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
	AL11968796	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENCES OF PANAMA CITY BEACH	95 GRAND HERON DR PANAMA CITY BEACH, FL 32407

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A 000	Initial Comments An unannounced complaint survey was conducted at Residences of Panama City Beach Assisted Living Facility on - to review complaint number 2023008991. Deficient practice was identified at the time of the survey. The following Class I deficiency was identified on : A0025 Resident Care- Supervision: The facility failed to adequately supervise residents residing in the memory care unit, including maintaining a general awareness of the residents' whereabouts, to prevent for 2 of 20 memory care residents. (Residents #1 and #2) The facility census at the time of the survey was 85, with 20 residents residing in the locked memory care unit. The Senior Divisional Director of Operations and Nursing was notified of the class I deficiencies on at approximately 2:50 PM.	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 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	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 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 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (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	A 025		

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A 025	Continued From page 2 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 record reviews, staff interviews, and policy review, the facility failed to adequately supervise 2 of 20 residents residing in the memory care unit (Resident #1 and #2) resulting in an allegation of . . . assault on . . . . . After the assault, the facility failed to maintain a general awareness of Resident #1's whereabouts to prevent further allegations of . This failure placed all 20 residents residing in the memory care unit at risk for assault. The facility's failure to appropriately supervise residents to prevent . . . . . and maintain a general awareness of residents' whereabouts resulted in a Class I deficiency. These failures had the potential to affect all 20 residents of the facility's memory care unit. The findings include: A review of Resident #1's record revealed the resident was admitted to the facility on with a diagnosis of . . . . The resident was placed in the memory care unit on after he tried to leave the facility. A facility assessment dated revealed he did not always recognize when to make decisions but follows directions and was able to put on, fasten, and remove clothing independently. A daily log note dated at 2:39 PM indicated a facility nurse called Resident #1's primary contact to make her aware of an incident the night before when he was caught having intercourse with Resident #2.	A 025		

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A 025	Continued From page 3 A review of Resident #2's record revealed she was admitted to the facility on with a diagnosis of . Resident #2's health assessment dated revealed the resident was "pleasantly secondary to , required supervision with ambulation, and required assistance to bathe and dress". A daily log note dated at 7:25 PM indicated the nurse was called to memory care to assess a resident that was found in Resident #1's room on the bed completely naked. Resident #2 was also naked. Resident #2's soiled brief, underwear, pants, and shirt were found on Resident #1's bed and floor. The two residents had been engaged in intercourse, but the residents were separated. Resident #2 was examined and reported , in her region and . No or were observed on or around her thighs or . Resident #2 was given a brief mental status exam test during this check. She was not oriented to self, did not know who she was, believed the current year was "2089", the president was "a man", and that she was "in town". Resident #2 stated she was unable to recall anything that occurred in Resident #1's room. She had 2 to her right and a small to her left . Resident #2's daughter, who also acts as her power of attorney, was informed about the incident. The daughter declined when asked if she wanted the facility to take Resident #2 to the hospital. Later, Resident #2 needed assistance and went to the nurse's station and was complaining of and . A daily log note dated at 4:02 PM indicated the resident complained of in the area, but that was the only time she complained. A daily log	A 025		

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A 025	Continued From page 4	A 025		

note dated at 3:03 PM indicated Resident #2's daughter came in at about 1:00 PM and took the resident to the emergency room to have her seen after these new complaints. A daily log note dated at 5:37 PM indicated the hospital notified the facility Resident #2 was positive for . A daily log note dated at 2:44 PM indicated the hospital notified the facility that Resident #2 was also positive for 1 and 2.

A review of employee interviews was completed. Employees A and B (Certified Nursing Assistants, CNAs) stated Resident #2 was put to bed by CNA A. Shortly afterwards, CNA B (also a medication technician) went to give Resident #2 her evening medications and she was not in her room. After searching and not finding her, CNAs A and B went to Resident #1's room and it was locked. The staff knocked on the door several times with no response. CNA B used the master key to open the door. Resident #1 was found on top of Resident #2 and both were naked. CNA A stayed in the room. Resident #1 got off Resident #2 and placed Resident #2 in the bathroom and shut the door. Resident #1 then got dressed. CNA B came in the room and assisted Resident #2 out of the bathroom.

