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
	AL11964707	A. BUILDING: _____ B. WING _____	07/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIGO PALMS	570 NATIONAL HEALTHCARE BLVD DAYTONA BEACH, FL 32114

(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 A complaint investigation (complaint number 2021006088, 2021003205, 2021008335, 2021008334) was conducted at Indigo Palms on to . The facility had deficiencies at the time of the survey. Class I deficiencies were identified at A0025 Resident Care- Supervision and A0030 Resident Care- Rights and Facility Procedures.	A 000		
A 025 SS=J	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 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	A 025		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 025	Continued From page 1 supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (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 observations, interviews, and review of records, the facility failed to provide sufficient supervision to 1 of 4 residents reviewed (Resident #1). The failure to provide adequate supervision to Resident #1 following an aggressive act toward staff resulted in the assault of 2 residents, each who required transfer to the emergency department (Residents #2 and #3). Resident #3 eventually as a result of the	A 025		

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A 025	Continued From page 2 The findings include: 1. During a facility tour on at 9:55 am, multiple residents were greeted. In an interview with Employee D, Licensed Practical Nurse (LPN), at 11:14 am on , he reported the majority of the residents in the building were and explained most did not make any sense when speaking. Review of the census at the time of the survey found there were 30 residents living in the facility. A record review conducted for Resident #1 revealed he was admitted to the facility on . He was . Per his Resident Health Assessment (AHCA form 1823) dated , he had a diagnosis of and ( ). The form also noted with behavioral disturbances. He received (, a stimulant medication used to treat) 10 milligrams twice a day. Resident #1 required hourly oversight for his whereabouts "for the time being". There was no further explanation as to why hourly oversight was needed at the time of the exam. The form was not signed off as being completed by a licensed assessor on page 4. Photographic evidence was obtained. A review of the facility's policy on "24 Hour Supervision" (#111) stated the facility shall provide twenty-four (24) hour supervision 7 days a week on each shift. There was no specific explanation as to what that supervision entailed and the policy did not address the need for additional supervision should resident behavior dictate the need. Photographic evidence	A 025		

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A 025	Continued From page 3 obtained. A review of Resident #1's record found a Nursing Progress note authored by the Director of Nursing (DON) on . It stated Resident #1 was admitted this day and described him as polite and sociable. The note said the resident's representative would return with clothing and medications the next day. It included information about Resident #1 throwing coffee on someone. On , the DON noted Resident #1's representative reported she had seen a change in Resident #1 over the last 4 months after all of his medication was stopped by his former facility. He changed after that. They said he could not return. Photographic evidence obtained. A facility incident report was completed by Employee A, Residential Aid ( ), stated on at 4:30 am, Resident #1 was sitting at a table. Employee A asked him to get up and go to his room. Resident #1 threatened to kill Employee A and punched him in the , causing it to swell. The form asked whether he was treated by a physician, whether emergency treatment was given, and what steps were taken to prevent recurrence, but they were all blank. Photographic evidence obtained. Later that same day ( ), the DON completed an incident report stating at 11:00 pm, Resident #1 entered the unlocked room of another resident (Resident #3). When Resident #3 tried to kick him out if his room, he was assaulted by Resident #1. Responses to the questions, "Emergency Treatment Given", "Treated by Physician", and "Hospital Admission" for Resident #1 were all answered "No." There was no response to the question that asked what steps were taken to prevent recurrence. A	A 025		

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A 025	Continued From page 4 corresponding nursing note by the DON reflected his telling the staff to continually monitor Resident #1 following the incident. Photographic evidence obtained. On , Employee I documented Resident #3 was complaining of , and was noted. Resident #3 was sent to the hospital for evaluation and treatment. On at 3:00 pm the hospital notified Employee I Resident #3 had sustained a and was to follow up with his primary care physician and plastic surgeon. A soft diet, medication and treatment was prescribed. After Resident #3's return from the hospital, a progress note by the DON revealed on at 8:00 am, the resident was not able to stand or talk right and he was sent to the hospital a second time, where he was readmitted. A family member provided an electronically transmitted copy of Resident #3's Certificate on . The certificate reported Resident #3 he expired on under hospice care. The manner of was "Homicide". Photographic evidence obtained. Employee C, Medication Technician (MT), was interviewed on at 5:33 pm. She had heard that Resident #1 punched a staff member. She was asked about what level of supervision was provided to Resident #1 after the aggressive act. She said they always "kept an " on Resident #1 because he was always moving. Mostly they tried at night to get him in his room. He would be up all night. That night, close to 11:00 pm, she was doing last rounds and checking on everyone to make sure they were ok. She noticed Resident #1 wasn't in his room, so she checked all the rooms. She found Resident #3 on the floor of his room on his . He had on his and	A 025		

