further stated, "There is no resident call system."

On , at 11:35 AM, an interview was conducted with Staff J, Resident Care Aide. When asked if she thought there was sufficient staff to meet the needs of the residents on all shifts, she responded, "No, I do not." She further stated the new owners have not addressed the concerns as to how residents can call for help, they either have to yell or call the facility to get staffs' attention. There is no working phone on the third floor, there are also two phones on the first floor, one on second floor which residents can use but, most need assistance to place a call. When asked if she thought the residents receive proper care to meet their needs, she stated, "No I don't, I think a lot gets put on the . . . burner."

An interview was conducted with Resident #7 on at 1:00 PM. Resident #7 stated there is a lack of housekeeping services. She stated she has gone weeks without housekeeping. The

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A 079	Continued From page 51 floor in her bathroom is dirty and she can't clean it by herself. Residents are helping each other with mopping floors and picking up garbage. An interview was conducted with Resident #14 on at 3:00 PM. Resident #14 stated her room is dirty. It hasn't been vacuumed in a couple of months. Her roommate asked to use the facility's vacuum so they could clean the room themselves, but this was not allowed. There is no staff to do her laundry. An observation of Resident #12 was conducted on at 11:45 AM. Resident #12 has an and was observed sitting in her power wheelchair. She was wearing stained clothing, her skin had streaks of dirt, and she had an unpleasant odor. An interview was conducted with Resident #12 on at 11:45 AM. Resident #12 stated she hasn't had a shower in three weeks. When the resident inquired when she can get a shower, she was informed there isn't enough staff to help with that. A review was conducted of Resident #12's Resident Health Assessment for Assisted Living Facilities, AHCA Form 1823, dated Resident #12 has diagnoses of left, and The comments section notes resident is a total assist with ambulation. An interview was conducted with Resident #15 on at 1:45 PM. Resident #15 was upset with staff because she stated she had not received her medications. She returned from the hospital on and the Med Tech did not	A 079		

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(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 079	Continued From page 52 have all her medications yet. A review of Resident #15's Resident Health Assessment for Assisted Living Facilities, AHCA Form 1823, dated [redacted], revealed she was diagnosed with [redacted], Type 2 [redacted], history of [redacted], and [redacted]. Her admission date was [redacted]. The special precautions section noted the resident is at risk for [redacted], [redacted] and [redacted]. The resident is noted to require medication administration from licensed staff. An interview was conducted on [redacted] at 11:00 AM with Resident #10. He stated there is not enough staff to care for the needs of the residents. There is no housekeeping to clean the resident rooms or do the laundry. He was informed by staff that there was not anyone here that could help clean his room. An observation of Resident #10 was conducted on [redacted] at 11:00 AM. Resident #10 was observed sitting in his wheelchair. His clothing was dirty with stains on his shirt and pants. His hair was not combed, and he was unshaven. There was an unpleasant odor in his room. There was a trash can full of garbage at the entrance of the room. The floors in the room were dirty and additional trash was observed around the room. On [redacted], at 2:50 PM, an interview was conducted with Staff E, Med Tech. Staff E stated she works on the second floor during the first shift and is responsible for the medications for 38 residents. Staff E stated that she is also assisting with stripping beds due to lack of housekeeping staff. When asked if the residents are receiving care to meet their needs, she stated, "No, not at	A 079		

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

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NOBLE SENIOR LIVING AT BROOKSVILLE	307 HOWELL AVENUE BROOKSVILLE, FL 34601

