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
	AL11969506	A. BUILDING: _____ B. WING _____	02/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PADDOCK RIDGE AT OCALA	4001 SW 33RD COURT OCALA, FL 34474

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced complaint investigation (complaint number 2024000841) was conducted at Paddock Ridge at Ocala on February 7, 2024 through February 9, 2024 and February 12, 2024. Deficiencies were identified at the time of the survey.	A 000		
A 025	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 dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. 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 appointments 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 observation, interview, and record review the facility failed to provide adequate supervision to maintain awareness of the safety and physical and emotional well-being for 1 of 4 sampled residents, Resident #10. Findings include: Review of Resident #10's clinical record documented the resident was admitted to the facility on 2/9/2020. A review of the Resident Health Assessment, dated 10/5/2023, documented the resident as an elopement risk.	A 025		

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A 025	Continued From page 2 The resident's primary diagnoses included Alzheimer's Disease; Hyperlipidemia; Gastro-esophageal reflux disease; Osteo-arthritis; Disorder of the Autonomic Neuropathy; Malignant Neoplasm of the Bone; Hypertension; and Varicose Veins of lower extremities. Resident #10's health assessment also documented physical/sensory limitations of "poor balance" and "may need assistance with ambulation." The resident requires assistance with all activities of daily living and needs medication administration. Resident #10's clinical record also included an incident report dated 1/30/2024 that read, "While doing rounds at 5 am in neighborhood 3 care staff did not find resident in her bedroom or in the common areas. All the care staff was notified and searched all the bedrooms. Resident was not found inside but, out in front of the building sitting in the grass. Resident was unable to give a description." (The incident report was type-written and not signed, but the name of Staff N, Medication Technician was listed on the incident report.) Further review of Resident #10's clinical record revealed a discharge summary from a local hospital, dated 1/30/2024, that documented Resident #10 was treated for hypothermia and generalized weakness. During an interview on 2/8/2024 at 10:45 AM, Staff L, Care Partner stated Resident #10 eloped from the facility's locked memory care unit on 1/30/2024. The last time the resident was accounted for was at 4:45 AM on 1/30/2024. Staff L stated Resident #10 was found outside in the cold lying in a ditch next to a retention pond at approximately 7:30 AM. Staff L stated, "The outside temperature on that day at that time was 37 degrees."	A 025		

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A 025	Continued From page 3 During an interview on 2/8/2024 at 2:30 PM, Staff C, Care Partner stated she and Staff K, Lead Care Partner found Resident #10 on 1/30/2024, at about 7:30 AM. Staff C stated, "It was a cold morning. I arrived that morning about 6:45 AM and was told Resident #10 was missing and had last been accounted for at 4:45 AM. Several of us began searching outside because she had not been found inside the facility. We first saw her feet as we went behind where the van was parked. [Resident #10's name] was found lying on her side, dressed in a nightgown, slippers, and socks, she was soaking wet, and covered in poop. At first glance I thought she was dead. [Staff N's name] called 911. [Resident #10's name] was taken to the hospital and was treated for hypothermia. I don't have access to PCC [Point Click Care, an electronic medical charting system] to write an incident report, I told [Staff K's name] to write it as she saw it and as I understood it, she wrote what "they" [the administration] told her to write. When I tried to talk to [Staff K's name] about it she dismissed me and said, 'I don't want to talk about it.' People are scared to state the truth they think they are going to lose their jobs." On 2/8/2024, at 2:35 PM, an observation with Staff C was conducted of the area of the facility's campus where Resident #10 was reportedly found on the morning of 1/30/2024. The facility is located approximately 1000 feet north of a busy six-lane highway situated on a large parcel of unlevel ground. Approximately 600 feet from the entrance is a large wet marshy water retention area surrounded by high sawgrass. Potential hazards observed outside included a large iron grate in the middle of the paved parking lot, a large concrete culvert, sloping uneven terrain	A 025		