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A 025	Continued From page 5 shirt and had [redacted] on his [redacted]. Resident #1 was in the other bed. Resident #3 explained Resident #1 had injured him. She said she was scared what would have happened if she hadn't come in when she did. Employee C stated the DON told her to tell the night shift what happened and to supervise Resident #3 during the night. She denied direct instructions to do so for Resident #1, but explained of course, they would normally know to increase his supervision. She acknowledged she was told to keep a close [redacted] on Resident #1, but she was unable to relay a specific frequency or oversight schedule. She denied any instructions for one on one supervision, saying the facility doesn't provide that level of supervision. Employee C said staff rotated checking on Resident #1, but she could not say how often that was supposed to be. She denied ever receiving any special training on the management of Resident #1's behavior or how to recognize that he was escalating. Review of Resident #1's Residency Agreement, which was executed and signed by his Responsible Party on [redacted], stated under Exhibit 4, "Assurance Care Level 1", that 24-hour supervision by trained staff would be provided. It did not specify how often direct supervision would be provided. The agreement also provided under section VIII: Termination of Agreement section B that the community held the right to end the agreement under circumstances that endangered other residents. A corresponding policy titled "Termination Agreement" was located which mirrored this, stating they could "terminate the agreement any time if the resident engaged in behaviors that threatened the mental or physical safety of the residents." Photographic evidence was obtained.	A 025		

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A 025	Continued From page 6 A telephone interview was conducted with Resident #1's next of kin/responsible party on [redacted] at 5:00 pm. She explained that on [redacted], prior to his admission to this facility, Resident #1 had been sent under an emergency transfer to a [redacted] hospital by his former facility. He had thrown coffee at one of the girls and threatened to throw the mug but didn't. They didn't want to deal with him. The current facility's staff knew about the emergency transfers prior to Resident #1's admission. She said she was told about his resident-to-resident altercation with Resident #3, and Resident #1 should have been transferred to a psych hospital that same night. The Director of Nursing (DON) was interviewed about the incidents involving Resident #1 at 1:45 pm on [redacted]. He explained that after admission, Resident #1 was fine for a couple of days, then he "snapped". He was resistant to some care and needed redirecting at first but was not violent. He did not recall seeing warning signs leading up to the [redacted]. He confirmed he was notified when Resident #1 went into Resident #3's room and beat him up. When asked what the facility response was to the incident, the DON said he called Psych services, who made a medication change for Resident #1. The DON was asked what was done to increase supervision of Resident #1 after the incident(s). The DON could only explain that staff "saw him all the time" because Resident #1 walked the halls. The DON said the facility could not afford a 1:1 staff assignment. 2. Review of the DON's progress notes described an incident occurring on [redacted] with Resident #1. The DON reported Residents #1 and #2 were last seen at about 11:00 pm in Resident #2's room. They were talking and	A 025		

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A 025	Continued From page 7 watching TV. At 12:15 am, Resident #2 was found in his room down on the bed. He had all over his and . He was sent to the emergency room and returned on at 9:00 am. He had a bandage around his and multiple scratches to his , and arms. Photographic evidence obtained. Review of the hospital records for revealed Resident #2 was seen in the emergency department as a alert. Examination revealed serial too numerous to count on the right side of his and . There was a 4-centimeter (cm) . Several superficial were noted on his anterior , abdomen, and left . Resident #2 was placed on given the number of he received. Photographic evidence obtained. When discussing Resident #2 with the DON at 1:45 pm on , he explained Employee A and the CNA Supervisor were on duty. The first time they checked on the pair, Residents #1 and #2 were talking and watching TV. The residents assured staff they were ok. Resident #2 asked what the big deal was, so staff left the room. During a third visit to the room, staff were assured again by the residents they were fine. Five minutes later, Resident #1 was observed in the hallway with brown substance all over his arms. Staff went to Resident #2's room and found the room had been trashed. Chairs had been moved all around and there was trash on the floor. Resident #2 was found on his bed with scratches on his and a 2-centimeter on the top of his . He did not know what Resident #1 hit Resident #2 with, but there was a broken and bent lamp on the floor.	A 025		

