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
	AL11968102	A. BUILDING: _____ B. WING _____	11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER FAMILY HOME 11, INC	1024 SW 11 STREET MIAMI, FL 33129

(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 was conducted at Ebenezer Family Home 11, Inc. on , to , . Deficiencies were identified at the time of survey. .	A 000		
A 027 SS=H	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making , , and remind residents about scheduled , , , for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a , health care provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to assist with arranging healthcare services for one out of six residents (Resident #1). The facility failed to timely report the resident's change of condition to his healthcare provider. The facility also failed to inform the resident's guardian of the change of physician and his hospitalization. Findings include: A review of Resident #1's progress notes dated showed, "[Resident #1] was sent to the hospital due to low platelets; the doctor sent	A 027		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 027	Continued From page 1 him to the hospital for . . . . . ." On . . . . . at 11:44 AM, when asked about Resident #1's hospitalization, Resident #1's primary care provider #1 stated he did not send the resident to the hospital. He further said, "I saw him until the end of . . , . I am no longer working with that facility." In an interview on at 12 PM, Resident #1's guardian stated from her knowledge, Resident #1's primary health provider#1, requested for the resident to be transferred to the hospital. She was not aware that the facility changed the resident's physician. In an interview on . . . . . at 11:03 AM, Resident #1's primary care provider #2, stated that he was contacted on . . . . . to inform him that Resident #1 was weak. He further stated that when unfamiliar with a patient, he orders work. He ordered a , and platelet lab test, which came . . . low. He asked the facility to send the resident to the hospital. During an interview on at 11:20 AM, when asked about Resident #1's hospitalization, the Administrator stated, "I sent him to [hospital]. He always suffered that . . . . issue. Normally, he goes to the hospital for every 6 or 7 months." A review of Resident #1's progress notes showed no documentation of the resident receiving . . . . . or having any medical condition with his . A review of Resident #1's hospital records dated . . . . . showed that the hospital contacted the Administrator, who informed them that "as of	A 027		

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A 027	Continued From page 2 three or four days ago, patient began to feel weak during the evenings." A review of Resident #'1 record showed no documentation that the facility contacted Resident #1's primary care provider about his or to coordinate care. Further view showed no notation that the resident's guardian was contacted about his change in condition. Further review of Resident#1's hospital records dated showed, "Male who came to the ER (emergency room) due to abnormal labs. Patient with PMHx (patient medical history) of who was sent due to low platelets count, persistent and getting worse without alleviating or aggravating factors. At ER evaluation, platelets count was reported on 21. Due to severe in the setting of pancytopenia and high risk for complications, admission to the was decided for further assessment and management." The hospital also stated that Resident #1 to follow up with and his physician for a test within five days of being discharged. A review of Resident #1's progress notes showed no notation that there was any follow-up care with the resident's health care provider. A review of Resident #1's health assessment dated showed diagnoses of in the left of the , hypertensive , and left . The resident was independent with and needed supervision with ambulation, eating, toileting, bathing, grooming and transferring.	A 027		

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A 027	Continued From page 3 On at 11:03 AM, when asked if he had a follow-up with Resident #1, Resident #1's primary care provider #2 stated he did not see the resident for any follow-up care. Class II	A 027		
A 030 SS=J	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 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The	A 030		

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A 030	Continued From page 4 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 calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there	A 030		

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A 030	Continued From page 5 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. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or	A 030		

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A 030	Continued From page 6 attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the	A 030		

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A 030	Continued From page 7 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 complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a	A 030		

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A 030	Continued From page 8 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 review and interview, the facility failed to provide a safe living environment free from and neglect for one of seven sampled residents (Resident #1) . Resident #2 Resident #1 punching him repeatedly. Resident #1 suffered multiple on his , and , and the facility did not acquire medical care for the resident. Upon discharge from the	A 030		

