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
	AL11969347	A. BUILDING: _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDING OF LAKE WORTH	9948 WOODWIND LANE LAKE WORTH, FL 33467

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced Complaint (#2023001712) survey was conducted on [redacted] at The Landing of Lake Worth. The facility had a deficiency identified at the time of the survey.	A 000		
A 030	59A-36.007(5) FAC; 429.28(..) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) 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; [redacted], 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- [redacted] or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.	A 030		

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A 030	Continued From page 1 (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 standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (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.	A 030		

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A 030	Continued From page 2 429.28 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, 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.	A 030		

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A 030	Continued From page 3 (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 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	A 030		

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A 030	Continued From page 4	A 030		

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 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

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A 030	Continued From page 5 call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder [redacted] Hotline operated by the Department of Children and Families, and [redacted], 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 [redacted] or [redacted] 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 record review and interviews, the facility failed to ensure that 3 of 3 facility staff who were notified of alleged [redacted] involving Resident #1, immediately reported the [redacted] allegation to the appropriate entities and take immediate steps to implement protective protocols. The facility waited 3 days after having knowledge of the [redacted] allegation to take any preventative action and to inform the State via an Adverse Incident Report, report to the Department of Children and Family Services and	A 030		

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A 030	Continued From page 6 the local Law Enforcement agency, as required when notified of the alleged incident. The findings included: A review of the Facility's Suspected Resident Policy (Rev) states: "Every resident in a Leisure Care managed retirement community has the right to be free from ...In addition, of any type is a violation of company policy and is strictly prohibited. All employees are required to comply with this policy at all times. Violations of this policy will result in discipline up to and including termination of employment and may be punishable by law. Mandatory Reporters: All team members at a Leisure Care community are considered mandatory reporters and must comply with company policy and applicable laws if he/she has knowledge of , has witnessed or reasonably suspects that has occurred.. Failure to report of a resident is a violation of company policy and may be punishable by law... Reporting Requirements: If an employee witnesses physical or , threats of or a resident is in imminent danger, they must call 911 immediately. If a resident does not appear to be in imminent danger, staff must notify the General Manager or designee immediately to direct the implementation of protective protocols to prevent further potential for , neglect or , . The General Manager will ensure protocols are respectful of the resident's rights and dignity. a. If the allegation involves an employee of the community, that staff member will be immediately suspended with pay pending/during an in-house investigation...	A 030		

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A 030	Continued From page 7 After ensuring resident safety, all staff must immediately report any reasonably suspected [illegible] in accordance with company policy and applicable law." Resident #1 was admitted to the Memory Care Unit on [illegible] with diagnoses that included Memory Loss, [illegible], and [illegible]. Resident #1 was [illegible] and forgetful and required assistance with grooming and total care for bathing and [illegible]. Review of the Investigative Report submitted to the Agency for Health Care Administration on [illegible] at 2:50 PM documented in part the following details: - On [illegible] at approximately 11:30AM, (Husband of Resident #1) came to (the facility) and requested a meeting for [illegible] with General Manager (GM) and Memory Care Manager (MCM). - On [illegible] at approximately 12 Noon, (Resident #1's husband) physically arrived at the community; Resident #1's sons were on FaceTime during the meeting. Resident #1's husband stated he had proof his wife was being [illegible]. Resident #1's husband had installed a camera in his wife's apartment without facility permission or acknowledgment. Resident #1's husband stated there was recent video depicting a staff member being physically aggressive with his wife during care from a camera installed in his wife's apartment; however, the husband declined to share proof at this time. - On [illegible], Resident #1's husband allowed the MCM and GM to view the video stored in his cell phone which depicted a health care worker being physically aggressive with Resident #1. The GM and MCM were able to possibly identify the	A 030		

