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
	AL11968716	A. BUILDING: _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALM BAY MEMORY CARE	350 MALABAR RD SW PALM BAY, FL 32907

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A re-licensure survey with Limited Nursing Service (LNS), a complaint investigation (#2023010281) and a generator monitoring were conducted at Palm Bay Memory Care on . . . . . and . . The facility had deficiencies at the time of the survey.	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 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 025		

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A 025	Continued From page 1 (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide adequate supervision to prevent resident on resident for 3 of 6 sampled residents (#10, 11 and #15), which resulted in a , , to 1 of 6 sampled residents (#10) and failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision and ensure safety through proactive measures to minimize the potential for and injuries for 1 of 6 sampled residents (#9). Findings:	A 025		

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A 025	Continued From page 2 1. Review of resident #11's record revealed a facility admission date of . . . . . A . . . . . 1823 indicated his medical history included 's and memory . . . . . The form also indicated " precautions", A 6:03 pm facility note indicated that it was reported to the nurse that at about 3 pm he was in a verbal altercation with another resident (resident #15). He hit the other resident on the right side of their . A 6:22 am facility note indicated he was up all night . . . . . up and down the hallways. Checking and trying all the resident's doors for entry. He also went out to the courtyard a few times exit seeking. He was very . A 10:28 pm facility note indicated a noise was heard from the hallway at about 7pm. He was observed standing in the hallway holding another resident's walker (resident #15) with one . A nurse yelled to him. The same nurse then observed him raise his right . . . and use an open to smack resident #15 three times. The nurse continued to yell and run towards him. Once there he let go of the walker and stepped . . . . . He then said "he tried to hit me with it, so I smacked him. I didn't punch him, I just smacked him." He then started walking in the other direction. A health care provider was notified and ordered a . . . . . consult. When notified, his family member said, "he was a police officer for thirty years so if he thinks someone is trying to do harm to him intentional or unintentional, he's going to react". A . . . . 2:39 pm facility note indicated he was seen by . . . . and 10 mg daily was	A 025		

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A 025	Continued From page 3 prescribed for . A . . . . . 2:07 pm "late entry" facility note indicated that the activities assistant reported to the nurse that resident #15 was napping on a couch in the common area and resident 11 sat down next to the resident. The activities assistant heard the two residents start to bicker and when she looked, they were wrestling with their . . . . Resident 11 then slapped resident #15 on the left side of his . . . . On . . . . . a health care provider ordered to increase to 20 mg daily for , . On a health care provider ordered to decrease . . . . . from 75mg to 25mg daily. A . . . . 6:42 am facility note indicated that at approximately 11:40 pm he was observed in the hallway standing near the resident in . . . (resident #10). Resident 11 said, "he me, so I hit him". He was redirected and removed from the area. On a health care provider ordered an emergency discharge due to the resident being a danger to others. A 7:05 pm, facility note indicated a hospice crisis care nurse arrived to provide one on one services due to his previous agitation and aggression. A . . . . . 11:30 am, facility note indicated he moved out of the facility at around 11:15 am. During an interview on at 3:55 pm, caregiver B said resident #11 was very smooth going, respectable and never someone	A 025		

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A 025	Continued From page 4 unless he was provoked. She did not witness any of the physical altercations involving him and other residents but rather, she only heard of them. She said she did not receive behavioral training specific to resident #11. She said following the incident between residents #10 and #11 on . . . . . she received training and was instructed to diffuse resident to resident altercations and to speak calmly. During an interview on . . . . . 4 pm, nurse D described resident #11 as mostly quiet and said he would just sit around. She said sometimes he'd get agitated with other residents. For example, if another resident was going through the same door as him, resident #11 would tell them to hurry up. She said regarding the incident between resident #11 and #15 on , she saw both residents holding onto resident #15's walker. Before she could reach them, she saw resident #11 slap #15 three times on the left side of his . She said resident #15 suffered a burst . . . . . in his left . . She said neither resident offered an explanation as to what happened. She recalled that at some point there were trainings held to tell staff to monitor resident #11 more closely and put him on behavior monitoring, which meant to check him frequently and chart any behaviors. On . . . . . at 10:35 am, a request was made of the administrator to provide the , and . . . . facility incident reports for the resident to resident incidents involving resident #11. On . . . . . at 11:01 am, the director of nursing (DON) said the incident reports requested would not be given because they were an internal document.	A 025		