The statement by the Director of Resident Services (DORS) revealed that, on Saturday , the DORS received a call from CNA B just after 6:00 PM. CNA B was working in the memory care unit. CNA B reported she had just caught Resident #1 and #2 having in Resident #1's room. CNA B observed the residents actively having and did not know how Resident #2 got in Resident #1's room. The DORS contacted the Executive Director (ED) and she did not answer. The DORS then contacted

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A 025	Continued From page 5	A 025		

the Senior Divisional Director of Operations and Nursing (SDDON) and explained the situation. The DORS was instructed to notify the family. CNA B reported she observed Resident #1 standing behind Resident #2 having [redacted] intercourse. The DORS contacted the daughter of Resident #2. She explained what CNA B had reported and she would review the camera footage. Resident #2's daughter was informed that Resident #2 had complained of [redacted]. The DORS notified the facility nurse to assess Resident #2 for injuries. The DORS offered to notify the police of the incident and Resident #2's daughter declined. The DORS reviewed the camera footage. Resident #1 and #2 were observed talking in the hallway. Resident #1 walked toward the nurse's station after Resident #2 pointed in that direction. Resident #2 then walked down the hall. Resident #1 walked down the hall and met with Resident #2. The 2 residents appeared to talk for a short amount of time. When another resident got closer to Resident #1 and #2 in the hallway, the two residents went into Resident #1's room holding [redacted]. The DORS reported [redacted] to Resident #2's daughter what she observed on the camera footage. The daughter requested that staff monitor her mother and keep Resident #1 away. The DORS relayed this information to the staff working that night. On the Sunday after the incident, the DORS did not hear anything else from staff regarding the incident.

An interview was conducted with CNA B on [redacted] at 1:49 PM. CNA B stated, on [redacted] at approximately 6:20 PM, she was not able to locate Resident #2 in her room for medications. She checked all the resident rooms, then realized she did not check Resident #1's room. She knocked on Resident #1's door several times and

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A 025	Continued From page 6	A 025		

received no answer. She used her key to open the door and observed Resident #1 standing to the side of the bed with his on the floor and Resident #2 bent over the bed under Resident #1. Both residents had a shirt on but were naked from the waist down. Resident #1 was going and forth on top of Resident #2. Resident #2 was attempting to say something, but her was in the covers and her voice was muffled. CNA B stated she instructed Resident #1 to get off Resident #2 and asked him what he was doing. Resident #1 attempted to have CNA A and B leave the room. Resident #1 slammed the door on the staff and the staff went in the room. Resident #1 stated he "needed ". The staff removed Resident #2 from Resident #1's room. CNA B stated Resident #2 could not dress or undress herself and does not feel she could have removed her own pants. Resident #1 also had a key to his room that would open all bedroom doors on the memory care unit, and it was taken away from him after this incident.

An interview was conducted with CNA A (Certified Nursing Assistant) on at 3:46 PM. CNA A stated, on at around 6:00 PM, CNA B called out to her and stated she could not find Resident #2. They knocked on Resident #1's door because the door was locked. On the 3rd knock, Resident #1 cracked the door, then slammed the door in their faces. CNA B then opened the door. CNA A saw Resident #2 laying on Resident #1's bed. Resident #1 was on top of Resident #2. Resident #2 was naked from the waist down, and Resident #1 had his pants down to mid- . Resident #2 could not tell the staff what happened. The staff told the aides to keep the residents separated.

An interview was conducted with the DORS on

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at 4:17 PM. She stated Resident #2 was severely . On , she was not very familiar with Resident #2 because she had only moved into the facility on . She stated she did not come in and assess Resident #2 after the incident occurred on . She did not consider reporting this incident as a allegation.

A telephone interview was conducted with the Administrator on at 10:12 AM. She stated that it was relayed by the DORS on the afternoon of that Resident #1 and #2 were caught in Resident #1's room having . She advised the DORS to contact the SDDON and her recommendation was to let the families know what occurred. She stated the facility did not report the incident to the hotline or law enforcement on Saturday when it occurred. She stated, on the following Monday, DCF came to the facility to investigate, but she does not know who contacted them. She reported the event to law enforcement on after DCF came to the facility. She confirmed both Resident #1 and #2 are and have . She also confirmed that staff reported they found the 2 residents engaged in activity. She stated the facility was not able to determine if Resident #2 could consent to activity. They informed the family they do not provide one to one care. Resident #1's family was asked to get him a 24-hour sitter, then the corporate office stated it was not fair to insinuate Resident #1 did something wrong, so both residents would need a sitter. Resident #1's family declined to provide a sitter, and she does not know if the facility asked Resident #2's family to provide a sitter. The DORS suggested to Resident #1's family that they take him home and they refused. They complete frequent checks on all residents. She

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could not say the facility has changed anything since this incident had occurred, other than memory care bedroom doors being locked during the day and unlocked if the resident needs to go in the room. No processes have changed related to supervision.