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A 079	Continued From page 53 this time due to us being short staffed." When asked if there is sufficient staff to meet the needs of the residents, she stated, "No I do not, we do the best we can but we are unable to give quality care at this time." An observation of Resident #17 was conducted on at 11:10 AM. Resident #17 was observed sitting in a chair in his room. He was dressed in clothes that were stained and had an unpleasant odor. His hair was uncombed, and he was unshaven. His room had soiled laundry piled in three corners. There was an overflowing trash container in the corner. An interview with Resident #17 was conducted on at 11:10 AM. The resident stated he has not had clean sheets on his bed in two weeks. He was told by a Resident Aide that there are not enough staff to wash the laundry and he would have to wait. An observation of Resident #4 was conducted on at 3:00 PM. Resident #4 was sitting in his power wheelchair in his room. He had stains on his shirt and crumbs of food visible on front of his clothing. He had food remains in his beard and he smelled of . He had an of his left . His room had two piles of soiled laundry along one wall which smelled of feces and . An interview with Resident #4 was conducted on at 3:00 PM. Resident #4 stated he can stand and pivot to get into his bed if there is someone there to steady him. With the lack of staffing, he must wait sometimes until 11:00 PM to 12:00 AM before anyone can help him into bed. He has had to spend the night in his chair many times, because there were no staff to assist him	A 079		

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A 079	Continued From page 54 ... into bed. A review was conducted of Resident #4's Resident Health Assessment for Assisted Living Facilities, AHCA Form 1823, (not dated). Resident #4 has diagnoses of , , , left , abnormal posture, , , and , following , affecting right dominant side, aphasia, Type 2 , and . The comments section noted the resident requires assistance with ambulation, toileting, and transferring. On , at 4:54 PM, a telephone interview was conducted with Staff K, Resident Care Aide. Staff K confirmed there is not sufficient staff on the third shift. Staff K stated that on most days, she and another Resident Care Aide are responsible for the residents on all three floors, and they are also expected to do housekeeping and laundry. She and the other Resident Care Aide try to check on the residents every two hours, but it isn't always possible. The only way the staff knows the residents need help is if they call out. The residents do not receive the kind of care they deserve." 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	A 079		

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A 079	Continued From page 55 name] and I don't know if he reported it." On . . . . . at 9:15 AM, an observation of Resident #9 was conducted. Resident #9 was observed walking around the lobby and hallway in front of the library in wet stained pants. Resident #9's clothing was disheveled. On . . . . . at 9:55 AM, an interview was conducted with Staff S, Hospice Aide for Resident #27. The Hospice Aide stated, "I do not feel she is getting care. I would come one time a week. Her laundry is not getting washed. It piles up each week. I came in on Friday and found one of my other patients, [Resident #26's name] lying in ." On at 10:22 AM, an interview was conducted with Staff E, Med Tech. She reported she started working today at 7:00 AM. She stated she is running behind today. When asked about staffing, she stated, "I do not feel that there is enough staff here to care for the residents. There is not enough staff on the second shift. I am responsible for 39 residents today." On . . . . . at 10:25 AM, an interview was conducted with Resident #11. He stated, "There is not enough staff to help with showers. I would like two showers a week but cannot get two showers each week because they say there is not enough staff." He stated he needs assistance due to falling in the past. On . . . . . at 10:30 AM, an interview was conducted with Resident #24. He stated there is not enough staff to take care of him and the residents. On at 10:59 AM, an interview was	A 079		

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A 079	Continued From page 56 conducted with Resident #25. He stated that staff do not respond when the residents call and need assistance. On at 11:11 AM, an observation was conducted of Resident #26, who is receiving hospice services. The resident's hair was observed to be matted. On at 11:13 AM, an interview was conducted with Staff T, LPN, Agency Nurse. She stated, "I am responsible for 29 today - the whole first floor. I have been assigned here since the second week of . The residents on the first floor need more care. I believe some of them need long term care. They are short staffed here on this floor. There are roaming residents and the fact that the ward is not secure it is a concern. There is no housekeeper assigned to this area all the time." On at 11:23 AM, an interview was conducted with Staff U, CNA, Agency Staff. She stated, "There is not enough housekeepers. There is not enough staff here to provide care." On at 11:30 AM, an observation of Resident #23's bathroom revealed soiled bathroom towels on the floor around the toilet. There is a reddish-brown substance on the frame of the three in one commode seat over the toilet. (Photographic evidence obtained.) On at 11:35 AM, an interview was conducted with Staff V, PTA (Assistant. She stated, "They have not had enough staff here." On at 11:50 AM, an observation of the male and female restrooms adjacent to the dining	A 079		