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A 025	Continued From page 5 During an interview on at 11:05 am, the administrator said there were no investigation notes regarding the , and involving resident #11 and no documented analysis and trends. She said she believed an investigation file is created only when something was preventable. During an interview on at 11:59 am, the activities assistant said she recalled that on she saw resident #15 laying on a couch in the common area when resident #11 approached him and without provocation, slapped resident #15 hard on his , leaving his red. She said there was no indication from resident #11 that he was going to hit resident #15. She said there were times when resident #11 became agitated towards other residents. She said she received resident training only from an online training program. During an interview on at 1:34 pm, Nurse F said resident #11 was pleasant towards staff but did not socialize with other residents. She said she was trained on the facility's resident policy. She could not recall if she received specific training regarding resident #11's behaviors. She said if she witnessed a resident-to-resident altercation she would notify the wellness director, executive director, doctor, family, and hospice. She would complete an incident report and pass the information on during shift report. During an interview on at 1:55 pm, when asked what the facility put in place to protect the other residents from resident #11, the administrator said a evaluation was ordered for resident #11. She said residents #11	A 025		

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A 025	Continued From page 6 and #15 lived on the same side of memory care but there was no discussion of moving one of them to the other side, there was no increase in staffing to provide additional supervision and no one-on-one caregivers provided to increase supervision. She said increased staff monitoring was done but not documented. The facility's [redacted], neglect and [redacted] policy read, in part, the facility will monitor residents with needs and behaviors which might lead to conflict or neglect, such as residents who have behaviors such as entering other resident's rooms, residents with self-injurious behaviors and residents with communication [redacted]. The facility will immediately assess the resident, notify the physician and responsible party, and implement interventions to protect the resident or other residents from further harm or incident. Facility's documentation and staff interviews revealed the facility did not take measures to protect the other residents from resident #11, despite resident #11 physically harming resident #15 three times and prior to physically harming resident #10, which resulted in resident #10 suffering a [redacted]. In addition, despite knowledge of resident #11's aggressive behavior, no measures were taken to increase supervision of the residents, such as increasing the staffing levels or providing one on one supervision and facility never contemplated moving either resident #11 or #15 to another section of the facility despite repeated altercations between the two of them. The facility is divided up into three sections and at the time of the [redacted] incident between residents #10 and #11, only one caregiver was assigned to each section and only one nurse was assigned to oversee all the sections.	A 025		

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A 025	Continued From page 7 2. Review of resident #15's record revealed a facility admission date of . . . . . A . . . . . 1823 indicated his medical history included , ... , ... , ... , and . . . . There was no documentation in the record regarding an incident between him and resident #11 on . A 4:45 pm facility note indicated that at about 7 pm the nurse heard a noise in the hallway and looked around the corner to see what it was. She observed resident #15 and resident #11 in the hallway. Both residents were holding onto resident #15's walker. She yelled out to both residents to stop until she was able to reach them. She then stepped between the two of them and resident #11 stepped and let go of the walker. She then observed resident #11 hitting resident #15 in his with an open , smacking him three times in the . . . . Resident #15 said "he smacked the hell out of me". Resident #11 said "he tried to hit me with it", referring to the walker. Resident #11 then walked off stating "I didn't punch him, I just smacked him". Resident #15's left , was shot. The nurse applied ice to the area but resident #15 refused treatment. Family and hospice were notified. A . . . . . 10:23 pm facility note indicated ice was applied to his . He had a small, raised area on his left lower , and purple discoloration. A . . . . . 3:05 pm facility note indicated the nurse was called to the dining room where the activities assistant reported that resident #11 struck resident #15 in his . Resident #11 said	A 025		