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A 025	Continued From page 4 which surrounds the retention pond, large landscape rocks, and concrete curbing on the property. (Photographic evidence obtained.) During an interview on 2/8/2024 at 2:45 PM, Staff C stated Resident #10 was found on the far east side at the edge of the retention pond, approximately 700 feet from the "Neighborhood 3" section of the facility. Resident #10 was found on 1/30/2024 at 7:15 AM. Staff C stated Resident #10 was lying on her side in wet socks and slippers and a nightgown when she was found. During an interview on 02/8/2024 at 3:10 PM, the Health and Wellness Director stated, she was not here [at the facility] when Resident #10's elopement happened, but she was notified of the incident around 7:30 AM. She stated she was told by staff on duty that the resident was found in the grass in front of the facility. She stated, "I don't know what grass, but they just said the grass." She stated she spoke to the resident's husband and informed him that his wife had been found outside in the grass. She stated, "I did not file an Adverse Incident Report because I did not know I needed to." During an interview on 2/8/2024 at 3:40 PM, the Executive Director stated the Maintenance Director found Resident #10 in front of the facility at about 6:30 AM sitting in the grass between the two palm trees. Resident #10 had walked through the lobby and got out through the front doors by following behind a family member. The Executive Director stated, "We saw it on the cameras. She was only out there about ten minutes and was taken to the hospital because her physician recommended she be checked out. She was fine and returned the same day." When asked if she had filed an adverse incident report, she stated, "I	A 025		

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A 025	Continued From page 5 didn't know I would need to. Check with [Health and Wellness Director's Name], that's her department. I don't think so because this wasn't an elopement. They said, as long as the resident doesn't leave the property it isn't an elopement. (When asked who "They" were, she stated the Department of Children and Families.) This is [Health and Wellness Director's Name], the Health and Wellness Director's responsibility to handle incident reports. I don't understand why it isn't documented. When she was read the details from the incident report written by the Health and Wellness Director, the Executive Director stated, "I just told you what I was told." During a telephone interview on 2/8/2024 at 4:17 PM, Resident #10's husband stated he was contacted by the nurse (Staff E) and then, the Health and Wellness Director. He stated, "The nurse had told me that she was found outside in the enclosed restricted area of memory care. Initially, I was led to believe she had fallen outside. Then the Health and Wellness Director assured me she had been found in an enclosed restricted area of memory care. There were a certain number of differences between the two stories I was told." He further stated that Resident #10 was diagnosed with Alzheimer's Disease over ten years ago. She [Executive Director] thinks she knew the code by watching me enter it, but I do not believe she is capable of remembering a code, her memory is not good." During a telephone interview on 2/8/2024 at 5:09 PM, Staff I, Care Partner, confirmed she was working 11 PM to 7 AM on January 30, 2024. She was the only one on the floor in Neighborhood 3. She stated, "Resident #10 likes to roam around and was restless that particular night. I last saw her in the hallway in front of her door at 4:45 AM.	A 025		

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A 025	Continued From page 6 When making my rounds at 5:00 AM, I didn't see her in her room, but I was not too concerned because she likes to walk about and goes into other peoples' rooms sometimes, so I didn't find it unusual that she wasn't in her room. I heard no alarms, during this time, and I know they were working because another resident that same night kept going to the door and sounding the alarm. I do not know how she could have gotten out. Around 6:00 AM, I still had not yet laid eyes on her and that is when I called for assistance from [Staff N's name] and the nurse [Staff E's name], and they began to help me look through the entire inside of the building, as well as the Lead Care Partner, [Staff K's name]. By 6:45 AM, there was still no sign of [Resident #10's name], by now we had searched the entire building. By this time, the first shift was arriving to work, and the first shift began searching the entire area outside along with the maintenance director. [Resident #10's name] was spotted in the high grassy marshy area of the retention area [pond] behind where the bus is parked near the far end of the building on the opposite side from Memory Care, Neighborhood 3. When I first saw her, I thought she was dead. She looked very pale, lying there on the ground in a nightgown, it was really cold that morning, too. I did not write an incident report, [Staff N's name] did." During a telephone interview on 2/9/2024 at 9:20 AM, the Florida Director of Operations for the facility stated, "An elopement would be when any resident left the building and has the potential for them to be harmed, kind of what it reads in the Adverse Policy regulation." When the details of the incident as described by staff were provided, he responded, "If those are the facts, then yes. If those are the facts, then that is something that should have been reported to AHCA."	A 025		