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A 025	Continued From page 8 The DON was asked at 1:45 pm on if he recognized Resident #1 had hit Employee A and Resident #3 days before, and that Employee A then permitted Resident #1 to visit with another resident unsupervised several later. The DON confirmed knowing Resident #1 punched Employee A in the bottom . The Administrator, who was present in the room, interjected that it was just a little "smack". The Administrator explained the facility "kept a better " on Resident #1 after Resident #3's . Staff would go into the room and make sure Resident #1 was ok. He could not expand on how often staff were checking on Resident #1. He said he thought staff went into the room twice on the evening of Resident #1's incident with Resident #2. The Administrator explained the facility does not provide 1:1. They rarely provide any 1:1 supervision. The DON was asked if staff received any individualized training on how to manage Resident #1's behavior. He replied he had all staff do an on-line care training. He denied any individualized training. The DON and Administrator were asked if they had considered the appropriateness of continued residency for Resident #1 after he demonstrated the needed a higher level of care. They acknowledged the Administrator was responsible for determining the appropriateness of continued residency when a resident's needs could not be met in the facility. The DON stated Resident #1's sister withheld information and they did not know the name of his prior facility, or they would have called them for information. The chart was reviewed and Resident #1's sheet from the prior facility was located within it, which contained the name and phone number for their facility. Photographic evidence obtained.	A 025		

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A 025	Continued From page 9 On . . . . . at 3:30 pm, the DON was made aware of thw form and said someone may have filed that without his knowledge because he was not aware it was in the chart. A telephone interview was conducted with Employee A at 8:35 am on . He confirmed he had been struck by Resident #1 the morning of . but didn't know why the resident hit him. Perhaps he was just adjusting to the new facility. He was also working the night Resident #1 Resident #2. He was asked what instructions he had regarding how often to check on Resident #1, given his violent history before that night. He said, "frequently". He was asked what frequent meant, for example, was that every 15 minutes, every hour, or every two hours? He said every two hours, as that is what they typically did. He denied receiving any instructions for more frequent than normal supervision of Resident #1. A telephone interview was conducted with the Certified Nursing Assistant (CNA) Supervisor on at 9:12 am. He stated they were having difficulty with Resident #1's behavior the day of the incident with Resident #2 ( ). He was moving furniture, yelling at people, and bulldozing his way into other residents' rooms. Resident #1 would say he kills people. That evening he was cool and calm. They do not receive formal training on the management and de-escalation of those types of behaviors and the other staff really didn't know how to de escalate him. That evening, they assumed his (new) meds were taking hold. He witnessed Resident #1 having an intelligent conversation with Resident #2 in Resident #2's room. He checked on them roughly every 2 hours to make sure they were ok, because he knew there was a possibility Resident #1 could change. Close to 11:00 pm while doing	A 025		

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A 025	Continued From page 10 last rounds, he and Employee A walked into the room and saw the two residents speaking calmly and intelligently. The CNA supervisor thought it was strange that they seemed to be interacting so well and asked Employee A, "Is this all good, you think?" Employee A said, yes, he would keep checking on the two. The CNA Supervisor explained they were supposed to check on all residents every 2 hours. There were no special instructions for increased supervision of Resident #1 at the time. He left but was called after Resident #1 and Resident #2's altercation. When he arrived to the facility, Resident #1 was walking in the hall with on his pants. His and his right side were also bloody. In Resident #2's room he discovered what did look like "a scene." Resident #2 was covered in . There was a bent warped lamp and on several surfaces. He does not know why Resident #1 was permitted to remain in the facility for so long and stated several staff members had posed the same question. The ARNP was interviewed on at 11:02 am. She confirmed she was contacted about Resident #1 following the incident with Resident #2, but was unaware about the altercation with Resident #3 that happened before that, and wasn't told until afterwards. Review of the policies and procedures found nothing the management of aggressive behaviors. A review of facility staff training records found there was no individualized training provided on the management of Resident #1's violent tendencies or related to his supervision following his first demonstration of aggression. In an interview with the Director of Nursing on at 5:40 pm, he was asked if the	A 025		

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A 025	Continued From page 11 facility had a policy on the management of aggressive resident behaviors. He confirmed they did not. 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 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	A 030		

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A 030	Continued From page 12	A 030		

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;
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.

