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 |
|---|---|---|---|
| | AL11910357 | A. BUILDING: _____ B. WING _____ | 11/30/2022 |

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| A 000 | Initial Comments<br><br>An unannounced Complaint (#2022009054, #2022011037, #2022011507, #2022014024) and Generator Monitoring survey was conducted on through at Parkside Inn. The facility had deficiencies identified related to the Complaint survey (#2022009054, #2022011507, #2022014024) at the time of the visit. | A 000 | | |
| A 025 | 429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision<br><br>429.26<br>(7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition.<br><br>59A-36.007 Resident Care Standards.<br>An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.<br>(1) SUPERVISION. Facilities must offer personal | 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<br><br>supervision as appropriate for each resident, including the following:<br>(a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C.<br>(b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident.<br>(c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.<br>(d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change.<br>(e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.<br>(f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to provide care and services appropriate to meet the needs of Residents by failing to provide adequate personal supervision for 2 out 2 sampled residents, Resident #1 and Resident #2.<br><br>The findings included:<br><br>A review of the facility's Policy and Procedure for Incidents and Adverse Incidents reveal that it | A 025 | | |

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| A 025 | Continued From page 2<br><br>focuses on the reporting of those incidents as follows: "The purpose of reporting incidents is to enable an employer an opportunity to see where exactly and how the accidents (incidents) in their company are occurring. Then the employer studies the information and decides ways to prevent such incidents in the future. The employees are then educated in prevention techniques, such as safety training, hoping that the number of incidents will be lowered, the employees, and the residents will be safer and happier"<br><br>1) A review of Resident #1's Health Assessment 1823, dated [redacted], revealed a medical history and diagnoses of unspecified [redacted] risk, [redacted], [redacted], [redacted], replacement and [redacted]. Under Special Precaution documented: [redacted] precaution and activities of daily living (ADLs) needs were as follows: Ambulation (assist), Bathing (total), [redacted] (assist), Eating (assist), Selfcare (grooming) (assist), Toileting (total), Transferring (assist).<br><br>A review of the Agency's report revealed that on [redacted] at 7:30 AM, Resident #1 was found on floor in her room near her bed. When Caregiver Staff C woke her up, Resident #1 was unable to move her left [redacted] and it was [redacted]. The Administrator with assistance from Caregiver Staff C and Caregiver Staff B, made Resident #1 comfortable and then called the doctor at 8:00 AM. The doctor ordered an [redacted]. At 9:00 AM, Resident #1 was taken to a local hospital where they did the [redacted]. A review of the findings at the hospital revealed that a moderately angulated [redacted] was noted. Resident #1 was diagnosed as having moderate to severe [redacted]. | A 025 | | |

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| A 025 | Continued From page 3<br><br>A review of the facility's Internal Investigation Report dated ..., revealed that when Caregiver Staff B went to wake up Resident #1 with Caregiver Staff C, they noticed ... of left ... and she was unable to move. Hospice called and an ... was ordered. The ... showed left ... with no ... and no ... Hospice suspected that because she sleeps with her ... pressed into the bed, it led to the ... because Resident #1 has severe ..., ... and ..., .... No follow-up required. Physician and Responsible Party notified.<br><br>On ... at 10:00 AM, during an interview conducted with the Administrator, she stated that Medication Technician/Supervisor Staff F told her that she found Resident #1 on the floor. The Administrator said that Resident #1's ... was a function of her ..., ... and not from a ... A further review of the facility's Investigation Report revealed that on ..., the facility wrote that there was some new information that would be included in a new report to AHCA.<br><br>On ... at 10:20 AM, during an interview conducted with Caregiver Staff C, she said that on ... at 6:30 AM, she saw Resident #1 in her bed. She said that the Hospice Nurse cared for Resident #1 for the rest of the day on .... Caregiver Staff C said that Hospice was the one that requested that Resident #1 have an ..., because the Hospice Nurse noticed Resident #1's .... During an interview conducted with Caregiver Staff B, she said that she knew nothing about the incident and was not in the room with Caregiver Staff C on the day of the incident on .... | A 025 | | |