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A 025	Continued From page 7 During an interview on 2/8/2024, at 9:55 AM, the Maintenance Director stated on the morning of 1/30/2024 at 6:40 AM, he found Resident #10 sitting in front of the east side of the building in the grass. [This is the opposite side of the facility entrance described by the Executive Director as to where the resident was found.] He stated that the resident walked inside with him to Neighborhood 3. He said, "She seemed okay, she is always a little bit confused, nothing alarming or different. I can't speak to when the ambulance got here or who called. I assume it was the Med Tech in Neighborhood 3. I wasn't asked to write an incident report." He further stated no other staff was outside when he arrived at 6:40 AM. He stated, "I was the only one there when I found her. Whoever you you've been speaking to weren't [sic] there. When asked if the camera footage was available to view, he replied, "No, it is not available past 72 hours, and that happened nearly two-weeks ago." During an interview on 2/9/2024 at 10:43 AM, Staff N, Medication Technician confirmed she was working in Neighborhood 2 the morning of 1/30/2024. She received a call at approximately 6:10 AM from Staff I, Care Partner in Neighborhood 3. Staff N stated, "She informed me she had not seen Resident #10 since 4:45 AM, before making her rounds at 5:00 AM and still had not located her. At that moment I began looking in Neighborhood #2 and assisted her looking again in Neighborhood #3. We looked in every single room. By 6:30 AM, all staff were searching through the entire facility. At about 6:45 to 7:00 AM, the first shift had arrived for work, and began searching outside, along with the Maintenance Director and Housekeeper. There was a group of us. [Staff K's name] and [Staff C's	A 025		

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A 025	Continued From page 8	A 025		

name] found her in a ditch lying on her side at the edge of the retention pond on the far east side of the property. The Maintenance Director was in a foul mood that morning, he was cursing at us, telling us not to call 911. I ignored him because I knew that calling 911 was the right thing to do. We knew [Resident #10's name] needed medical attention, she was shivering really bad, her feet were soaking wet, and she was in only a nightgown which was covered in poop. When I called 911, Dispatch told us to lift the resident into the wheelchair and meet them up in front of the facility's entrance. [Staff C's name] then ran and got a wheelchair and between she and [Staff K's name] got her into the wheelchair, she was held in a sitting position so she would not slide out. Because she was soiled and wet, we made the decision to bring her inside to clean her up and change her clothing before EMS [Emergency Medical Services] got there. She was dressed by [Staff I's name] and [Staff P's name]. I was asked to write a statement which I gave to the Assistant in the Business Office which I know she changed, but I kept my original statement to protect myself."

Review of the typed statement provided by the facility for Staff N read, "While doing rounds at 5:00 AM in Neighborhood 3, staff did not find resident in her bed or common area. All care staff was notified and searched the resident rooms. Resident was not found inside, was out in front of the building sitting in the grass. Resident unable to give description."

Review of the statement written in Staff N's handwriting as pictured in her cell phone (which she states was turned in re-typed by someone in the business office) read, "Staff [Staff I's name] called around 6:10 AM informed me that the