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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 13 (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . . . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, 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,	A 030		

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	AL11964707	A. BUILDING: _____ B. WING _____	07/12/2021

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A 030	Continued From page 14 autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate 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	A 030		

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A 030	Continued From page 15 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, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names	A 030		

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A 030	Continued From page 16 and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or 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 a review of resident and facility records, and interviews with staff and resident representatives, the facility failed implement sufficient safeguards to preserve the rights of residents to live in an environment free from , for 2 of 4 residents reviewed (Residents	A 030		

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A	Continued From page 17 #2 and #3). Additionally, the facility failed to ensure the rights of 1 of 9 were not violated, by denying him access to his own bedroom, and delaying his discharge to a higher level of care following repeated destructive behavior within the facility (Resident #9). The findings include: 1. A telephone interview was conducted with a complainant as part of pre-survey work on . . . . at 3:20 pm. He explained Resident #3 had been assaulted at the facility by another resident in the facility. Resident #3's bedding had to be discarded because of all the . . . resulting from the accident. When the family visited after the accident, they asked who the . . . . was. In response, a nurse pointed out Resident #1. The complainant said Resident #1 was walking around freely with no staff supervision. Following the . . . . , Resident #3 went 24 days without the ability to eat. A week prior to the , Resident #3 was walking, talking and enjoying a birthday celebration. He in the weeks following the accident, and his . . . . was ruled a homicide. A closed resident record review revealed Resident #3 was admitted to the facility on and was . He had a Resident Health Assessment dated . . . which noted a diagnosis of with behavioral disturbances and . . . . . Resident #3 presented with . . . , , and the need for constant reminders and prompts with activities of daily living. He required daily oversight for his elbowing, whereabouts and important tasks. Photographic evidence was	A 030		

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A 030	Continued From page 18 obtained. Review of facility records found an incident report for Resident #3 dated . It noted at 10:49 pm, staff were doing a last round check of the facility when they found Resident #3 on his on the floor of his room. Resident #1 was asleep in the bed in Resident #3's room. Employee C, Medication Technician (MT) and report author, cleaned Resident #3 up. The DON and physician were notified. A corresponding incident report completed by the DON explained Resident #3 was assaulted after attempting to kick the other resident out of his room. Photographic evidence was obtained. Employee C, Medication Technician (MT), was interviewed on at 5:33 pm. She explained the circumstances of the incident report and that she discovered Resident #3 in his room after his . She asked who did this to him, and Resident #3 pointed to Resident #1 and said, "that guy." She cleaned up Resident #3 who had all over. She said he was scared what would have happened if she hadn't come in. Review of Nursing Progress notes found Employee I, Licensed Practical Nurse (LPN), noted the incident on . The events were consistent with the facility incident reports. Employee I reported mild and to Resident #3's as a result of the incident. Subsequent notes by Employee I revealed on from 8:00 am - 9:15 am, Resident #3 was complaining of , was noted, and he was sent to the hospital. The hospital notified Employee I on at 3:00 pm that Resident #3 would be returning to the facility. The diagnosis was a left zygomatic	A 030		

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A 030	Continued From page 19 ( ) and he was to follow up with his primary care physician and plastic surgeon. Hospital records for Resident #3 showed a report dated which revealed a remote infarct of the right and left frontal and parietal (a occurring in the of the , which can be caused by a clot or burst) and the left (a small area of the just above the stem). There was (from a ,) within the left . A of bones performed on revealed a non-depressed of the left zygomatic arch. Slightly depressed involving the , left orbital (the bony , that houses the eyeball) floor, of the lateral wall of the left orbit and lateral and anterior wall of left , . Photographic evidence obtained. A facility note dated by the DON noted Resident #3 was not able to stand or talk right. He was sent to the hospital for re-evaluation related to his slurred speech and inability to follow commands. Resident #3 was admitted to the hospital. Photographic evidence was obtained. Hospital records documented Resident #3's re-admission on . He was seen for since being seen there on the 23rd. The Discharge Summary noted Resident #3 was and not responding to questions at the time. He was not to baseline and was discharged to Hospice . Photographic evidence obtained. A review of Resident #3's Certificate, which was transmitted electronically by a family member	A 030		