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A 025	Continued From page 8 resident #15 bit him on the . No apparent injuries to resident #15's . A 3:28 pm facility note indicated the activities assistant reported to the nurse that resident #15 was napping on a couch in the common area when resident #11 sat down next to him. The activities assistant heard the two residents start to bicker and when she looked, they were wrestling with their . Resident #11 then slapped resident #15 on the left side of his . 3. Review of resident #10's record revealed a facility admission date of . A 1823 health assessment form indicated his medical history included , , , and type 2. The form indicated he was alert with . A health care provider signed medication list included , ( ) 325 milligrams (mg) daily and ( ) 75 mg daily. A 4:48 am facility note indicated that at approximately 11:40 pm resident #10 was heard yelling for help. Another resident (resident #11) was seen standing near him. Resident #10 had to his left cheekbone, forehead, and the of his , /discoloration to both of his and a cut on his . He said that resident #11 into his room and when he entered behind resident #11, he told resident #11 to get out of his room. Resident #11 then threw him on the bedroom floor and began to stomp and kick him in the . First aide was rendered. Resident #11 was removed from the area. 911 was called and resident #10 was	A 025		

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A 025	Continued From page 9 transported to a hospital. A 6:04 am facility note indicated resident #10 was transferred from the initial receiving hospital to a center due to a . A hospital history and physical read, in part, that he arrived from a memory care unit. According to a report he was kicked in the by his roommate. When he arrived, he had notable injuries to his and . A demonstrated a significant hematoma as well as . The resident on . 4. A review of resident #9 record revealed he was admitted on . His record contained a Resident Health Assessment form (1823) dated . His diagnoses included unspecified , , and . He ambulated with a walker. He required assistance with all activities of daily living. A review of the Facility Notes revealed resident #9 sustained 14 . On at 2:43 am Resident was on the floor on his left side with straight out. Sent to the hospital for possible injury. On a resident was admitted to the hospital for an unspecified . On at 3:13pm Resident found next to the gazebo on the cement path outside with . On at 12:40pm Resident was laying on his in the grass. Walker was next to him on the sidewalk. On at 3:49pm Resident on the patio, On Residents daughter in facility and was	A 025		

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A 025	Continued From page 10 informed resident was found on the floor at around 11:30am. to right arm. On . . . . Documented status post . day 3. No documentation of a 3 days prior found in record. On Resident was laying on his on the patio. On at 1:08pm. Resident found on the floor in the dining room with his walker tipped over beside him. On . . . . . at 3:47pm Resident was observed by staff sitting on the floor. On . . . . . at 7:23am Resident . in the bathroom in the dining room. On . . . . . at 3:01pm Resident found on the floor in the hallway. On at 2:59pm Resident observed on the floor sitting on his bottom. On . . . . . at 4:46pm On the floor in the dining room. On . . . . . at 10:54pm Resident had a second in the dining room. Hit and transferred to the hospital. A review of resident #9 Service Plan revealed dated entries on: . . . . . Independently mobile with assistive device/walker. . . . . . : Will encourage to call for assistance when needed. . . . . . Safety checks every 2 hours. A review of the facility's undated . prevention policy revealed they would assess each resident for . risk and each resident would receive care and services with their individualized level of risk to minimize the likelihood of . . . If a resident experienced a the facility would review the residents Plan of Care and update as indicated.	A 025		

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A 025	Continued From page 11 On . . . . . at 3pm in an interview with the Director of Nursing, she confirmed the facility staff did not document resident safety checks. On . . . . . at 5:25pm in an interview with the Administrator she confirmed resident had multiple . . . resulting in injury. Class I	A 025		
A 030 SS=G	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; . . , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline	A 030		

