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
	AL11964730	A. BUILDING: _____ B. WING _____	04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC MEMORY CARE BY RSR	1200 ARTHUR STREET HOLLYWOOD, FL 33019

(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 licensure Complaint survey (#2023015481, #2023015699, #2024003930) commenced on and concluded on at Majestic Memory Care By RSR. The facility had deficiencies identified related to Complaint numbers 2023015699 and 2024003930 at the time of the survey. This survey resulted in deficient practice identified as a Class I deficiency for A 0025, due to the facility failing to prevent and failing to provide a safe living environment free from potential . A determination was made that the findings of the survey posed immediate danger to the health and safety of the residents admitted to the facility. The census was a total of 78 residents throughout 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 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	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the 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:	A 025		

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A 025	Continued From page 2 Based on record review and interview the facility failed to ensure the proper supervision of 1 of 3 sampled residents reviewed (Resident #3) to prevent , , from taking place with 2 of 3 sampled residents (Resident's #2 and #4). And to provide a safe living environment free from potential , , ... for seventy-seven (77) of seventy-eight (78) residents residing at the facility, as of the date of the survey. The findings include: In an interview with the Administrator on at 11:45 AM, a request was made for the facility's policy and procedure for supervision. The Administrator provided the surveyor with a Policy & Procedures binder and pointed to an undated document in section 9 entitled, "Safety and Well-Being. A review of the policy documented the following: 1. Caregivers should make rounds each morning before breakfast. 2. Caregivers should make rounds before leaving the facility and endorse pending duties to -incoming caregivers. 3. Caregivers should make rounds every two hours to ensure a comfortable level of security for residents including but not limited to residents who have high tendencies to . For a higher level of care, rounds should be made every hour or as needed. 4. Problems should be resolved as promptly as can be. Caregivers will call for help should help be needed. 5. Problems found should be reported immediately to the supervisor. 6. Proper documentation should be noted. 7. Proper reporting should be considered.	A 025		

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A 025	Continued From page 3 Things to be checked: 1. Resident's ADL which includes grooming and/or showers. 2. Resident's health status. 3. Cleanliness of surroundings including clean linen and towels. 4. Clean bathrooms. A) A review of a confidential document noted the following: On , at 8:30 PM, Residents #2 and #3 were brought to their room for bed by Staff B as they shared a room. It further documented in the report that on , , Resident #2 was asleep in the room he shared with Resident #3. Between 9:40 PM to 9:50 PM Staff B stated she heard noises from the room and went inside the room. Staff B found Resident #2 on the floor, while Resident #3 was standing next to him. Resident #2 was observed having on his , a small cut was noted on left upper , and middle of his . Facility adverse incident report also documents at at 5:39 PM that Resident #3 will be in a different room until he moves out of the facility. Resident returned to the facility on at 5:30 AM. At the time of the survey Resident #3 is still at the facility. A review of the facility's ALF (Assisted Living Facility) Report dated revealed the following: Resident #2, nature of incident noted as resident injury. Location [...], date noted as at 9:48 PM. The report documents that during round in [...], Resident #2 on the floor with on the , Roommate standing next to him. Injury noted to left side of as small cut was noted on left upper , and middle . Record review revealed Resident #2 was	A 025		

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A 025	Continued From page 4 admitted on . Review of Resident #2's Resident Health Assessment (AHCA Form 1823) dated documented his diagnosis as: , , , wasting and Atrophy, , , unspecified , history of of & . Further review of the Resident's 1823 documented his Activities of Daily Living (ADL) needs as the following: -Independent: Ambulation, , Eating, Toileting, Transferring. -Supervision: Bathing, Self-Care (Grooming). - Status: Alert and oriented to self, to date/situation/place. Exit seeking. Review of Resident #3's record revealed an admission date of to the facility and an AHCA form 1823 dated (completed prior to admission to his current assisted living facility). Resident #3's AHCA Form 1823 dated documented his diagnosis as: and . Further review of his AHCA form 1823 revealed the box regarding the appropriateness of ALF placement was not checked. His ADLs needs were documented as: -Supervision with Bathing, Self-Care (Grooming). -Independent with Ambulation, , Eating, Toileting, Transferring - Status: N/A Further review of Resident #3's file revealed Hospital discharge instructions dated for an Emergency Room visit with an admit date of , documenting the following: " , Danger to self and others, , per medical record, Patient was due to physically aggressive behaviors towards staff	A 025		

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A 025	Continued From page 5 and residents at his ALF. .[Patient] threw food, attempted to throw a chair, grabbed a resident by the shirt, and kicked a resident in the . It also documented his diagnosis as: " , with behavioral disturbances and moderate unspecified ." A review of Resident #3's updated AHCA Form 1823 (completed by the current facility) dated documented his diagnosis as: , and . His ADL needs were documented as: -Assistance with Bathing, Self-Care (Grooming). -Supervision: Ambulation, , Eating, Toileting, Transferring - Status: Review of Resident #3's Resident Observation log revealed the following. On (10PM): Resident was "nailed" over another resident. Resident #3 was standing over the resident in the room, on . Resident sent to the hospital for evaluation. At 5:30 AM, resident (Resident #3) returned to the facility. On : Daughter notified of the incident and spoke to Administration. Will continue to monitor. However, further record review revealed the facility had no documentation of the monitoring. A review of the staff schedule for , and interviews with Staff C and Staff D revealed they were working the 3:00 PM to 11:00 PM shift at the time of the incident regarding Resident #2 and #3. In an interview with Staff D, Certified Nursing Assistant (CNA) on at 2:55 PM she stated the following, on that she was	A 025		

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on duty that evening for her 3:00 PM - 11:00 PM shift. She stated she remembers being in the Nurses Station around 8:00 PM, when she heard Staff B, calling out for Staff D to call 911 because Resident #2 was hurt. Staff D stated she used the phone in the Nurses Station to call the paramedics. Staff D stated she recalls after calling 911, she went immediately to the resident's room and saw Resident #2 laying on the floor with on his and yelling out "stop hitting me." She stated she also observed Resident #3 standing over Resident #2 with on his . She stated her and Staff B walked Resident #3 out of the room. She stated Resident #3 appeared agitated and angry but did not speak. Staff D stated she remembered calling 911 for another ambulance for Resident #3 because of his mental status, and that she felt he might need to adjust his medication.