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A 030	Continued From page 20 on , revealed the manner of Resident #3's was "Homicide". The date of was in hospice. Photographic evidence obtained. A Residency Agreement was signed on behalf of Resident #3 on by his responsible party. Exhibit 6, Statement of Resident Personal Rights and Community Rules and Regulations, referenced receipt of the Resident Handbook and Bill of Rights. Review of the referenced materials found the facility Bill of Rights stated: No resident of a facility shall be deprived of any civil or legal rights... Every resident shall have a right to: a. Live in a safe and decent living environment, free from and neglect... Photographic evidence was obtained. A closed record review for Resident #2 revealed he was admitted to the facility on and was . Per the Resident Health Assessment dated , he had diagnoses of , bi-polar II. He was hard of hearing and required daily oversight for his whereabouts and well-being. Photographic evidence obtained. Resident #2's record contained a nursing progress note by the DON dated that Resident #2 had been found in his room down on the bed. There was all over his and . The incident report showed he was also by Resident #1. Photographic evidence obtained. A record review conducted for Resident #1	A 030		

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A 030	Continued From page 21	A 030		

revealed he was admitted to the facility on . He was , Per his Resident Health Assessment (AHCA form 1823) dated , he had a diagnosis of and ( ). The form also noted with behavioral disturbances.

A review a facility incident report completed by Employee A, Residential Aid ( ), stated on at 4:30 am, prior to his physical confrontations with Residents #2 and #3, Resident #1 threatened to kill Employee A and punched him in the , causing it to swell.

A telephone interview was conducted with Employee A at 8:35 am on . He was working the night Resident of Resident #2's . He denied receiving any instructions for more frequent than normal supervision of Resident #1 and said he checked on him every 2 hours.

A telephone interview was conducted with the Certified Nursing Assistant (CNA) Supervisor on at 9:12 am. He stated the day of the incident with Resident #2 ( ), Resident #1's was yelling, going onto people's rooms, and moving furniture. Resident #1 would say he kills people. That evening he was cool and calm. He saw Resident #1 and #2 having normal conversation, in Resident #2's room. He checked on them roughly every 2 hours to make sure they were ok, and that Resident #1 was not having any more behaviors. Prior to leaving his shift, he consulted with Employee A (who was previously punched by Resident #1), and Employee A said he would keep checking on the two. Thirty

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A 030	Continued From page 22 minutes after he went home, he received a call from Employee A, who reported Resident #2 had been beaten with a lamp and it looked "like scene." When he arrived to the facility, Resident #1 was walking in the hall and was bloody. The room was disheveled when he went in and he saw . . . . on several surfaces. Review of related hospital records confirmed Resident #2 was seen in the emergency department on . Their examination revealed . . . . . too numerous to count on the right side of his and . There was a 4 cm on his . . . . Several superficial . . . . . were noted on his anterior , abdomen, and left . . . . Resident #2 was placed on , , , ... given the number of . . . . . he received. Photographic evidence obtained. A Residency Agreement was signed on behalf of Resident #2 on by his responsible party. Exhibit 6, Statement of Resident Personal Rights and Community Rules and Regulations, referenced receipt of the Resident Handbook and Bill of Rights. Review of the referenced materials found the facility Bill of Rights stated: No resident of a facility shall be deprived of any civil or legal rights... Every resident shall have a right to: a. Live in a safe and decent living environment, free from and neglect... Photographic evidence was obtained. In interview was conducted with the DON at 1:45 pm on . He confirmed Resident #3 had been beaten up by Resident #1, resulting in a hospital trip for Resident #3. He was diagnosed	A 030		

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A 030	Continued From page 23	A 030		

with a broken , orbit and broken floor. After returning to the facility he still didn't look good. He couldn't walk or chew and had to stay in a wheelchair. Resident #3 was sent to the hospital and never returned. The second incident occurred with Resident #2 when Resident #1 was in his room watching television (TV). Employee A and the CNA Supervisor were on duty and checked on the pair but the residents assured staff they were ok, so staff left the room. After a third visit to the room, Resident #2 was found in his room and the room had been trashed. Resident #2 was on his bed with scratches on his and a 2 centimeter on the top of his . He did not know what Resident #1 hit Resident #2 with, but there was a broken bent lamp on the floor.