On at approximately 9:50 AM, an interview was conducted with Staff C/LPN (Licensed Practical Nurse). Staff C stated she was called from the Assisted Living unit to the Memory Care unit on at approximately 6:15 PM. She stated there were two aides in Memory Care, Staff A/CNA (Certified Nursing Assistant) and Staff B/Medication Technician & CNA, who stated they witnessed an incident. Staff C was contacted by Staff E/RN (Registered Nurse) & the DORS via phone, who informed her there was an incident in Memory Care and instructed her to complete an assessment on Resident #1. She stated Staff E/RN did not tell her what the incident was but told her she needed to do a -to-assessment on Resident #1, which included looking for and palpating around the abdomen. Staff C/LPN stated, before she conducted the exam on Resident #1, she was told by Staff A and B it was in reference to a incident. She stated Resident #1 was wearing only a shirt with a towel wrapped around her and was not wearing pants or shoes. She further stated she assessed Resident #1's outer area and did not see any or . She stated she only observed on both of Resident #1's and neither Staff A nor Staff B knew if the were old or new. Staff C stated during the exam that Resident #1 complained of in her lower abdomen and area. She stated Resident #1 could not scale the and just said "it hurt". Staff C observed Resident #1 had grimacing during

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the palpation of her [redacted] and outer [redacted] area. She also stated Resident #1 was unsteady when she was standing to look at her backside during the assessment, but no marks were observed in that area either. Staff C stated, while Resident #1 was in the nurses' station, Resident #2 kept trying to enter the room. She further stated Resident #2 kept walking by the windows of the nurses' station and then sat across from the nurses' station looking in the window. She stated, after the assessment, Staff A took Resident #1 in a wheelchair to get dressed. She also stated she did not observe any further contact between Resident #1 and Resident #2 while she was in Memory Care. Staff C stated she asked Staff A and Staff B about the incident, then documented what they said and documented her assessment. She stated she was told by Staff E/RN to keep Resident #1 and Resident #2 separated and to chart all her findings. She also stated she briefed the aides during shift change on keeping Resident #1 and Resident #2 separated and keeping their [redacted] on them. Staff C stated she thinks someone in administration contacted the families, but she was not sure who. She stated she did not know if anyone reported the incident to the [redacted] hotline. She stated she has heard Resident #2 was [redacted] active with residents in the Assisted Living unit but could not say for sure as she did not witness it. Staff C stated she has received [redacted] training.

A review of the facility policy entitled "Prevention and Reporting of Resident [redacted] (revised [redacted]; policy number 3.09)" revealed, "This policy is to help caregivers prevent elder [redacted] by recognizing [redacted] behaviors, changing stressful situations, increasing the level of assistance when needed and teaching caregivers how to

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A 025	Continued From page 10 provide an [redacted] free environment. SPECIAL INFORMATION: [redacted], and/or suspected [redacted] must be reported to the Executive Director immediately. In addition to this responsibility, you are required by law to follow the procedure below. REPORTING DUTIES: When any employee of the Community has reasonable cause to believe that a [redacted] adult has suffered [redacted], [redacted], neglect, or abandonment, he or she shall report the incident to the ELDER [redacted] HOTLINE at 1-800-962-2873 from the time the determination has been made that the reportable incident occurred. o An employee who observes the incident or hears the victim state it happened. o An employee who hears about an incident from a permissive reporter with direct knowledge of the incident. A permissive reporter is a visitor or family member. o The Executive Director receiving the information from a mandated reporter. The person who does not have to report is an employee other than the employee's supervisor or community designated person who hears about the incident from a mandated reporter and who believes that the report has been made. The mandated reporter reports whenever there is cause to believe or suspect, with reasonable cause, an incident or [redacted], abandonment, neglect, or financial [redacted] has taken place. . If the employee has reason to suspect an incident is [redacted] or physical assault, report to the local law enforcement agency and to the hotline number. If it is an emergency call 911. When there is reasonable cause to believe the incident is [redacted], abandonment, neglect or financial [redacted], report within twenty four	A 025		