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A 025	Continued From page 9 resident was missing from the neighborhood. I left neighborhood 2 and went to neighborhood 3 with the rest of my coworkers we began to search all the neighborhoods in the facility. The resident was later found outside lying in the ditch." Signed by [Staff N's name]. (Photographic evidence obtained.) During an interview on 2/09/2024, at approximately 2:00 PM, Staff P, Care Partner stated she had assisted Staff I with changing Resident #10 the morning of 1/30/2024 at around 7:30 AM. She further stated, "[Resident #10's name] was damp and cold and had defecated on herself so was in need of a clean brief. She stated the resident was able to follow simple commands while I assisted her." During an interview on 2/12/2024, at 10:25 AM, Staff E, Floor Nurse stated, "I was working in Neighborhood 2 the day of [Resident #10's name] elopement on 1/30/2024, not Neighborhood 3 and yet was asked to write the incident report. I refused because I was not working in that unit." Staff E stated she was not comfortable with the "deceit and untruths." She stated, "I have my license to protect, and I always strive to protect the residents and serve them with sincerity, good faith and to the best of my ability. Management seems to struggle with transparency, which hurts everyone, particularly the residents and their families. [Resident #10's name] husband should know the truth, and he doesn't, because of the deception here." On 2/12/2024, at approximately 10:35 AM, an observation was made of the side door leading to the outside in Neighborhood 3. There was a sign to the left of the door which read, "Do Not Exit." (Photographic evidence obtained.)	A 025		

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A 025	Continued From page 10 During an interview on 2/12/2024, at 10:36 AM, Staff B, Care Partner stated, "The door when pressed for 12 seconds will release and is not set to alarm but only beeps. This is a secluded corridor away from the activity and the majority of the rooms. If a staff member is bathing a resident or assisting them in the bathroom, there is no way they would hear it sound." On 2/12/2024 at 10:40 AM, a second observation of the Neighborhood 3 side door revealed a beep that sounded when opened. The beep was not very loud. It was confirmed that the beep could not be heard beyond the immediate corridor of Neighborhood 3 near where the door is located. Review of the facility policy titled "Elopement Prevention," dated 11/2019, last revised 10/2022, revealed it read, "Elopement is the ability of a resident who is not capable of protecting himself or herself from harm to successfully leave the facility unsupervised and unnoticed and who may enter into harm's way ...A situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision, if necessary, would be considered elopement. This situation represents a risk to the resident's health and safety and places the resident at risk of heat or cold exposure, dehydration and/or other medical complications ...4. Interventions that may be used for residents identified at risk for elopement includes: a. Frequent monitoring of the resident's whereabouts to assure he or she remains in the facility ...6. The physical plant is secured to minimize the risk of elopement such as: a. Functional alarm system for egresses and stairwells ..." Review of the facility policy titled "Safety and	A 025		

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A 025	Continued From page 11 Supervision of Residents", dated 7/2018 and revised 1/2023, revealed it read, in part, "Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision to prevent accidents are facility-wide priorities ...3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices ...7. Resident supervision is a core component if the systems approach to safety. The type and frequency resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment." Review of historical temperature data for Ocala, Florida was conducted on two separate Internet websites, Weather Underground (https://www.wunderground.com/history/daily/us/fl/ocala/KGNV/date/2024-1-30) and Timeanddate (https://www.timeanddate.com/weather/usa/ocala/historic?month=1&year=2024.) Both sources reported the temperature on 1/30/2024 at 7:34 AM was 37 degrees Fahrenheit. Review of the "Marion County Sheriff's Call for Service Transcript", dated 01/30/2024, documented Incident Report #2401300179 which read, in part, "(Suspicious Incident) 911 call received on 1/30/2024 at 7:14 AM ("Female got out of building and found lying in swamp") Marion Fire Rescue Arrived at 7:36 AM at [facility name and address], Priority Changed to Sick Person, arrived at Hospital at 7:47 AM." Class I	A 025		
A 030	59A-36.007(5) FAC; 429.28(1-2) FS 429.27 Resident Care - Rights & Facility Procedures	A 030		

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A 030	Continued From page 12 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; Disability Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Abuse Hotline, 1(800)96-ABUSE 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;	A 030		

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A 030	Continued From page 13 2. Alcohol and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident abuse, neglect, and exploitation; 6. Administrative and housekeeping schedules and requirements; 7. Infection 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 restraints. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 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	A 030		

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A 030	Continued From page 14 facility shall have the right to: (a) Live in a safe and decent living environment, free from abuse and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (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	A 030		