The DON was asked if he realized Employee A had been hit by Resident #1 before assaulting Resident #3, and that after the incident with Resident #3, staff still permitted Resident #2 to remain in the bedroom unsupervised with Resident #1. He confirmed he knew Employee A had been punched in the bottom , . The Administrator, who was present in the room, interjected that it was just a little "smack". When asked what was done to increase supervision and prevent future incidences from occurring after the first assault on Employee A and then Resident #3. The Administrator could only state that staff "saw him (Resident #1) all the time" because he walked the halls. The facility did not use 1:1 staff assignments, only on rare occasions. After Resident #3's , the facility "kept a better " on Resident #1. Staff would go into the room and make sure Resident #1 was ok. When asked what that meant and how often they were checking on Resident #1 he could not explain.

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A 030	Continued From page 24 A review of the facility and Neglect Policy and Procedures, Policy #609, found it stated the facility prohibits the or neglect of the residents it serves. This applies to employees, consultants and any residents... Definitions: . . . . . is defined as any intentional or negligent act or omission resulting in physical or mental injury to a resident of a facility. ... Should it be the case that a resident of the facility is being abused by another resident, staff shall immediately initiate action to cause such . . . . . to cease. The action will be designed to provide the least amount of infringement upon each residents' rights. (7). This accident will also be documented and immediately reported to the Director and District Manager. (8). The Director shall make a complete report of the incident and the actions taken... (A photocopy was obtained.) In an interview at 5:40 pm on , the Director of Nursing was asked for a policy and procedure on the supervision and management of aggressive residents. He stated the facility had none. 2. Record review for Resident #9 found he had a Nursing Progress note from Employee D, LPN, explaining that on , podiatry services could not be provided this day due to Resident #9's aggressive behavior. On , Employee	A 030		

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A 030	Continued From page 25 D documented Resident 9's [illegible] and behaviors continued to be unstable and his medications have been adjusted. Photographic evidence obtained. A note authored on [illegible] by the DON reflected Resident #9 tearing his room apart and being destructive. Another note reported on [illegible], he punched staff twice in the jaw after she tried to remove a bottle of conditioner from him. Last night, Resident #9 tore apart his room and mattress. The DON called the police for an emergent transfer to a [illegible] hospital. A corresponding review of facility records found an incident report for the occurrence on [illegible]. It confirmed that Resident #9 punched Employee G, MT after she had asked him not to spill a bottle of conditioner. He also kicked her. Notes documented he returned on [illegible]. Photographic evidence obtained. The record contained correspondence from the DON to the Psychiatrist on [illegible] reporting Resident #9 was not sleeping well and was to breaking things. He was fine during the day but night is a "nightmare". A photocopy was obtained. A progress note by Employee D noted another [illegible] hospital admission occurred due to disruptive and impulsive behaviors. Resident #9 caused destruction to property including breaking toilet bowls, cupboards light fixtures. He gets combative and unpredictable with staff. A corresponding incident report by the DON this same day ([illegible]) confirmed that at 6:30 pm, Resident #9 was pulling everything off of the walls	A 030		

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A 030	Continued From page 26 including the TV, pictures and wall sconces. He was turning over tables and chased an employee into a closet. He was sent to a , , hospital for evaluation and treatment. A review of the associated hospital records found Resident #9 was admitted on and had a diagnosis of , . He returned on . Photographic evidence obtained. Further review of the record found he had a Resident Health Assessment dated that noted diagnoses of , and . The examiner indicated Resident #9 required frequent supervision. On , Employee D noted increased , impulsive, and . The DON completed a corresponding report that on at 6:00 pm, Resident #9 was chasing staff around and trying to break the TV and air conditioning units. He was again admitted to the , , hospital. Photographic evidence was obtained. Employee D, LPN, was interviewed at 11:14 am on . He stated he had to send Resident #9 out for emergent , , evaluation and hospitalization this week. He was still in the hospital at the time of the survey. Resident #9's behaviors were impulsive and unpredictable and he acted out in a threatening manner. Employee E, Resident Aide ( ), was interviewed at 1:15 pm on . She was asked about Resident #9. She explained he was always out in the common area sitting on the chair and staff knew, because he was impulsive and	A 030		