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A 030	Continued From page 12 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- . . . . or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident . . . . . , neglect, and . ; 6. Administrative and housekeeping schedules and requirements; 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	A 030		

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A 030	Continued From page 13 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. 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.	A 030		

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	AL11968716	A. BUILDING: _____ B. WING _____	08/23/2023

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

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A 030	Continued From page 15 relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the	A 030		

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A 030	Continued From page 16 complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder . . . . Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated . . . , . . . or . . . , ... under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to honor resident rights by failing to maintain a safe living environment, free from resident-on-resident . . . . for 3 of 6 sampled residents (#10, #11 and #15).	A 030		

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A 030	Continued From page 17 Findings: 1. Review of resident #10's record revealed a facility admission date of [redacted]. A [redacted] 1823 health assessment form indicated his medical history included [redacted], and [redacted] type 2. The form indicated he was alert with [redacted]. A [redacted] health care provider signed medication list included [redacted], 325 milligrams (mg) daily and [redacted] ([redacted]) 75 mg daily. A [redacted] 4:48 am facility note indicated that at approximately 11:40 pm resident #10 was heard yelling for help. Another resident (resident #11) was seen standing near him. Resident #10 had [redacted] to his left [redacted] cheekbone, forehead, and the [redacted] of his [redacted]/discoloration to both of his [redacted] and a cut on his [redacted]. He said that resident #11 [redacted] into his room and when he entered behind resident #11, he told resident #11 to get out of his room. Resident #11 then threw him on the bedroom floor and began to stomp and kick him in the [redacted]. First aide was rendered. Resident #11 was removed from the area. 911 was called and resident #10 was transported to a hospital. A [redacted] 6:04 am facility note indicated resident #10 was transferred from the initial receiving hospital to a [redacted] center due to a [redacted]. A [redacted] hospital history and physical read, in part, that he arrived from a memory care unit. Per a report he was kicked in the [redacted] by his roommate. When he arrived he had notable injuries to his [redacted] and [redacted]. A [redacted] demonstrated a significant [redacted] hematoma	A 030		

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A 030	Continued From page 18 as well as . . . . . . 2. Review of resident #15's record revealed a facility admission date of . A 1823 indicated his medical history included . . . . . , , , , and . . . . . . There was no documentation in the record regarding an incident between him and resident #11 on . . . . . . A . . . . . 4:45 pm facility note indicated that at about 7 pm the nurse heard a noise in the hallway and looked around the corner to see what it was. She then observed this resident and another resident (resident #11) in the hallway. Both residents were holding onto resident #15's walker. She yelled out to both residents to stop until she was able to reach them. She then stepped between the two of them and resident #11 stepped and let go of the walker. She then observed resident #11 hitting resident #15 in his with an open , smacking him three times in the . . . . Resident #15 said "he smacked the hell out of me". Resident #11 said "he tried to hit me with it", referring to the walker. Resident #11 then walked off stating "I didn't punch him, I just smacked him". Resident #15's left , . was shot. The nurse applied ice to the area but resident #15 refused treatment. Family and hospice were notified. A 10:23 pm facility note indicated ice was applied to his . . . . He had a small raised area on his left lower , and purple discoloration. A 3:05 pm facility note indicated the nurse was called to the dining room where the activities assistant reported that resident #11 struck	A 030		