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A 079	Continued From page 57 hall revealed dirty floors, no toilet paper or paper towels in either restrooms, a clogged toilet in the female restroom and a green and reddish-brown substance on the sink in the male restroom. (Photographic evidence obtained.) On . . . . . at 12:33 PM, a follow-up interview was conducted with Staff T, LPN, Agency Nurse. She stated, I do not feel that they schedule enough people to care for the level of care needed by the facility. The residents do not have personal clothing, shampoo and conditioner and body wash. She stated, "The laundry does not get done around here." On at 1:23 PM, an interview was conducted with Resident #1. She stated, "I went to the laundromat and do my laundry. Laundry has not been done for five weeks. We have one housekeeper on the third floor, but all she has is Windex to clean the toilet bowl. I bought my own cleaning supplies this weekend." On at 1:50 PM a review was conducted of the staffing schedule for . . . . . - 24/2021. The hours were requested from the Administrator to verify the hours documented on the staffing schedule. No documentation was provided to verify the actual hours worked by direct care staff. Class I	A 079		
A 152 SS=E	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.;	A 152		

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A 152	Continued From page 58 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable . . to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . . . . . . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure a safe living environment free of hazards and failed to ensure linens and personal laundry services were provided for 10 of 20 residents sampled, resident numbers 1, 4, 5, 6, 7,	A 152		

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A 152	Continued From page 59 10, 14, 15, 17, and 23. Findings: During the initial tour on at 9:30 AM, the following observations were noted: The facility hallways were observed to have piles of soiled laundry and trash throughout. There were torn curtains on the windows. There were spider webs visible on the windows as well as corners of the hallways. Two mattresses were found lying on the floor at the end of the third-floor hallway. Three pillows without pillowcases, were found at the end of the second-floor hallway. Piles of soiled laundry, full bags of trash, as well as loose garbage was observed in the residents' rooms. There was an unpleasant odor throughout the facility. On , at 9:50 AM, an observation was conducted of Resident #1's room. Dirty laundry was observed piled in a corner of the room. On , at 9:50 AM, during an interview Resident #1 stated that her laundry hasn't been completed by staff in a month. Resident #1 stated that she had to go to the laundry room to collect her dirty clothes and ask her daughter to wash them for her. She reported she was very upset that staff were not helping her get her room floor clean On at approximately 10:15 AM, an observation was conducted of the laundry room on the first floor. A large volume of soiled laundry was observed piled up, some unbagged, and some bagged in large clear bags. (Photographic evidence.) On , at approximately 10:15 AM, an	A 152		

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A 152	Continued From page 60 interview was conducted with Staff M, who stated she was hired on , and she is trying to catch up on weeks and weeks of dirty laundry. An interview with Resident #5 was conducted on at 11:00 AM. Resident #5 stated, "Staffing has become a real concern as well. There isn't enough staff to clean the facility or do the laundry. The hallways are always full of laundry, trash, and food trays. This is causing an increase in bugs. There are roaches everywhere." An interview with Resident #6 was conducted on at 11:15 AM. Resident #6 stated, residents take their laundry down to the laundry room, take their own garbage out, and try to help each other. There are roaches in my room and in the hallways." On , at 10:35 AM, an interview was conducted with Staff C, Medication Technician (Med Tech). When asked if the facility had a problem with roaches she stated, "Yes, it does. The facility does have a problem with roaches." On , at 11:36 AM, an interview was conducted with Staff L, Resident Care Aid. When asked if the facility has a problem with roaches she stated, "Yes, it does. Due to the residents eating in their rooms it has created more of a problem." An interview with Resident #7 was conducted on at 1:00 PM. Resident #7 reported having a lot of roaches in her room. She bought a can of bug spray because they still had a bug problem. She stated she had roaches in her inhaler one morning when she went to use it. The resident stated there is a lack of	A 152		