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| A 025 | Continued From page 4<br><br>A review of an addendum dated to the facility's Investigation Report, revealed that after fully investigating, it was revealed that Resident #1 was not on the floor nor had she . A Representative from the hospital concluded that Resident #1's was because of her , and , Resident #1 did not have any on her .<br><br>On at 11:20 AM in an interview conducted with the Administrator, she confirmed the statements that Resident #1 had not and that her was because of her , and that Resident #1 should have been better supervised.<br><br>2) A review of Resident #2's Health Assessment 1823 dated , revealed the following medical history and diagnoses: with , generalized Lumbago and sleep . The Special Precautions section revealed that Resident #2 is a moderate risk. Her ADL's were as follows: Ambulation (assist), Bathing (supervision), (supervision), Eating (assist), Selfcare (grooming) (assist), Toileting (independent), Transferring (independent).<br><br>A review of the AHCA report revealed that on at 10:40 PM, Resident #2 could not sleep so she came out of her room and she was walking in a hallway of the facility. At 10:50 PM Caregiver Staff A heard a loud noise and ran to the hallway where Resident #2 was down on | A 025 | | |

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| A 025 | Continued From page 5<br><br>the floor. Resident #2 was [illegible] from her [illegible]. She was alert and communicated that she did not know what happened and she [illegible]. Caregiver Staff A called the Administrator who then called 911 and the Paramedics arrived at 11:00 PM. Resident #2 was transferred to a local hospital. As per the facility investigation report there was no hospital admission. On at 3:35 PM, in an interview conducted with Caregiver Staff A, she stated that she found Resident #2 on the floor, saw that she was [illegible] from her [illegible] and immediately called the Administrator who called 911.<br><br>A review of the report from the local hospital revealed that Resident #2 had [illegible] of her [illegible] bones and possibly [illegible]. Follow up with the [illegible] ([illegible] and [illegible]) listed or [illegible] of her choice. Return to the emergency department if she develops any new or concerning symptoms, has difficulty breathing or has uncontrollable [illegible] from her [illegible]. As per the facility's records, Resident #2 returned to the facility at 2:00 AM on [illegible] with a diagnosis of a [illegible] and with the recommendation to see an [illegible] if warranted. Upon the return to the facility a Nurse Practitioner and Nurse visited Resident #2 on [illegible], and stated that they will review the medications for Resident #2.<br><br>Observed in the Agency Report that on [illegible] at 9:08 PM, the facility wrote that Resident #1 has a low hospital bed. Facility will monitor Resident #1 closely when she is alone sleeping at night and that she should have been rotated so that she would not have had continuous pressure on one [illegible] during her sleeping time. The Administrator said that there should have been better supervision of Resident #2. The Administrator said that she will put in | A 025 | | |

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| A 025 | Continued From page 6<br>place individualized care and supervision processes for the residents that are designated as . risks. Those individualized processes will be placed in the files of each of those residents.<br><br>Class III | A 025 | | |
| A 080 | 429.52( ) FS; 59A-36.011(1) FAC Training - Core & Competency Test<br><br>429.52<br>(2) Administrators and other assisted living facility staff must meet minimum training and education requirements established by the agency by rule. This training and education is intended to assist facilities to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements.<br>(3) The agency, in conjunction with providers, shall develop core training requirements for administrators consisting of core training learning objectives, a competency test, and a minimum required score to indicate successful passage of the core competency test. The required core competency test must cover at least the following topics:<br>(a) State law and rules relating to assisted living facilities.<br>(b) Resident rights and identifying and reporting , neglect, and , .<br>(c) Special needs of elderly persons, persons with mental illness, and persons with , and how to meet those needs.<br>(d) Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food.<br>(e) Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication. | A 080 | | |