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A 030	Continued From page 27 unpredictable, to keep an [illegible] on him. There was someone always out here. They didn't leave him alone with other residents or unsupervised. He once destroyed some lights and a table in the hall. In a second interview at 1:20 pm on [illegible], Employee D stated Resident #9 was provided visual supervision and the staff knew to keep an [illegible] on him because of his behaviors. The LPN was asked to unlock Resident #9's bedroom at this time, but his master key would not unlock the door. He stated they must have changed the lock. He called maintenance, who unlocked the door at approximately 1:40 pm on [illegible]. The room was completely [illegible] of furniture. The [illegible] of the large wall mounted air conditioning unit was completely off, exposing the inner coils. The bathroom was [illegible] of a toilet and sink. There were multiple patches on the walls in the room. The Maintenance Director, who was in the room at the time, insisted the room was just being remodeled, and denied Resident #9's involvement. The Administrator was interviewed at 1:45 pm on [illegible]. The Administrator stated Resident #9's behavior began to change and he would pull things off the walls. He was sent out for emergency [illegible] treatment, but the judge sent him [illegible]. He started pulling [illegible] out of the air conditioner and chasing staff so we sent him [illegible] out. The voices were telling him to do it. Resident #9 destroyed approximately 5 mattresses. You could take your [illegible] off of him for merely 5 seconds and he would turn and destroy something. The Administrator explained they kept Resident #9 out in the common area so people could watch him. The DON, also present	A 030		

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A 030	Continued From page 28	A 030		

in the room, was asked if any interventions were implemented in Response to Resident #9's behaviors. He said they just provided increased supervision. Resident #9 was impulsive and had broken 6 or 7 beds, torn cabinets off the walls, broke the toilet and ripped the sink from the wall. He says the devil makes him do it. He has gone after staff and chased one staff member twice. She locked herself in a closet. His behavior would change very quickly. He started this about a month ago, he used to turn over his room but was never like this. He denied knowledge of the resident sleeping in the living room. The DON and Administrator were asked if they had considered the appropriateness of continued residency for Resident #1 after he demonstrated the needed a higher level of care. Without an answer, they acknowledged the Administrator was responsible for determining the appropriateness of continued residency when a resident's needs could no longer be met in the facility.

A telephone interview was conducted with the Certified Nursing Assistant (CNA) Supervisor at 9:12 am on . He explained Resident #9 was destructive to the facility and a danger to himself. He cut himself on the broken toilet. Resident #9 has been staying in the day room area (the living room on the unit) since he destroyed his room completely. At first it was to keep him out there and keep him visible. Nobody gave him those instructions but "it was common sense" to keep him out of his bedroom and prevent him from destroying it. As a result, all staff did that. We used a vacant room to change him in. Resident #9 has lived in the living room for probably the last 4 months. The CNA Supervisor had observed the resident's bedroom door key

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A 030	Continued From page 29 had been changed so he couldn't even put Resident #9 in his own room. The DON and Administrator knew. The DON said "Keep him on the couch and keep an , on him." A telephone interview was conducted with Employee G, Med Tech, on at 5:30 pm. She explained she longer worked in the facility. Resident #9 was a handful, it was something all the time. He destroyed probably 6 mattresses and everything in his room. She confirmed Resident 39 punched her in the . . . twice, because of his . He had hit her in the past as well. It was a collaborative effort to keep him constantly supervised. The DON told them to watch him. Resident #9 was always in the living room. His favorite chair was there, and the other residents knew not to sit in it. Employee G confirmed Resident #9 slept on the couch in the common area. A review of Resident #9's Residency Agreement found it was signed by his responsible party on . The agreement noted on page 1 under: Accommodations: 1.) Your Apartment: You may occupy and use Apartment 140... subject to the terms of this agreement. Exhibit 6, Statement of Resident Personal Rights and Community Rules and Regulations referenced receipt of the Resident Handbook and Bill of Rights, was also signed by the resident's representative on . The material referenced in the exhibit revealed the Bill of Rights stated: No resident of a facility shall be deprived of any	A 030		