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A 025	Continued From page 11 hours from the time the determination has been made that the reportable incident occurred." Per the policy entitled "Resident Rounds, Section III- Procedure Memory Care" (latest update ,), "The associates will account for current residents throughout their shift by doing frequent rounds." The policy does not define what the phrase "frequent rounds" entails. The Administrator did not specify what "frequent rounds" meant and no documentation of rounds was provided. Class I	A 025		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice	A 081		

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A 081	Continued From page 12 training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in infection control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its infection control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of	A 081		

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	AL11968796	A. BUILDING: _____ B. WING _____	06/09/2023

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A 081	Continued From page 13 29 CFR 1910.1030, relating to borne , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment.	A 081		

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A 081	Continued From page 14 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 5 sampled staff received the required training on recognizing and reporting resident within 30 days of employment. (Staff B) The findings include: On , an employee record review was conducted for Staff B, a Medication Technician and Certified Nursing Assistant, with a hire date of . The record review revealed Staff B did not have the required training on recognizing and reporting resident . On at approximately 11:33 AM, an interview was conducted with the facility's Administrative Assistant, who confirmed Staff B did not have the required training in her employee file. She further stated the facility's corporate office was unable to locate the training for Staff B. On at approximately 12:25 PM, a copy of the facility's policy for training was requested. At approximately 1:00 PM, the Senior Divisional Director of Operations and Nursing stated the facility does not have a policy for	A 081		

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A 081	Continued From page 15 training. She further stated they follow the state regulation for training requirements. Class III	A 081		
A 086 SS=D	59A-36.011(10) FAC Training - ADRD (10) AND RELATED ("ADRD") TRAINING REQUIREMENTS. Facilities which advertise that they provide special care for persons with ADRD, or who maintain secured areas as described in Chapter 4, Section 464.4.6 of the Florida Building Code, as adopted in rule 61G20-1.001, F.A.C., Florida Building Code Adopted, must ensure that facility staff receive the following training. (a) Facility staff who interact on a daily basis with residents with ADRD but do not provide direct care to such residents and staff who provide direct care to residents with ADRD, shall obtain 4 hours of initial training within 3 months of employment. Completion of the core training program between , and shall satisfy this requirement. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. Initial training, entitled " and Related Level I Training," must address the following subject areas: 1. Understanding 's and related ; 2. Characteristics of ; 3. Communicating with residents with 's ; 4. Family issues; 5. Resident environment; and, 6. Ethical issues. (b) Staff who have successfully completed both	A 086		

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A 086	Continued From page 16 the initial one hour and continuing three hours of ADRD training pursuant to sections 400.1755, 429.917 and 400.6045(1), F.S., shall be considered to have met the initial assisted living facility and Related Level I Training. (c) Facility staff who provide direct care to residents with ADRD must obtain an additional 4 hours of training, entitled " and Related Level II Training," within 9 months of employment. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. and Related Level II Training must address the following subject areas as they apply to these : 1. Behavior management, 2. Assistance with ADLs, 3. Activities for residents, 4. Stress management for the care giver; and, 5. Medical information. (d) A detailed description of the subject areas that must be included in an ADRD curriculum which meets the requirements of paragraphs (a) and (b) of this subsection, can be found in the document "Training Guidelines for the Special Care of Persons with 's and Related ," dated , incorporated by reference, available from the Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000. (e) Direct care staff shall participate in 4 hours of continuing education annually as required under section 429.178, F.S. Continuing education received under this paragraph may be used to meet 3 of the 12 hours of continuing education required by section 429.52, F.S., and subsection (1) of this rule, or 3 of the 6 hours of continuing	A 086		

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A 086	Continued From page 17 education for extended congregate care required by subsection (7) of this rule. (f) Facility staff who have only incidental contact with residents with ADRD must receive general written information provided by the facility on interacting with such residents, as required under section 429.178, F.S., within three (3) months of employment. "Incidental contact" means all staff who neither provide direct care nor are in regular contact with such residents. (g) Persons who seek to provide ADRD training in accordance with this subsection must provide the department or its designee with documentation that they hold a Bachelor's degree from an accredited college or university or hold a license as a registered nurse, and: 1. Have 1 year teaching experience as an educator of caregivers for persons with . . . . . or related . . . . . , or 2. Three years of practical experience in a program providing care to persons with or related , or 3. Completed a specialized training program in the subject matter of this program and have a minimum of two years of practical experience in a program providing care to persons with or related . . . . . (h) With reference to requirements in paragraph (g), a Master's degree from an accredited college or university in a subject related to the content of this training program can substitute for the teaching experience. Years of teaching experience related to the subject matter of this training program may substitute on a year-by-year basis for the required Bachelor's degree referenced in paragraph (g). This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 5 sampled staff received the	A 086		