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| A 080 | Continued From page 7<br>(f) Firesafety requirements, including fire evacuation drill procedures and other emergency procedures.<br>(g) Care of persons with 's and related . . . . . .<br><br>59A-36.011<br>(1) ASSISTED LIVING FACILITY CORE TRAINING REQUIREMENTS AND COMPETENCY TEST.<br>(a) The assisted living facility core training requirements established by the department pursuant to section 429.52, F.S., shall consist of a minimum of 26 hours of training plus a competency test.<br>(b) Administrators and managers must successfully complete the assisted living facility core training requirements within 3 months from the date of becoming a facility administrator or manager. Successful completion of the core training requirements includes passing the competency test. The minimum passing score for the competency test is 75%. Administrators who have attended core training prior to , , , and managers who attended the core training program prior to , , shall not be required to take the competency test. Administrators licensed as nursing home administrators in accordance with chapter 468, part II, F.S., are exempt from this requirement.<br>(c) Administrators and managers shall participate in 12 hours of continuing education in topics related to assisted living every 2 years.<br>(d) A newly hired administrator or manager who has successfully completed the assisted living facility core training and continuing education requirements, shall not be required to retake the core training. An administrator or manager who has successfully completed the core training but | A 080 | | |

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| A 080 | Continued From page 8<br><br>has not maintained the continuing education requirements will be considered a new administrator or manager for the purposes of the core training requirements and must:<br>1. Retake the assisted living facility core training; and,<br>2. Retake and pass the competency test.<br>(e) The fees for the competency test shall not exceed $200.00. The payment for the competency test fee shall be remitted to the entity administering the test. A new fee is due each time the test is taken.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to ensure the Administrator and direct care staff were trained to properly maintain resident care and to report resident . . . . . promptly.<br><br>The findings included:<br><br>Review of the facility's undated policy and procedures on "Incident Reporting" revealed the following language which included "Incidents are accidents or unusual situations that may involve the residents, their family, or the employee. Incidents should not be ignored but reported as soon as they occur because the incident is fresh in the employee's mind. You should make out an accident/incident report carefully. Included in this report will be information regarding the name of the person completing the report, identification of witnesses, date, time circumstances under which the accident or incident occurred, its effect upon the person, and the action taken. In addition, prompt action can be taken, if necessary, to assure the residents safety. The staff member | A 080 | | |

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| A 080 | Continued From page 9<br><br>who is the first person having knowledge of the incident must fill out the incident report as soon as possible. The initial adverse incident report (1-day) must be completed and sent to AHCA within 1 business day of the incident. The complete adverse incident report (15-day) must be completed and sent to AHCA within 15 calendar days of the incident. Provide those actions that the facility has taken to prevent this type or similar type of incident from reoccurring to this resident." Further review of the facility's policy and procedures revealed that there were no explicit directions on specific circumstances when a staff member must call the DCF (Department of Children and Families) hotline, but there was identification of " hotline 1-800-96- ." on top of page 18 of this document. (Photographic evidence was obtained).<br><br>Review of the facility's full Adverse Incident report dated on revealed that Medication Technician/Supervisor Staff F pushed Resident #3's upper arm while the resident was eating in the dining room on . Review of this report indicated that Caregiver Staff E witnessed this event and reported it to the Administrator on . Review of this report indicated that the Administrator deemed Medication Technician/Supervisor Staff F's behavior towards Resident #3, despite causing no physical injury to the resident. Review of this report indicated that DCF was not informed of this event and it was unclear whether law enforcement was contacted. (Photographic evidence was obtained).<br><br>In an interview conducted with the Administrator on at 10:00 AM, she stated that Caregiver Staff E did not call the DCF | A 080 | | |

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| A 080 | Continued From page 10<br><br>hotline after witnessing Medication Technician/Supervisor Staff F tap Resident #3 on the arm on . . . . . . . She stated that she attempted to report this event to DCF on . . . . . , which was 11 days after this event, and when she contacted DCF, the DCF representative did not accept this report for investigation of potential resident . She stated that observed or suspected resident . . . . . must be reported immediately by all facility staff members, who are mandatory reporters by law. She stated that part of the facility's corrective action plan was to re-train all staff members in prevention and reporting.<br><br>Review of the facility's , Neglect and . . . . . Prevention Training Log dated on . . . . . revealed that this training session was conducted by an individual other than the Administrator and who was employed by a hospice service provider. Review of this Log and related facility records indicated that this was the only . . . . . prevention training offered by the facility after the Adverse Incident on and there was no agenda or specific topics documented for this training. Further review of this Log indicated that Caregiver Staff E did not sign this Log to represent her attendance to this training session.<br><br>In an interview conducted with the Administrator on at 3:20 PM, she stated that she did not know the reason why Caregiver Staff E did not sign the Prevention training Log and that she only knew of another staff member, who presently did not work in the facility, and who did not attend this training. She stated that the . . . . . Prevention Training was offered only once on . . . . . and that she did not arrange for additional training dates to ensure all of the staff | A 080 | | |