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A 030	Continued From page 19 resident #15 in his . . . . Resident #11 said resident #15 bit him on the . No apparent injuries to resident #15's . . . . A . . . . . 3:28 pm facility note indicated the activities assistant reported to the nurse that resident #15 was napping on a couch in the common area when resident #11 sat down next to the resident. The activities assistant heard the two residents start to bicker and when she looked, they were wrestling with their . . . . Resident #11 then slapped resident #15 on the left side of his . . . . 3. Review of resident #11's record revealed a facility admission date of . . . . . A . . . . 1823 indicated his medical history included . . . . . 's . . . . . and memory , ... The form also indicated " . . . . . precautions". A . . . . . 6:03 pm facility note indicated that it was reported to the nurse that at about 3 pm he was in a verbal altercation with another resident (resident #15). He hit the other resident on the right side of their . . . . A . . . . . 6:22 am facility note indicated he was up all night . . . . . up and down the hallways. Checking and trying all the resident's doors for entry. He also went out to the courtyard a few times exit seeking. He was very . . . . . . A . . . . . 10:28 pm facility note indicated a noise was heard from the hallway at about 7pm. He was observed standing in the hallway holding another resident's walker (resident #15) with one . . . . . A nurse yelled to him. The same nurse then observed him raise his right . . . . and use an open . . . . to smack resident #15 three times. The nurse continued to yell and run towards him.	A 030		

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A 030	Continued From page 20 Once there he let go of the walker and stepped . He then said "he tried to hit me with it, so I smacked him. I didn't punch him, I just smacked him." He then started walking in the other direction. A health care provider was notified and ordered a , , consult. When notified, his family member said, "he was a police officer for thirty years so if he thinks someone is trying to do harm to him intentional or unintentional, he's going to react". A 2:39 pm facility note indicated he was seen by , , , and 10 mg daily was prescribed for , . A 2:07 pm "late entry" facility note indicated that the activities assistant reported to the nurse that resident #15 was napping on a couch in the common area when this resident sat down next to the resident. The activities assistant heard the two residents start to bicker and when she looked, they were wrestling with their . This resident then slapped resident #15 on the left side of his . On a health care provider ordered to increase to 20 mg daily for , , . On a health care provider ordered to decrease from 75mg to 25mg daily. A 6:42 am facility note indicated that at approximately 11:40 pm he was observed in the hallway standing near the resident in (resident #10). This resident said, "he me, so I hit him". He was redirected and removed from the area. On a health care provider ordered an emergency discharge due to the resident being a	A 030		

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A 030	Continued From page 21 danger to others. A 7:05 pm facility note indicated a hospice crisis care nurse arrived to provide one on one services due to his previous agitation and aggression. A 11:30 am facility note indicated he moved out of the facility at around 11:15 am. During an interview on at 3:55 pm, caregiver B said resident #11 was very smooth going, respectable and never someone unless he was provoked. She did not witness any of the physical altercations involving him and other residents but rather, she only heard of them. She said she did not receive behavioral training specific to resident #11. She said following the incident between residents #10 and #11 on she received training and was instructed to diffuse resident to resident altercations and to speak calmly. During an interview on 4 pm, nurse D described resident #11 as mostly quiet and said he would just sit around. She said sometimes he'd get agitated with other residents. For example, if another resident was going through the same door as him, resident #11 would tell them to hurry up. She said regarding the incident between resident #11 and #15 on , she saw both residents holding onto resident #15's walker. Before she could reach them, she saw resident #11 slap #15 three times on the left side of his . She said resident #15 suffered a burst in his left . She said neither resident offered an explanation as to what happened. She recalled that at some point there were trainings held to tell staff to monitor resident #11 more closely and put him on behavior	A 030		

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A 030	Continued From page 22 monitoring, which meant to check him frequently and chart any behaviors. On at 10:35 am, a request was made of the administrator to provide the and facility incident reports for the resident to resident incidents involving resident #11. On at 11:01 am, the director of nursing (DON) said the incident reports requested would not be given because they were an internal document. During an interview on at 11:05 am, the administrator said there were no investigation notes regarding the and involving resident #11 and no documented analysis and trends. She said she believed an investigation file is created only when something was preventable. During an interview on at 11:59 am, the activities assistant said she recalled that on she saw resident #15 laying on a couch in the common area when resident #11 approached him and without provocation, slapped resident #15 hard on his , leaving his red. She said there was no indication from resident #11 that he was going to hit resident #15. She said there were times when resident #11 became agitated towards other residents. She said she received resident training only from an online training program. During an interview on at 1:34 pm, Nurse F said resident #11 was pleasant towards staff but did not socialize with other residents. She said she was trained on the facility's resident policy. She could not recall if she received	A 030		