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A 030	Continued From page 15 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 appointments for health care services, the provision of or arrangement of transportation to health care appointments, 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 incapacitated, the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free 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	A 030		

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A 030	Continued From page 16 of the facility, governing officials, or any other person without restraint, 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, obligations, 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 Abuse Hotline operated by the Department of Children and Families, and, if applicable, Disability Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Abuse Hotline operated by the Department of Children and Families, and Disability Rights Florida. 429.27 Property and personal affairs of	A 030		

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A 030	Continued From page 17 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 incompetent or incapacitated 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 observation, interview and record review, the facility failed to ensure resident rights to a safe and decent living environment, free from abuse for 3 of 3 residents sampled for abuse, Residents #1, #2, and #8. Findings include: Review of Resident #1's clinical record revealed she was admitted to the facility on 10/28/2022. Resident #1's AHCA (Agency for Health Care Administration) Form 1823, dated 7/13/2022 documented the resident has a diagnosis of memory loss, confusion, type 2 diabetes, edema, hyperlipidemia, insomnia, HTN (hypertension), hypokalemia, and h/o (history of) leg amputation. Requires supervision in bathing, dressing, eating, and grooming and requires assistance in	A 030		

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A 030	Continued From page 18 ambulation, toileting, transferring and self-administration of medication. On 2/8/2024 at 11:20 AM an observation of Resident #1 was conducted. She was observed alert and fidgeting in her chair at the dining room table. The Resident is very petite, slight in stature, and is a left leg above the knee amputee. During an interview on 2/8/2024, at 11:22 AM with Resident #1, when asked how she was feeling she stated, "Not so good." When asked if she is treated well by the staff she stated, "Not always, sometimes they aren't nice, sometimes they hit me. I don't know their names." Review of Resident #2's clinical record revealed she was admitted to the facility on 12/12/2022. Resident #2's AHCA Form 1823 with no examination date documents the resident has a diagnosis of muscle weakness, anxiety, depression, and dementia. Resident in an Elopement Risk has Memory Deficits-loss of focus. Requires supervision in ambulation, dressing (set-up/cues), eating (set-up), grooming (set-up/cues), toileting, and transferring; requires assistance in ambulation (cueing), bathing, and toileting (clothing management) and assistance in self-administration of medication. Review of a Progress Note for Resident #2 dated 2/4/2024 at 7:41 PM read, "Resident complaining of pain in leg and shoulder, ankle swollen at this time. Resident stated during a shower a staff member was rough with her. DON notified." The entry was stricken over on 02/06/2024 at 10:25 AM. The entry was stricken by an unidentified staff member. During an observation on 02/08/2024, at 10:38	A 030		

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A 030	Continued From page 19 AM, Resident #2 was lying on her bed in her room. Resident #2's left foot was swollen; larger than right foot, and the right foot was purplish in color. Review of Resident #8's clinical record revealed he was admitted to the facility on 07/21/2023. Resident #8's AHCA Form 1823, dated 07/21/2023 documents the Resident has a diagnosis of benign prostatic hyperplasia, colostomy, hypertension, subdural hemorrhage, atrial fibrillation, diverticulitis of intestine, muscle weakness, and falls. Requires assistance with self-administration of medication. During an interview on 02/07/2024 at 11:18 AM Staff B, Care Partner stated, "I've been told that [Staff A's Name] has been physically abusing residents [Resident #1's name, Resident #2's name, and Resident #8's name]. I witnessed [Staff A's name] hitting [Resident #8's name] in the shower one day. I'm not sure of the exact date, but there were a few other staff in the room, but they are afraid to speak up because they are threatened with losing their job. I verbally reported this to [Health and Wellness Director's name and Executive Director's name] and they have done nothing about it. I did not write an incident report, I just told them. [Staff C's name] told me that [Staff A's name] hit [Resident #1] while she was standing in the bathroom after a shower. I was assisting [Staff A' name] with the shower but I must have been doing something else, because I didn't see [Staff A's name] hit [Resident #1's name]. [Staff C's name] walked out of the room and told me later that day that she had reported to the nurse that [Staff A's name] hit [Resident #1's name] in the back of the head." During an interview on 02/07/2024 at 2:43 PM	A 030		