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| A 080 | Continued From page 11<br>were adequately trained in this subject. She also stated that she did not ensure the effectiveness of the training in any way, so to ascertain the staff member's retention of the material after the training.<br><br>In an interview conducted with Caregiver Staff E on at 2:00 PM, she stated that she was in the dining room on when she saw Medication Technician/Supervisor Staff F touch Resident #3 on the . She stated that she did not report this suspected to the hotline and she did not know the hotline telephone number by memory.<br><br>In an interview conducted with Caregiver Staff G on at 2:20 PM, she stated that she was a Caregiver since of 2022 and she received initial orientation training which included prevention training sometime in . She stated that she knew to report to the Administrator and she did not know what a mandatory reporter was. She stated that she did not know the hotline telephone number by memory.<br><br>In an interview conducted with Caregiver Staff H on at 2:30 PM, she stated that she was a Caregiver there for about 8 months and she received initial orientation training sometime in , . She stated that she knew to report to the Administrator and the police. She stated that she did not remember receiving prevention training on and also did not know the hotline telephone number by memory.<br><br>Review of the facility's full Adverse Incident Report dated on , revealed Resident #4 was transferred the hospital due to a on | A 080 | | |

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| A 080 | Continued From page 12<br><br>. . . . . Review of this report indicated that the resident was transferring from his chair independently without having his wheelchair for support while standing up in the activity day room, which led to the resident falling and injuring his . Review of this report indicated that the resident used his wheelchair as a walker for ambulation before this event and used it "to move around" with staff supervision after the event. (Photographic evidence was obtained).<br><br>In an interview conducted with the Administrator on . . . . at 1:00 PM, she stated that on when Resident #4 while transferring from sitting to standing, he was doing so independently, to grab his wheelchair because Activities Caregiver Staff I in the activity day room was positioned away from the resident and could not directly see the resident. She stated that the resident used to transfer and ambulate independently before this event, despite his medical examination dated on requiring supervision for these tasks. She stated that the resident also had a Physician order for using a wheelchair for ambulation, but this order did not specify the resident's actual use of this assistive device, for ambulation while standing, which he used like a rolling walker. She stated that part of the facility's corrective action plan was to re-train all staff members to actively observe the residents while in the facility common areas and to properly position themselves to maintain visual contact with all residents inside the activity day room.<br><br>In an observation conducted on at 11:45 AM, Activities Caregiver Staff I was in the activity day room serving the residents drinks from a wheeled cart located in the western-most side of the room. It was observed at this time, that there | A 080 | | |

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| A 080 | Continued From page 13<br><br>were 6 residents inside this room and approximately 4 residents were towards the and outside Activities Caregiver Staff I's line of sight while she was serving drinks behind the cart. It was observed that Activities Caregiver Staff I was not positioned against the southern wall of the room, which would have afforded her visual contact with all of the residents in the room at that time.<br><br>In an interview conducted with Activities Caregiver Staff I on 11-30-22 at 11:50 AM, she stated that she realized that she could maximize her field of vision had she rolled the cart closer to the wall behind her so she could better supervise the residents in the activity day room. She stated that this positioning against the wall of the room would have optimized her observation of the residents in the room and the patio, despite the fact that there were additional staff members supervising the residents who were in the patio at that time. (Photographic evidence was obtained).<br><br>Class III | A 080 | | |
| A 085 | 59A-36.011(7) FAC Training - Nutrition & Food Service<br><br>(7) NUTRITION AND FOOD SERVICE. The administrator or person designated by the administrator as responsible for the facility's food service and the day-to-day supervision of food service staff must obtain, annually, a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility. This requirement does not apply to administrators and designees who are exempt from training requirements under paragraph 59A-36.012(1)(b). A certified food manager, | A 085 | | |