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A 030	Continued From page 9 hospitalization which followed the assault, Resident #2 was subsequently placed into the same room with Resident #1, and threatened to assault Resident #1 again nine days after the initial incident. Findings included: Review of the facility's records and an adverse incident report showed: Resident #1, and Resident #2 were in their room at 4:15 AM when caregiver, Staff B heard a noise and ran to the room where she found Residents #1, and #2 fighting. Immediately with the help of Resident #5, they separated Residents #1 and #2 . Staff B was able to see that Resident #1's was red. The records further stated that Staff Bf was going to call the emergency services, but Resident #2 refused to be sent out, and stated that he was 'Ok.' Resident #1's guardian was called several times, and the resident's health provider was also called. Neither of them returned the calls. There record reflected that Staff B concluded that Resident #1 was very agitated and talkative, unable to let Resident #2 sleep. According to the incident report, the action to be taken by the facility was to talk to Resident #1 to make sure that he understood that the room was shared with another resident, and that the health provider would check on Resident #1's sleeping medications. Further review of the facility's adverse incident report report dated . . . . . showed, 'Analysis done by the facility concluded that the resident was very agitated and talkative, unable to let the other resident sleep. According to the report, the action to be taken by the facility was to talk to the resident to make sure that the resident	A 030		

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A 030	Continued From page 10 understood that the room was shared with another resident, and that the health provider would check on Resident #1's sleeping medications.; Review of Resident #1's record showed an admission to the facility on [redacted]. The health assessment dated [redacted] showed diagnoses of [redacted] in left [redacted] on [redacted] left [redacted]. The resident needed supervision with activities of daily living except [redacted], and medications, . Resident #1 was able to ambulate 80 ft. with caregiver assistance and or standby assistance. A review of hospital records showed that Resident #1 was also diagnosed with [redacted] According to the National Institutes of Health, [redacted], a condition where the person diagnosed has a low platelet count, [redacted], may cause the person diagnosed to have trouble stopping [redacted]. Without proper treatment, [redacted] can cause serious [redacted] can happen inside your body, underneath your skin, or from the surface of your skin. [redacted] is a condition that occurs when the platelet count in your [redacted] is too low. Platelets are tiny [redacted] cells that are made in the bone [redacted] from larger cells. When you are injured, platelets stick together to form a plug to seal your [redacted]. This plug is called a [redacted] clot. [redacted] can be life-threatening, especially if you have serious [redacted] or [redacted] in your [redacted]. Review of Resident #1's record showed that on [redacted], during the night, the resident 'had a fight' with Resident #2. Staff B went to the	A 030		

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A 030	Continued From page 11	A 030		

resident's bedroom and saw Resident #2 hitting Resident #1. The staff asked Resident #5 for assistance in separating both residents. The facility documented that staff tried to contact Resident #1's health provider, but because it was a Saturday, the provider did not return the call. The note showed that at 11:00 AM, the facility called Resident #1's guardian, and sent text messages, but the guardian did not return the calls or texts. According to the notes, the resident never stopped eating, drinking water, and was acting like himself. The facility documented that staff asked Resident #1 if he wanted to go to the hospital, and he said no. At 12:30 PM, the resident continued stable; the guardian still did not return the calls, neither did the health provider. The notes stated that Resident #1 refused to go to the hospital because he felt Ok. Further review of the facility's adverse incident report report dated showed, 'Analysis done by the facility concluded that the resident was very agitated and talkative, unable to let the other resident sleep. According to the report, the action to be taken by the facility was to talk to the resident to make sure that the resident understood that the room was shared with another resident, and that the health provider would check on Resident #1's sleeping medications.

A review of facility records found that Resident #2 was sent to the hospital on at 12:40 PM, several hours after the incident, when the resident's physician was contacted.