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A 030	Continued From page 20 Staff C, Care Partner stated, regarding Resident #1 and [Staff A' name] "I can't remember the exact date, but I was floating that day between neighborhood 3 and 1. I went over to help [Staff B's name] on neighborhood 3 give Resident #1 a shower and when I arrived, [Staff A's name] was already there helping. They were still standing in the shower, but the water was off, and [Staff A's name and Staff B' name] were drying [Resident #1] off. [Staff B's name] was putting on Resident #1's shirt and [Staff A's name] slapped the lady [Resident #1] in the back of the head three times. I reported to the nurse on duty [Staff J's name] what had just happened. I am new and I do not tolerate things like that. I only reported to the nurse on duty, I did not do an incident report or document anything because I thought she would do all that." During an interview on 02/8/2024 at 2:55 PM Staff M, Care Partner, stated, on January 29, 2024, it was a Monday. I heard [Resident #2's name] crying out in pain. When I went to her room, she was crying saying I got hurt in the shower, my foot, my foot. When I asked her what happened she said, the ladies that gave me the shower hurt me. She couldn't say their names except that she said, I used to like them but, I don't anymore." Staff M denied knowing their names [the staff members who assisted Resident #2 with the shower]. She stated she reported it to the Floor Nurse, Staff J, and she [Staff J] documented it. During an interview on 2/8/2024 at 10:30 AM Staff J, Licensed Practical Nurse stated, "I am a nurse on the floor I work in all the neighborhoods, I go where most needed." I know [Resident #2's name] foot is still bothering her, an x-ray was ordered, it is still quite swollen, and it has been over a week now." I made a note in PCC [Point	A 030		

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A 030	Continued From page 21 Click Care, an electronic medical charting program] and someone struck through it. I don't know who would do that but, it makes me very upset. I was the one who contacted DCF [Department of Children and Families], because there are too many things happening and nothing is being done to address it. I also contacted the facility's Ombudsman, [the Ombudsman's name] but have not seen her come yet. You may wish to speak to [Staff M's name], she is the Care Partner, that [Resident #2's name] told. The Care Partners are trained to report any incidents to me or the nurse on duty and we document the incident in PCC." During an interview on 02/08/2024 at 10:46 AM the Executive Director stated, "I am aware of the note in [Resident #2 name's] record and what it says and there was no incident report completed or any follow-up done." During an interview on 02/07/2024 at 3:25 PM Staff H, Care Partner, stated, I filed a report with AHCA [Agency for Health Care Administration], DCF, and the [name of local police department] regarding my concerns about abuse and staffing. I have never witnessed abuse, but I heard about [Staff A's name] physically abusing several residents during their showers and staff do not feel that management is doing anything about it. Although I did not witness any abuse, I felt I should report it. During an interview on 02/08/2024 at 11:24 AM the Investigator with the Department of Children and Families stated, "I first came to the facility on January 24th [2024] to investigate abuse for [Resident #8's name] and [Resident #1's name]. On February 6th my co-worker came out to investigate a report about abuse for [Resident	A 030		

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A 030	Continued From page 22 #2's name]. Her abuse [Resident #2's] investigation involved the same staff and [Staff A's name] seems to be the consistent problem employee. When I arrived at the facility I spoke with [the Health and Wellness Director's Name] and made her aware of everything [allegations of abuse]. I never spoke with the Executive Director; she was not available to speak with me." During an interview on 02/08/2024 at 10:20 AM, the Health and Wellness Director stated, "I did speak with the DCF investigator Regarding allegations of abuse that involved two residents [Resident #8's name and Resident #1's name] and the investigator also asked to speak with staff involved which were Staff A, Staff B, and Staff G. She stated after the DCF investigator left she spoke with the Executive Director to make her aware of the situation. During an interview on 02/07/2024 at 1:53 PM the Health and Wellness Director stated, "I was informed by the DCF investigator yesterday [02/06/2024] that there was a report that Resident #2 was roughed up during her shower. It was disclosed that it happened on her last shower day on the 30th but her last shower day was the January 29th. Her shower sheet showed that [Staff A's name and Staff K's name] signed that they had given the shower. I did speak to [Staff A's name and Staff K's name] about the allegation. I asked them what happened, and they both stated, 'there was no incident to report.' I did not speak to any other staff, only the two that were there for the shower. [Staff A's name] has an open DCF case regarding abuse towards [Resident #8's name] that DCF came out and investigated on 01/24/2024. I questioned [Staff A's name] about it and she stated 'the resident was not out of hand, and she didn't get out of	A 030		