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| A 085 | Continued From page 14<br><br>licensed dietician, registered dietary technician or health department sanitarian is qualified to train assisted living facility staff in nutrition and food service.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on employee record review and interview, the facility failed to ensure that 1 out of 1 sampled staff member, specifically the Cook, had received the required education pertinent to nutrition and food service.<br><br>The findings included:<br><br>During an employee record review for the facility's Cook, hired on , no training certificate was observed in his employee record that proved that he had received a minimum of 2 hours continuing education in topics pertinent to nutrition and food service. Further review indicated that the Cook was the individual responsible for the cooking and preparation of the Residents' daily meals.<br><br>On , at approximately, 12:01 PM, the Administrator stated that she had no training documentation to represent that the Cook had completed the required training for continuing education in topics pertinent to nutrition and food service in an Assisted Living Facility.<br><br>Class III | A 085 | | |
| A 165 | 429.23( & ) FS Risk Mgmt & QA<br><br>429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.-<br>(1) Every facility licensed under this part may, as | A 165 | | |

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| A 165 | Continued From page 15<br>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.<br>(2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means:<br>(a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in:<br>1. ;<br>2. or damage;<br>3. Permanent ;<br>4. or of bones or joints;<br>5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives;<br>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<br>7. An event that is reported to law enforcement or its personnel for investigation; or<br>(b) Resident elopement, if the elopement places the resident at risk of harm or injury.<br>(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 | A 165 | | |

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| A 165 | Continued From page 16<br>incident, and the status of the facility's investigation of the incident.<br>(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.<br>(6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415.<br>(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 s. 456.073 apply.<br>(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.<br>(9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and | A 165 | | |

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| A 165 | Continued From page 17<br>are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board.<br>(10) The agency may adopt rules necessary to administer this section.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to immediately report to the Department of Children and Families (DCF) when its staff determined that 1 out of 3 sampled residents (Resident #3) was suspected to have been [redacted] by a facility staff member. The facility also failed to provide to the Agency its preliminary and full Adverse Incident Reports within the required 1-business day and 15 calendar day limits, for events involving Resident #3 on , Resident #4 on and Resident #5 on [redacted].<br><br>The findings included:<br><br>Review of the facility's undated Policy and Procedures on "Incident Reporting" revealed the following language which included "Incidents are accidents or unusual situations that may involve the residents, their family, or the employee. Incidents should not be ignored but reported as soon as they occur because the incident is fresh in the employee's mind. You should make out an accident/incident report carefully. Included in this report will be information regarding the name of the person completing the report, identification of witnesses, date, time circumstances under which the accident or incident occurred, its effect upon the person, and the action taken. In addition, prompt action can be taken, if necessary, to assure the residents safety. The staff member | A 165 | | |

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| A 165 | Continued From page 18<br>who is the first person having knowledge of the incident must fill out the incident report as soon as possible. The initial Adverse Incident Report (1-day) must be completed and sent to AHCA within 1 business day of the incident. The complete Adverse Incident Report (15-day) must be completed and sent to AHCA within 15 calendar days of the incident. Provide those actions that the facility has taken to prevent this type or similar type of incident from reoccurring to this resident." Further review of the facility's Policy and Procedures revealed that there were no explicit directions on specific circumstances when a staff member must call the DCF hotline, but there was identification of the " hotline 1-800-96- " on top of page 18 of this document. (Photographic evidence was obtained).<br><br>1) Review of the facility's full Adverse Incident Report dated on revealed that it involved an event that was reported to law enforcement for investigation. Review of this report indicated that Medication Technician/Supervisor Staff F pushed Resident #3's upper arm while the resident was eating in the dining room on . Review of this report indicated that Caregiver Staff E reported to the Administrator of this event on and the Administrator retrieved and reviewed the recorded surveillance video of the event on . Review of this report indicated that the Administrator deemed Medication Technician/Supervisor Staff F's behavior towards Resident #3, despite causing no physical injury to the resident. Review of this report indicated that DCF was not informed of this event and it was unclear whether law enforcement was contacted. Further review of this report indicated that the facility was delayed in submitting both its | A 165 | | |