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A 152	Continued From page 61 housekeeping and supplies. She stated she has gone weeks without housekeeping. The floor in her bathroom is dirty and she can't clean it by herself. There is a lack of supplies which includes toilet paper, soap, and clean towels. Residents are helping each other with mopping floors and picking up garbage. She reports going without toilet paper for two to three weeks, and even now she must practically beg to get a roll of toilet paper. An interview with Resident #14 was conducted on [redacted] at 3:00 PM. Resident #14 stated her room is dirty. It hasn't been vacuumed in a couple of months. Her roommate asked to use the facility's vacuum so they could clean the room themselves, but this was not allowed. There is no staff to do her laundry. Resident #14 reported she has seen an increase in the roaches in her room because of the dirty floor. During an observation of Resident #1's room on [redacted] at 9:30 AM, showed the resident's room had soiled laundry piled in a corner. Resident #1 reported she was very upset that staff were not helping her get her room floor clean. The roaches were getting worse and she felt if she could get her floors clean that would help. An observation during the interview with Resident #1 on [redacted] at 9:30 AM showed there were two live roaches observed crawling on the wall. On [redacted], at 9:40 AM, an interview was conducted with the Acting Director. She confirmed the facility has run out of clean towels and that she is tempted to go to a store to buy some because the resident aides don't have clean towels to use when giving the residents	A 152		

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A 152	Continued From page 62 showers. An interview with Resident #15 was conducted on at 1:45 PM. Resident #15 stated she had a lot of roaches in her room. She sees them crawling on the wall at night. She told staff, but they didn't do anything about it. On at 2:50 PM, an interview was conducted with Staff C, Med Tech, Second Floor. When asked if the facility has a bug problem, Staff C stated, "That has always been a problem now and again, but now I have noticed more of a problem since COVID-19 because residents have been confined to their rooms and are eating in their rooms." During an observation of Resident #10 on at 11:00 AM, his clothing was dirty with stains on his shirt and pants. There was an unpleasant odor in his room. There was a trash can full of garbage at the entrance of the room. The floors in the room were dirty and additional loose trash was observed around the room. An interview with Resident #10 was conducted on at 11:00 AM. Resident #10 stated there is not enough staff to care for the needs of the residents. There is no housekeeping to clean resident rooms or do the laundry. An interview with Resident #17 was conducted on at 11:10 AM. The resident stated his supplies get shipped directly to him for the use with the home health nurse. He doesn't like the fact that he has seen roaches crawling on his supplies. He stated there is very little staff to assist with taking out the garbage and keeping the laundry washed. The resident stated he has not had clean sheets on his bed in two	A 152		

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A 152	Continued From page 63 weeks. During an observation of Resident #17 on at 11:10 AM, the resident was dressed in clothes that were stained and had an unpleasant odor. His hair was uncombed, and he was unshaven. His room had laundry piled in three corners. There was an overflowing trash container in the corner. An interview with Resident #4 was conducted on at 3:00 PM. Resident #4 stated, "No staff come in to get the laundry and so it piles up, which is why you see the roaches crawling everywhere. There is very little staff to keep the soiled laundry done so it piles up." An observation on at 3:00 PM was conducted during the interview with Resident #4 and showed the resident had stains on his shirt and crumbs of food visible on the front of his clothing. He had food remains in his beard and he smelled of . His room had two piles of soiled laundry along one wall which smelled of feces and . Live roaches were crawling on two of the walls in his room. On at 4:54 PM, a telephonic interview was conducted with Staff K, Resident Care Aide who works the third shift. She stated she not only has the responsibility of watching the residents, but also is expected to do housekeeping and laundry. She stated that is not possible because there is only one additional Resident Care Aide with her, and they are responsible for all three floors. Staff K, works the third shift [11 PM to 7 AM], when asked if the facility had a bug problem she stated, "Oh my, yes! There are rooms that are running with roaches, it is disgusting!"	A 152		