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A 086	Continued From page 18 required training entitled " . . . . . and Related Level I Training" within three months of employment and the required training entitled " and Related . . . . . Level II Training" within nine months of employment. (Staff B) The findings include: On , an employee record review was conducted for Staff B, a Medication Technician and Certified Nursing Assistant with a hire date of . . . . . The record review revealed Staff B did not have the required 's and Related . . . . . Level I or Level II training. On . . . . . at approximately 11:33 AM, an interview was conducted with the facility's Administrative Assistant who confirmed that Staff B did not have the required 's training in her employee file and she could not locate it. She further stated the facility's corporate office was also unable to locate the training for Staff B. On . . . . . at approximately 12:25 PM, a copy of the facility's policy for training was requested. At approximately 1:00 PM, the Senior Divisional Director of Operations and Nursing stated the facility does not have a policy for training. She further stated they follow the state regulation for training requirements. Class III	A 086		
A 165 SS=G	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and	A 165		

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A 165	Continued From page 19 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 (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	A 165		

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A 165	Continued From page 20	A 165		

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 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

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A 165	Continued From page 21 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. This Statute or Rule is not met as evidenced by: Based on record review, staff interviews, and job description reviews, the facility failed to establish a risk management and quality assurance policy. The facility failed to report an adverse incident and complete a thorough investigation of an allegation of to identify possible factors leading to the incident and develop action plans to reduce the likelihood of reoccurrence for 1 of 1 allegations of reviewed. (Resident #1 and #2) The findings include: Cross Reference to A0025. An interview was conducted with the Director of Resident Services (DORS) on at 4:17 PM concerning the incidence of on between Residents #1 and #2. She stated on she was not very familiar with Resident #2 because she had only moved into the facility on . She stated she did not come in and assess Resident #2 after the incident occurred on . She did not consider reporting this incident as a allegation. On Monday , the DORS was not able to complete her interviews regarding the incident, because a representative from the Department of Children and Families (DCF) came in to	A 165		

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A 165	Continued From page 22 investigate this incident. She was not sure who reported the incident, but stated that it was not anyone with the facility. A telephone interview was conducted with the Administrator on at 10:12 AM. She stated it was relayed by the DORS on the afternoon of that Residents #1 and #2 were caught in Resident #1's room having . . . She advised the DORS to contact the Senior Divisional Director of Operations and Nursing (SDDON) and her recommendation was to let the families know what occurred. She stated the facility did not report the incident to the hotline or law enforcement on Saturday when it occurred. She stated on , DCF came to the facility to investigate, but she does not know who contacted them. She reported the event to law enforcement on . . . . . after DCF came to the facility. She confirmed both residents were , . . . and have . . . . . She stated the facility was not able to determine if Resident #2 could consent to . . . . . activity. When asked about current supervision of Resident #1, she stated, "We have always completed frequent checks on all residents, but we have not really changed anything since this incident has occurred, other than memory care bedroom doors being locked during the day and unlocked if the resident needs to go in the room. No processes have changed related to supervision." There was no evidence of any retraining of staff or specialized follow up after the incident on . An interview was conducted with the SDDON on . . . . . at 10:50 AM. She stated the facility did not have a risk management or Quality Assurance policy or a policy that defines . . . . . The facility has a risk management program and	A 165		

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A 165	Continued From page 23 reportable events are sent to the corporate risk manager. Review of the DORS' job description signed and dated ..... revealed the DORS job duties included: * Reviews and investigates all incident reports and recommends appropriate action/follow-up to the Executive Director. * Maintains a safe and secure working environment free of objects/situations that could cause harm and/or to residents, families, visitors, and associates. Review of the Executive Director's (Administrator) job description signed and dated revealed the Executive Director's job duties included: * Responsible for and accountable for the organization, planning, and daily operations of the assisted living and/or memory care community. * Maintains a safe and secure working environment free of objects/situations that could cause harm and/or . . to residents, families, visitors, and associates. CLASS II	A 165		