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| A 165 | Continued From page 19<br><br>preliminary and full reports on . . . . . and . . . . . respectively, from the incident which occurred on . . . . . (Photographic evidence was obtained).<br><br>In an interview conducted with the Administrator on . . . . . at 10:00 AM, she stated that Caregiver Staff E did not call the DCF hotline after witnessing Medication Technician/Supervisor Staff F tap Resident #3 on the arm on . . . . . . She stated that the delayed review of the video which represented Medication Technician/Supervisor Staff F lightly touching and/or pushing the resident on . . . . . was due to technical difficulties with her . . . . access to the facility's surveillance videos. She stated that she attempted to report this event to DCF on . . . . . , which was 11 days after this event, and when she contacted DCF, the DCF representative did not accept this report for investigation of potential resident . . . . . She stated that she did not represent her delayed contact with DCF or that any staff member did not contact law enforcement for the investigation of this event, in the full report submitted to the Agency. She also stated that Caregiver Staff E did not complete any incident report for this event and that this was inconsistent with the facility's Policy and Procedures.<br><br>2) Review of the facility's full Adverse Incident Report dated on . . . . . revealed that it involved an event that required the transfer of Resident #4 to the hospital due to the incident rather than the resident's condition prior to the incident. Review of this report indicated that on . . . . . , Resident #4 rose up from his chair without having his wheelchair for support while standing up in the activity day room, which led to the resident falling and injuring his . . . . Review | A 165 | | |

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| A 165 | Continued From page 20<br><br>of this report indicated that Resident #4 was transported to the hospital immediately after this accident and the resident returned to the facility on or before with an order to receive hospice services. Review of this report indicated that the resident used his wheelchair as a walker for ambulation before this event and used it "to move around" with staff supervision after the event. Further review of this report indicated that the facility was delayed in submitting its full report on , from the incident which occurred on . (Photographic evidence was obtained).<br><br>In an interview conducted with the Administrator on at 1:00 PM, she stated that on when Resident #4 while transferring from sitting to standing, he was doing so independently to grab his wheelchair because the Caregiver in the activity day room was positioned away from the resident and could not directly see the resident. She stated that the resident used to transfer and ambulate independently before this event, despite his medical examination dated on requiring supervision for these tasks. She stated that the resident also had a Physician order for using a wheelchair for ambulation, but this order did not specify the resident's actual use of this assistive device, for ambulation while standing, which he used like a rolling walker. She stated that she did not represent all of the environmental issues that occurred during this event, like the staff member's positioning in the activity day room, or the resident's individual use of his wheelchair and his activities of daily living status, in the full report submitted to the Agency.<br><br>3) Review of the facility's full Adverse Incident Report dated on revealed that it involved an event that involved the of | A 165 | | |

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| A 165 | Continued From page 21<br><br>Resident #5's bone to her right . . . Review of this report indicated that on , Resident #5 was angry and punched the door to one of the rooms in the facility with her right . Review of this report indicated that on or before . . . . . , the resident was referred to her Physician due to . . . . and . . . . to the right . . . and her right . was subsequently determined to be . . . . . Review of this report indicated that the resident's behavior of becoming angry and punching doors was due to her underlying . condition as was presently being treated with medications. Further review of this report indicated that the facility was delayed in submitting its full report on . . . . . , from the incident which occurred on . . . . . (Photographic evidence was obtained).<br><br>In an interview conducted with the Administrator on at 10:05 AM, she stated that she was aware that the facility missed the deadlines of the submission of its preliminary and full Adverse Incident Reports to the Agency. She stated that she likely forgot when the facility had to submit its preliminary report, within 1 business day, and its full Adverse Incident Reports, which was within 15 calendar days after the determination of each adverse incident.<br><br>Class III | A 165 | | |