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A 152	Continued From page 64 On . . . . . at 11:30 AM, an observation of Resident #23's bathroom revealed soiled bathroom towels on the floor around the toilet. There is a reddish-brown substance on the frame of the three in one commode seat over the toilet. (Photographic evidence obtained.) On at 11:50 AM, an observation of the male and female restrooms adjacent to the dining hall revealed dirty floors, no toilet paper or paper towels in either restrooms, a clogged toilet in the female restroom and a green and reddish-brown substance on the sink in the male restroom. (Photographic evidence obtained.) On at 1:23 PM, an interview was conducted with Resident #1. She stated, "We have one housekeeper on the third floor, but all she has is Windex to clean the toilet bowl. I bought my own cleaning supplies this weekend." Class III	A 152		
AL240 SS=E	429.075; 59A-36.020(1) LMH - Licensing 429.075 Limited mental health license.-An assisted living facility that serves one or more mental health residents must obtain a limited mental health license. 59A-36.020 Limited Mental Health. (1) LICENSE APPLICATION. (a) Any facility intending to admit one or more mental health residents must obtain a limited mental health license from the agency before accepting the mental health resident. (b) Facilities applying for a limited mental health license that have uncorrected deficiencies or violations found during the facility's last survey,	AL240		

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NOBLE SENIOR LIVING AT BROOKSVILLE	307 HOWELL AVENUE BROOKSVILLE, FL 34601

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AL240	Continued From page 65 complaint investigation, or monitoring visit will be surveyed before the issuance of a limited mental health license to determine if such deficiencies or violations have been corrected. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility continued residency for residents who required mental health services without a limited mental health license for 11 of 102 residents reviewed, resident numbers 5, 11, 28, 30, 33, 34, 35, 36, 37, 38, and 40. Findings: A review of FloridaHealthFinder.gov website showed on the facility changed ownership. Under the previous owners, the facility had a limited mental health license. The facility has a provisional license without a limited mental health specialty license. Review of the MOVE IN RECORD - Resident Information for Resident #5 revealed an initial move in date of and the current move in date of with diagnosis to include dependence. Review of the Resident Health Assessment for Assisted Living Facilities revealed diagnosis to include , and medications to include , (used to treat ,), (used to treat , or a combination of the two), and , (used to treat , and). Review of the MOVE IN RECORD - Resident Information for Resident #11 revealed an initial move in date of with diagnosis to include .	AL240		

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 _____	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

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AL240	Continued From page 66 Review of the MOVE IN RECORD - Resident Information for Resident #28 revealed an initial move in date of . Review of the Resident Health Assessment for Assisted Living Facilities revealed medications to include , 600 mg (milligrams) three times daily by . (used as a stabilizer or , the dose is usually between 900 and 2,000 mg a day). Review of the MOVE IN RECORD - Resident Information for Resident #30 revealed an initial move in date of with diagnosis to include major . Review of the MOVE IN RECORD - Resident Information for Resident #33 revealed an initial move in date of with diagnosis to include major . Review of the Resident Health Assessment for Assisted Living Facilities for Resident #34 revealed diagnosis to include and medications to include (an used to treat). Review of the MOVE IN RECORD - Resident Information for Resident #35 revealed an initial move in date of with diagnosis to include major . Review of the MOVE IN RECORD - Resident Information for Resident #36 revealed an initial move in date of with diagnosis to include with Bodies. Review of the MOVE IN RECORD - Resident Information for Resident #37 revealed an initial move in date of with diagnosis to	AL240		

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 _____	01/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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AL240	Continued From page 67 include major , and - Review of the MOVE IN RECORD - Resident Information for Resident #38 revealed an initial move in date of with diagnosis to include . Review of the MOVE IN RECORD - Resident Information for Resident #40 revealed an initial move in date of with diagnosis to include , . On at 4:10 PM, an interview was conducted with the Acting Director. She stated, "Prior to the new owners buying the facility, this facility had a specialty license for limited mental health and now this owner only wanted a standard license, yet the same resident population exists that were here prior to the change in ownership. These residents are in need of more care than we presently are prepared to give." A review of the resident records revealed the following residents received , and were in need of mental health services, resident numbers 5, 11, 28, 30, 33, 34, 35, 36, 37, 38, and 40. Class III	AL240		