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A 030	Continued From page 8 care staff as Certified Nursing Assistant (CNA) Staff A. - On [redacted] at approximately 1:10 PM, Resident #1's husband provided a voice recording. Resident #1's Nurse Practitioner performed a physical assessment of the resident and noted discoloration to resident behind right [redacted] ([redacted]). - On [redacted] at approximately 2:03 PM, the GM called the Sheriff's department. The Sheriff arrived at 2:30 PM and met with the GM and MCM in the GM's office. At approximately 6:30 PM, DCF [Department of Children and Families] was notified by the GM. During an interview conducted on [redacted] at 11:41 AM, the MCM stated, "On Thursday ([redacted]), the husband showed me and the GM the video of the incident with CNA Staff A. CNA Staff A involved was off that day. When she returned the next day ([redacted]), we had planned on terminating her employment and walking her off the property. CNA Staff A accused of the [redacted] started employment in [redacted] of last year. I did not observe any questionable behaviors displayed by the aide. I never had any other complaints by families or other residents. CNA Staff A always displayed a very caring attitude. It was such a [redacted] to me. I did not observe any changes with the resident's behavior; she was always combative with people. Usually combative with caretakers, often refusing her medications. The Nurse Practitioner did a body assessment on Friday ([redacted] at 11:30 AM) and found [redacted] behind her [redacted]. DCF and the Police were notified at about 2:15 PM on Friday after we found the [redacted] on the resident. We never took any photos of the [redacted] on the resident because the husband did not want any photos taken of his wife. The MCM further stated, the Sheriff came to	A 030		

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A 030	Continued From page 9	A 030		

the facility on [redacted] at about 2:30 PM and interviewed the employee. We never got an opportunity to talk with her about the incident because the Sheriff took her away after speaking with her. She never had contact with the resident after we were made aware of the allegation on [redacted]. We did skin assessments and behavior observations on all Memory Care residents during this time to assess for any other residents who might have been affected. We did not find any other potential concerns."

In an interview conducted on [redacted] at 1:00 PM, the GM stated, "On [redacted], the husband did not voice any serious concern. He never stated his wife was being abused. The husband said he thought his wife may be singled out by staff because she was hard to take care of and resistant to care. [redacted] was not reported by the husband until [redacted] when the husband showed us the video. I saw the CNA on video attempting to take the resident's shirt off. Staff did raise a fist in a threatening manner, but never struck the resident. We reported the [redacted] on Friday, [redacted], when the Nurse Practitioner found a [redacted] behind the right [redacted]."

When asked why he did not report the immediately when hearing the allegation, he stated that they had waited until they had more evidence. "Once a [redacted] was found on the resident, I felt the [redacted] needed to be reported to law enforcement and DCF."

During an interview conducted with Resident #1's spouse on [redacted] at 1:38 PM, he stated: "On the evening of [redacted], after witnessing a video of my wife screaming while (CNA Staff A) was attempting to remove her top. I went to the facility and confronted (CNA Staff A) and the Medication

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A 030	Continued From page 10 Technician on duty (Staff D). I said my wife had claimed someone had hurt her. They both denied the incident and stated that my wife was combative during care. On , I spoke to the Administrator about the incident, but did not show him the video. The aide was at the facility, but was told to stay away from my wife. However, she was in the dining room serving food. On , I showed the Administrator and Memory Care Director the video of the CNA being rough with my wife while removing her top and raising a fist to her in a threatening way. On , I produced a voice recording of someone screaming, 'I didn't hurt you,' but could not be sure who was speaking. The Nurse Practitioner performed an assessment on this date and found a behind my wife's right . The Administrator notified the Sheriff's office and DCF. I hired someone to stay with my wife 24/7 until I could move her out of the facility this morning ( )." Per staff personnel record review, Level II Background Screenings had been completed on CNA Staff A and Medication Technician Staff D prior to employment and both staff were deemed eligible for employment at the time of hire. As of , CNA Staff A and Medication Technician Staff D were no longer eligible for employment. CNA Staff A's employment with the facility was terminated on , and Medication Technician Staff D's employment with the facility was terminated on . Class III	A 030		