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A 030	Continued From page 23	A 030		

hand' she denied it happening. I did talk to some other staff, but I don't have any written statements or anything. There were other employees assisting with Resident #8's shower who were also involved in this DCF investigation [Staff B's name and Staff G's name]. I spoke with [Staff B's name and Staff G's name] and they said it was a regular shower nothing happened. She stated no staff has ever come to me and reported any abuse. I am familiar with the Abuse Policy. When I conduct orientation, I go over it with the staff."

During an interview on 02/09/2024 at 3:15 PM, Staff B, Care Partner stated she did speak with a DCF investigator on 01/24/24. I did not meet with [Executive Director's name or Health and Wellness Director's name]. I was not told to write any statements."

During an interview on 02/08/2024 at 10:28 AM the Executive Director stated, "I am aware that DCF came out about a week or so ago and this Tuesday [2/6/2024]. According to [the Health and Wellness Director's name] it was a DCF investigator that came in on 01/24/2024 and asked to speak with specific staff that were involved in an allegation of abuse. DCF asked about three staff members [Staff A's name, Staff B's name, and Staff G's name]. I was told the investigator spoke to all the staff involved and then spoke with the Resident [Resident #8's name]. I spoke with each of the staff members, everyone keeps changing their stories, so I can't tell if anything happened, that's why no one has been suspended because I don't know if anything really happened. No adverse incident was reported because again, I don't know if anything really happened. I have been filing the adverse incidents, because [the Health and Wellness Director's name] doesn't have access to the

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A 030	Continued From page 24 AHCA adverse incident reporting system. The [Health and Wellness Director's name] was supposed to get statements, but I do not have knowledge of any statements being written. She stated we are still actively investigating all three of the staff [Staff G's Name, Staff B's name and Staff A's name]. I did not speak with any other staff. I am aware that DCF also came the other day about one of our residents [Resident #2's name] regarding another abuse allegation also involving [Staff A's name]." A request was made to review the facility's investigation, none was provided. During an interview on 2/8/2024 at 5:30 PM, Staff A, Care Partner stated, "My conversation with the lady from DCF was very short. She asked me if I worked in memory care and I answered, no. She asked me if I knew about any abuse and I answered, no. That was it. I did not have a meeting with the [Executive Director's name or Health and Wellness Director's name]. I work in the assisted living, and I only help out in memory care with serving meals and giving showers when they need help, but I work in assisted living." During an interview on 02/08/2024 at 10:28 AM the Executive Director stated, "My understanding of the abuse policy is the [Health and Wellness Director's name] would start an investigation, that includes calling the family members, getting written statements, and suspending staff involved. None of the three staff were suspended." Review of the policy and procedure titled, "Abuse Policy" last revised on 10/23/2022, Page. 4 read, "Protection: 1. The facility will take all steps necessary to ensure that further potential abuse will not occur while the investigation is in process.	A 030		

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	AL11969506	A. BUILDING: _____ B. WING _____	02/12/2024