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A 030	Continued From page 23 specific training regarding resident #11's behaviors. She said if she witnessed a resident-to-resident altercation she would notify the wellness director, executive director, doctor, family, and hospice. She would complete an incident report and pass the information on during shift report. During an interview on [illegible] at 1:55 pm, when asked what the facility put in place to protect the other residents from resident #11, the administrator said a [illegible] evaluation was ordered for resident #11. She said residents #11 and #15 lived on the same side of memory care but there was no discussion of moving one of them to the other side, no increase in staffing to provide additional supervision and no one-on-one caregivers. She said increased staff monitoring was done but not documented. The facility's [illegible], neglect and [illegible] policy read, in part, the facility will monitor residents with needs and behaviors which might lead to conflict or neglect, such as residents who have behaviors such as entering other resident's rooms, residents with self-injurious behaviors and residents with communication [illegible]. The facility will immediately assess the resident, notify the physician and responsible party, and implement interventions to protect the resident or other residents from further harm or incident. Facility's documentation and staff interviews revealed the facility did not take measures to protect the other residents from resident #11, despite resident #11 physically harming resident #15 three times and prior to physically harming resident #10, which resulted in resident #10 suffering a [illegible]. In addition, despite	A 030		

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A 030	Continued From page 24 knowledge of resident #11's aggressive behavior, no measures were taken to increase supervision of the residents, such as increasing the staffing levels or providing one on one supervision and facility never contemplated moving either resident #11 or #15 to another section of the facility despite repeated altercations between the two of them. The facility is divided up into three sections and at the time of the incident between residents #10 and #11, only one caregiver was assigned to each section and only one nurse was assigned to oversee all the sections. Class II	A 030		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at	A 032		

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A 032	Continued From page 25 risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S.	A 032		

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A 032	Continued From page 26 This Statute or Rule is not met as evidenced by: Based on review of the facility's documented elopement drills, personnel record reviews and interviews, the facility failed to have documentation that 1 of 4 sampled staff participated in a minimum of two resident elopement drills each year (B). Findings: Caregiver B was hired on . On at 9:30 am, a request was made of the administrator to provide all the resident elopement drills conducted during 2022. Review of the drills revealed they were conducted on , , and . Caregiver B was listed as a participant on only the drill. The facility's undated standards policy read, in part, the facility will conduct elopement drills twice a year. The ALF administrator and direct care staff will participate in the elopement drills. Class III	A 032		
A 077 SS=J	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable	A 077		

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	AL11968716	A. BUILDING: _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALM BAY MEMORY CARE	350 MALABAR RD SW PALM BAY, FL 32907

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A 077	Continued From page 27 core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core	A 077		

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A 077	Continued From page 28 competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to , , , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to	A 077		

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A 077	Continued From page 29 assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the administrator, who was responsible for the management of all staff and the provision of appropriate care to all residents, failed to ensure: 1. Adequate supervision was provided to prevent repeated incidents of resident-to-resident . 2. Adequate supervision and care and services appropriate to meet the needs of residents were provided to minimize the risk for with injuries. 3. Staff participated in a minimum of two resident	A 077		

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A 077	Continued From page 30 elopement drills each year. 4. Staff provided a written statement from a health care provider documenting freedom from communicable . 5. Personnel records contained evidence of a negative ( ) exam on an annual basis. Findings: During both a re-licensure survey with Limited Nursing Service (LNS) and a complaint investigation conducted on and , the following deficient practices were identified, all of which under the responsibility of the administrator: 1. A 4:48 am facility note indicated that at approximately 11:40 pm resident #10 was heard yelling for help. Another resident (resident # 11) was seen standing near him. Resident #10 had to his left cheekbone, forehead, and the of his /discoloration to both of his and a cut on his . He said that resident #11 into his room and when he entered behind resident #11, he told resident #11 to get out of his room. Resident #11 then threw him on the bedroom floor and began to stomp and kick him in the . First aide was rendered. Resident #11 was removed from the area. 911 was called and resident #10 was transported to a hospital. A 6:04 am facility note indicated resident #10 was transferred from the initial receiving hospital to a center due to a . A hospital history and physical read, in part, that he arrived from a memory care unit. According to a report he was kicked in the	A 077		