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A 030	Continued From page 30 civil or legal rights... Every resident shall have a right to: a. Live in a safe and decent living environment, free from [redacted] and neglect. b. Be treated with consideration and respect and with due recognition of personal dignity, individuality and the need for privacy. Photographic evidence obtained. The Resident Agreement stated under section VIII B: Termination of Agreement: The community may terminate this agreement at any time, if you are engaging in behavior which is a threat to the mental and /or physical health or safety of you or others. Photographic evidence was obtained. A review of the Director's job description found the following: Basic Function: Responsible for directing the overall operation of the facility's activities in accordance with federal, state and local standards, guidelines and regulations and as directed by the operating board and for ensuring the highest degree of quality patient/resident care is maintained at all times. Essential Functions: 1. Establish and direct the implementation of written policies and procedures... ...5. Review policies and procedures periodically and make changes as necessary... ...6. Ensure the residents right to fair and	A 030		

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A 030	Continued From page 31 equitable treatment... (A photocopy was obtained.)	A 030		
A 165 SS=D	429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident ' s condition and results in: 1. ; 2. or damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or	A 165		

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A 165	Continued From page 32 (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency ' s online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility ' s investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency ' s online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility ' s investigation into the adverse incident. (6) . . . . , neglect, or . , ... must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of	A 165		

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A 165	Continued From page 33 s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. 59A-36.016 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1), above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on a review of resident and facility records and interviews with staff, the facility failed to file an adverse incident report after a resident-to-resident altercation that resulted in the transfer of a resident to the hospital as a result of the incident, and led to his , for one of 4	A 165		

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A 165	Continued From page 34 residents reviewed. The findings include: A record review conducted for Resident #1 revealed he was admitted to the facility on . He was . Per his Resident Health Assessment (AHCA form 1823) dated , he had a diagnosis of and (/ , ,). The form also noted with behavioral disturbances. He received , , (, a stimulant medication used to treat) 10 milligrams twice a day. Resident #1 required hourly oversight for his whereabouts "for the time being". There was no further explanation as to why hourly oversight was needed at the time of the exam. The form was not signed off as being completed by a licensed assessor on page 4. Photographic evidence was obtained. A review of Resident #1's record found a Nursing Progress note authored by the Director of Nursing (DON) on . It stated Resident #1 was admitted this day and described him as polite and sociable. The note said the resident's representative would return with clothing and medications the next day. It included information about Resident #1 throwing coffee on someone. On , the DON noted Resident #1's representative reported she had seen a change in Resident #1 over the last 4 months after all of his medication was stopped by his former facility. He changed after that. They said he could not return. Photographic evidence obtained Review of facility records for Resident #3 found an incident report dated describing an	A 165		

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A 165	Continued From page 35 occurrence at 10:49 pm. Staff found Resident #3 on his on the floor after he had apparently gotten into a fight with another resident (#1). Employee C, Medication Technician (MT), cleaned up Resident #3 and notified the DON and physician were notified. A corresponding incident report authored by the DON this day explained Resident #3 was assaulted after attempting to kick the other resident out of his room. Photographic evidence was obtained. Hospital records for Resident #3 showed a report dated which revealed a remote infarct of the right and left frontal and parietal (a occurring in the of the , which can be caused by a clot or burst) and the left (a small area of the just above the stem). There was (from a) within the left . A of bones performed on revealed a non-depressed of the left zygomatic arch. Slightly depressed involving the left orbital (the bony that houses the eyeball) floor, of the lateral wall of the left orbit and lateral and anterior wall of left . Photographic evidence obtained. A review of Resident #3's Certificate, which was transmitted electronically by a family member on , revealed the manner of Resident #3's was "Homicide". The date of was in hospice. Photographic evidence obtained. An interview was conducted with the DON at 1:45 pm on . He said a staff member called him on a Sunday night and said Resident #3 had been beaten up by Resident #1. Resident #3	A 165		

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A 165	Continued From page 36 went to the hospital the next day and was diagnosed with a broken , orbit and broken floor. After further decompensation, he was sent to the hospital and never returned. When asked why an adverse incident report was not filed, the Administrator, who was also present for the interview, stated "We screwed up. That was a big mistake". He said he thought if they missed the (timeframe) window, then the window was gone. The DON said he didn't even think about at the time. It was a couple of days later that he finally thought about the report. At the time of survey closure on , review of Agency records produced no adverse incident filed for the incident between Resident #1 and Resident #3 that led to Resident #3's hospitalization and subsequent . Class III	A 165		