A review of Resident #2's hospital record showed that on the Resident #2 was admitted at 2:46 pm for aggression toward staff, guarded behavior, loose associations and suspiciousness. Further review showed that

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A 030	Continued From page 12 Resident #2 returned to the facility on . . . , . . Interviewed on . , Administrator stated that he did not send Resident #1 for a medical assessment or call for medical care because 'he looked fine.' Later, he stated that he asked Resident #1 if he wanted to go to the hospital and the resident said no, so he took no further action. The Administrator stated that Resident #1 had some . . . . . , but that he didn't send him to the hospital because he was an Emergency Medical Technician (EMT) and he determined that Resident #1 was fine and did not need medical care. The Administrator further stated that he did not send Resident #1 to the hospital because the resident's guardian didn't call him . He said that Resident #1 had a telemedicine visit with the facility's doctor on Monday, , two days after the assault. A review of the resident records found no documentation of this visit. Interviewed further on , the Administrator stated he readmitted Resident #2 to the facility when he was discharged from the hospital on . . . . . He stated that he wanted to change Resident #2's room but the resident begged him not to. A review of facility and resident records found no documentation of interventions were put in place to prevent further assaults. Resident #2 was placed in the room with Resident #1. The Administrator further stated that on Resident #2 threatened to assault Resident #1 again after another state agency came to the facility to investigate what happened. He stated that Resident #2 believed Resident #1 had reported the assault to the police. The Administrator stated he would have accepted Resident #2 a second time. He	A 030		

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A 030	Continued From page 13 stated, "[Resident #2] requested to be moved because otherwise, he was going to hurt [Resident #1]." A review of Resident #2's hospital records dated [redacted] showed that the resident was re-hospitalized due to agitation, [redacted], failing to cooperate with care and "trying to escape from the facility." The resident was discharged to a different facility per his own request on [redacted]. Interviewed on [redacted], at 8:38 AM, Staff B (caregiver) stated, "[Resident #2] would get upset if someone would take or touch anything that belonged to him. We called the psychiatrist, and they changed his medications. This started happening days before what happened. I was sleeping that night; I had the door open, so I immediately went to their room to see what what was going on. I asked [Resident #5] for help; I went to his room and asked him to help me." Interviewed On [redacted], at 8:28 AM, Resident #5 stated that Resident #2 often threatened and intimidated others. He stated that a few months earlier, Resident #2 walked into his personal space and spoke loudly, began screaming and got closer to his [redacted] as if he was going to hit Resident #5. Resident #5 pushed Resident #2 away. A review of facility records found no documentation of the occurrence. On [redacted] at 11:20 a.m. and on [redacted], [redacted], Resident #1's guardian stated that the guardian's office was closed on Saturday, [redacted], but that there was a weekend on-call staff system. She stated that there was no record of the facility contacting the the on-call guardian's	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968102	A. BUILDING: _____ B. WING _____	11/09/2023

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A 030	Continued From page 14 system to request authorization for the resident's medical treatment. She stated that the facility was authorized to obtain necessary care for the resident in an emergency even if they could not reach the Guardian, and that Resident #1's guardianship status did not allow him to refuse medical treatment. She also stated that she spoke to the administrator on , and he informed her that Resident #1 was fine and had been told to take , or , , and that the doctor had prescribed a cream for the resident. She further she stated that she received a call from the Administrator stating that Resident #1 was fine and had been given , and some cream by the facility physician. She stated that she'd gone to visit Resident #1 on and found that the right side of the resident's and were covered with purple . (photographic evidence obtained) . Class I	A 030		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents	A 152		

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A 152	Continued From page 15 must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable [illegible] to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be [illegible] This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe living environment free of hazards. The facility also failed to ensure that all existing architectural and structural were maintained in good condition. Findings: 1}	A 152		