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A 077	Continued From page 31 by his roommate. When he arrived, he had notable injuries to his and . A demonstrated a significant hematoma as well as . The resident on . 2. A 4:45 pm facility note indicated that at about 7 pm the nurse heard a noise in the hallway and looked around the corner to see what it was. She then observed this resident and another resident (resident #11) in the hallway. Both residents were holding onto resident #15's walker. She yelled out to both residents to stop until she was able to reach them. She then stepped between the two of them and resident #11 stepped and let go of the walker. She then observed resident #11 hitting resident #15 in his with an open , smacking him three times in the . Resident #15 said "he smacked the hell out of me". Resident #11 said "he tried to hit me with it", referring to the walker. Resident #11 then walked off stating "I didn't punch him, I just smacked him". Resident #15's left was shot. The nurse applied ice to the area but resident #15 refused treatment. Family and hospice were notified. A 10:23 pm facility note indicated ice was applied to his . He had a small, raised area on his left lower and purple discoloration. A 3:05 pm facility note indicated the nurse was called to the dining room where the activities assistant reported that resident #11 struck resident #15 in his . Resident #11 said resident #15 bit him on the . No apparent injuries to resident #15's . A 3:28 pm facility note indicated the activities assistant reported to the nurse that	A 077		

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A 077	Continued From page 32 resident #15 was napping on a couch in the common area when resident #11 sat down next to the resident. The activities assistant heard the two residents start to bicker and when she looked, they were wrestling with their . . . . Resident #11 then slapped resident #15 on the left side of his . . . . 3. Between . . . . . through . . . . . , resident #9 experienced fourteen . Two resulted in hospitalization and two in . . . . . The facility was unable to provide documentation to indicate proactive measures were implemented to minimize the resident's risk for repeated . . . 4. Caregiver B was hired on . . . . . The facility's documentation revealed it conducted four resident elopement drills during that same year. However, despite the facility's policy that elopement drills will be conducted twice a year and direct care staff will participate in them, caregiver B participated in only one of them. 5. Nurse E was hired on . . . . . Caregiver A on . Nurse E's personnel record did not contain a written statement from a health care provider documenting the nurse was free of communicable . . . . . Caregiver A's last documented negative exam was . The facility is under the supervision of the administrator who is responsible for the operation the day-to-day maintenance of the facility including the management of all staff and the provision of appropriate care to all residents of the facility as required by rule 59A-35. F.A.C. Class I	A 077		

Agency for Health Care Administration

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A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their	A 078		

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A 078	Continued From page 34 qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility . . . to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff . . . . . by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview, the facility failed to ensure 1 of 5 sampled staff submitted a written statement from a health care provider documenting that the individual did not have any signs or symptoms of communicable . . . . . within 30 days after beginning employment (E) and failed to ensure the personnel record for 1 of 5 sampled staff contained evidence of a negative (.) examination on an annual basis (A). Findings:	A 078		

Agency for Health Care Administration

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A 078	Continued From page 35 1. Nurse E was hired on . . . . . Her personnel record did not contain a written statement from a health care provider documenting that she did not have any signs or symptoms of communicable . . . . . . On . . . . . at 3:06 pm, the administrator confirmed the finding and was unable to provide additional documentation. 2. Caregiver A was hired on . . . . . The most recent negative exam in her record was dated . . . . . . On . . . . . at 4:30 pm, the business office manager confirmed the finding and was unable to provide additional documentation. Class III	A 078		