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A 030	Continued From page 25 2. Any employee who is accused of resident abuse, neglect, exploitation, or misappropriation of property will be suspended upon identification/immediately. The accused employee will not be permitted to enter the facility unless at the direction and under the direct supervision of the Administration or Director of Nursing. 3. Provide for the immediate safety of the resident/patient, upon identification of suspected abuse, neglect, mistreatment, and/or misappropriation of property. Which may include but not limited to: c. Immediate suspension of suspected employees, pending outcome of the investigation. Page 5. Investigation: 1. All alleged violations involving abuse, neglect, exploitation, and/or misappropriation of resident property will be thoroughly investigated by the facility under the direction of the Executive Director and in accordance with state and federal law." During an interview on 02/09/2024 at 9:20 AM the Florida Director of Operations for the facility stated, "I am aware that there have been three allegations of abuse investigated by DCF at Paddock Ridge of Ocala. I received an email from the Executive Director on 1/25/2024. Once the building becomes aware of it, [Executive Director's name] sends me an email or text informing me of the situation. Yes, I am familiar with the abuse policy in the sense that it would be patterned to what the state regulations are. He stated the expectation of the Executive Director when she has been made aware of an allegation of abuse regarding an employee abusing a resident would be for it to be reported and investigated. If it were a specific person or people, they would be suspended pending investigation. The investigation includes getting statements, suspending employees, and then reporting to appropriate agencies."	A 030		

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A 030	Continued From page 26 Class I	A 030		
A 165	429.23(1-4 & 6-10) 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: 1. Death; 2. Brain or spinal damage; 3. Permanent disfigurement; 4. Fracture or dislocation 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	A 165		

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A 165	Continued From page 27	A 165		

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) Abuse, neglect, or exploitation must be reported to the Department of Children and Families as required under chapter 415.
(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.
(8) If the agency, through its receipt of the

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A 165	Continued From page 28 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 record review and interview, the facility failed to report an adverse incident to the Agency for Health Care Administration for 1 of 4 sampled residents, Resident #10. Findings include: Review of Resident #10's patient record revealed an incident report dated 1/30/2024 that read, "While doing rounds at 5 AM on neighborhood 3 care staff did not find resident in her bedroom or in the common areas. All care staff was notified and searched all bedrooms. Resident was not found inside but, out in front of the building sitting in the grass. Resident was unable to give a description." Further review of Resident #10's clinical record revealed a discharge summary from a local hospital, dated 1/30/2024, that documented Resident #10 was treated for hypothermia and generalized weakness. Review of historical temperature data for Ocala,	A 165		

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A 165	Continued From page 29 Florida was conducted on two separate internet websites, Weather Underground (https://www.wunderground.com/history/daily/us/fl/ocala/KGNV/date/2024-1-30) and Timeanddate (https://www.timeanddate.com/weather/usa/ocala/historic?month=1&year=2024.) Both sources reported the temperature on 1/30/2024 at 7:34 AM was 37 degrees Fahrenheit. During an interview on 2/8/2024 at 2:45 PM, Staff C stated Resident #10 was found on the far east side at the edge of the retention pond, approximately 700 feet from the "Neighborhood 3" section of the facility. Resident #10 was found on 1/30/2024 at 7:15 AM. Staff C stated Resident #10 was lying on her side in wet socks and slippers and a nightgown when she was found. Review of facilities Adverse Incident Reports submitted in the last 3 months revealed no incidents reported for incidents involving Resident #10. During an interview on 02/8/2024 at 3:10 PM, the Health and Wellness Director stated, she was not here [at the facility] when Resident #10's elopement happened, but she was notified of the incident around 7:30 AM. She stated she was told by staff on duty that the resident was found in the grass in front of the facility. She stated, "I don't know what grass, but they just said the grass." She stated she spoke to the resident's husband and informed him that his wife had been found outside in the grass. She stated, "I did not file an Adverse Incident Report because I did not know I needed to." During a telephone interview on 2/9/2024 at 9:20 AM, the Florida Director of Operations for the facility stated, "An elopement would be when any	A 165		

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A 165	Continued From page 30 resident left the building and has the potential for them to be harmed, kind of what it reads in the Adverse Policy regulation." When the details of the incident as described by staff were provided, he responded, "If those are the facts, then yes. If those are the facts, then that is something that should have been reported to AHCA." Class III	A 165		