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A 152	Continued From page 16 Observation on at 8:05 a.m. found prescribed and over-the-counter medication in Staff B's (caregiver) room, which was unlocked and adjacent to a resident bedroom and the dining and living rooms near the kitchen: 5 mg, 12.5 mg, 100 mg, E 180 mg; 500 mg (Photographic evidence was obtained.) On at 8:09 a.m., Staff B stated the medications were on the nightstand because of her medical condition. She further stated that she was sorry and forgot to lock the medication cabinet. Staff B said the door was always locked. Observation s on from 8:00 am through 2:57 p.m., revealed that the door of the staff's room was unlocked and stood open. On at 3:05 p.m.,the Administrator said that the door of the staff's room was always closed but admitted that the medication had to be locked. 2) On at 9:33 a.m., found the closet in # (Resident # 7 and Resident # 1) full of blankets and sheets. Photographic evidence was obtained. On at 9:35 a.m., found an additional storage room in # (Resident # 3, and Resident # 4) full of diapers and other utility products for everyday use. On at 9:35 a.m., observed Staff B pass several times across # iunto the	A 152		

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A 152	Continued From page 17 utility storage room to take out adult briefs to use for other residents. . On at 9:35 a.m., a hole in the wall was observed in # behind the bed of Resident #1. (Photographic evidence was obtained.) On at 11:32 a.m., in an interview, the Administrator said that all blankets and utility products (diapers, electric cables, equipment, premium painting set, and wipes) found in #. were stored inside the storage room to be used as needed. Class III	A 152		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in:	A 165		

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A 165	Continued From page 18 1. [illegible]; 2. [illegible] or [illegible] damage; 3. Permanent [illegible]; 4. [illegible] or [illegible] 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 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) [illegible], neglect, or [illegible] 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,	A 165		

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A 165	Continued From page 19 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 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 the records review and interviews, the facility failed to file a report with the Department of Children and Families when on of six sampled residents (Resident # 1) was assaulted by his roommate. Findings:	A 165		

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A 165	Continued From page 20 A review of the incident report database revealed that the facility filed a report when Resident # 1 was assaulted by Resident #2. A review of facility records showed, " at 7:15 am: Today during the night, [Resident # 2] fought with [Resident #]. When [Staff B] went to see them, [Resident #] hit [Resident # 1]; Staff separated them and asked [Resident #5] to help [Staff B] separate them. We called the Doctor, but because it was Saturday, he didn't return the call. On Sunday, at 11:00 a.m., we called the guardian a few times and sent her a text message but did not return the calls. We asked [Resident # 1] if he wanted to go to the Hospital, and [Resident # 1] said no. At 12:30 p.m., [Resident # 1] continued to stabilize; the guardian still did not return the calls, and neither did the doctor. [Resident # 1] refused to go to the hospital because he felt ok." Review of the state agency's documentation dated . . . . . showed, "[Resident #1] was asleep when he was by his roommate, [Resident #2]. On . . . , . . . , ... , early in the morning. The resident who did the was sent to a , ... hospital for further evaluation, however there was no incident reported noted because the victim was supposedly seen by the facility house doctor. [Resident #1] was observed and appeared to have severe injuries. His was completely . . . . . on the right side. The administrator stated that the was at the facility living in the same room as the victim. The facility did not report this to the local authorities for proper investigation." A review of resident and facility records found no documentation that the . . was reported for	A 165		

Agency for Health Care Administration

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A 165	Continued From page 21 investigation, and there was no documentation that a police report was made. On at 11:20 a.m., during a telephone interview with the guardian of Resident # 1, she stated that she received a call from the Administrator stating that Resident #1 was fine and had been given , and some cream by the facility physician. She further stated that she'd gone to visit Resident #1 on and found that the right side of the resident's . . . and were covered with purple brusing (photographic evidence obtained) . During the interview, the Guardian also stated that the guardian's office had an on-call number where the agency could be reached when there was an emergency with a ward, but that the facility had not called the number. She further stated that the facility was authorized to obtain necessary care for the resident in an emergency even if they could not reach the Guardian, and that Resident #1's guardianship status did not allow him to refuse medical treatment. Class III	A 165		