In an interview with Staff C, MedTech on at 3:15 PM, she stated regarding the incident with Resident #2 and #3 on , that she was on duty for her 3:00 PM - 11:00 PM shift when she heard yelling from Staff B to call 911. She stated Staff D called 911 and she responded to the room to assist Staff B. She stated she could hear Resident #2 yelling "Stop hitting me" and when she entered the room, she saw Resident #2 lying on the floor with on his , and Resident #3 standing next to him with on his . She stated she stayed with Resident #2 until the ambulance arrived. She stated that after explaining to the paramedics what happened, they informed her to call the Police. She stated she did not call the police, but called the Administrator and Staff B informed him of what happened. She stated she does not know if the Police were called. She further stated she is not aware of any measures

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A 025	Continued From page 7 implemented regarding Resident #3's behavior. In an interview with Staff B on [redacted] at 3:35 PM, she stated regarding incident with Resident #2 and #3 on [redacted], that she was able to recount the events of the incident. She stated she was doing room checks when she saw Resident #3 standing over Resident #2. She stated Resident #3 was observed with [redacted] on his [redacted] and [redacted] and she called out for staff to call 911. She stated Resident #2 was yelling out "stop hitting me." Staff B stated she did not witness Resident #3 striking Resident #2. She stated the ambulance arrived quickly, and Resident #2 was removed from the room and taken to the local hospital and Resident #3 was sent to the hospital at 10:00 PM to be evaluated. Staff B stated she remembers a staff training on resident after the event but stated there were no special instructions as far as the incident regarding Resident #3. A review of Resident #2's Observation Log revealed an entry dated [redacted] at 10:00 PM documented he was taken to the hospital via stretcher in stable condition. Resident #2 was last seen prior to going to the hospital on as he did not return to the facility. Further record review revealed on [redacted] the facility was informed by Resident #2's guardian that he [redacted], at the hospital on [redacted], at 5:50AM. Resident #2 is said to have [redacted], at the hospital due to the injuries sustained during the altercation on [redacted]. A review of Resident #2's hospital Emergency Room records revealed the following. Patient	A 025		

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A 025	Continued From page 8 found down on floor for unknown amount of time. Per staff patient was possible assault from roommate. Patient has significant to . Patient has to the left forehead, dried to the whole and lac( ) to right cheek. Patient transferred to hospice medical unit on . Patient . B) Review of the facility's ALF (Assisted Living Facility) Report dated at 3:30 AM written by Staff E (LPN) documented Resident #4 was seen by staff coming out of Resident #2 and #3's room. It documented Staff E reported that the resident [Resident #4] was noted with discoloration one Hematoma to left . 911 was activated and Resident #4 was transferred to the hospital for evaluation & treatment. It documented that the family was made aware. Hospice nurse informed the facility that resident is going to be admitted due to and . Steps taken to prevent recurrence noted as "Resident [Resident #4] will be evaluated by MD for Med Review, Frequent Rounds will be done". A review of confidential documents dated revealed the following: Staff observed Resident #4 coming out of room[...]. Staff observed a discoloration/hematoma on the resident's left . Called 911, resident sent to hospital. Hospice nurse notified facility resident admitted due to and . Review of Resident #4's Emergency Room records revealed the following. The patient was found down on a different resident's bed with to his , left , and cheek . Admission reason noted as injury. Resident discharged to hospice care on .	A 025		

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A 025	Continued From page 9 A review for Resident #4's record revealed an admission date to the facility on [redacted]. A review of Resident #4's AHCA form 1823 dated [redacted] revealed the following: -Diagnosis: [redacted] and [redacted] -His ADL needs were documented as requiring assistance in all ADLs. - [redacted] or behavioral status: memory loss, alert and oriented to family members, [redacted] at times. In an interview with the Administrator on [redacted] at 10:45 AM he stated to the best of his knowledge Resident #4 had [redacted]. He further stated he was not aware of Resident #4 being injured therefore no additional supervision was needed. In an interview with Staff E on [redacted] at 11:15AM, she stated she remembers the incident regarding Resident #4. She stated she was working that evening and recalled Resident #4 coming from Resident 2 and 3's room and noticed an injury to the resident's [redacted]. She stated Resident #4 could not verbalize what happened to him, therefore she was unable to document how resident was injured. On [redacted] at 2:56 PM, the surveyor was accompanied to Resident #4's room by the Administrator. The resident was observed lying in his bed, with a roommate on the other side of the room lying in his bed. This surveyor attempted to interview the resident but was unable to as he only speaks a foreign language. Observation by the surveyor revealed that Resident #4's room is	A 025		

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located on the same hallway, approximately 25 from Resident #3's room, just on the opposite side (West) of the hallway. The facility produced no evidence of any additional supervision being conducted following the incident involving Resident #4 to prevent reoccurrence. No documentation was provided, as the Administrator had previously stated, that he thought Resident #4 had only and had no clue of injury by Resident #3.

A review of the facility's Resident census, and observation by the surveyors revealed Resident #3 is still currently residing in a single occupied room which is located on the northwest wing (wing1) on the eastside of the hall approximately 50-60 from the nurse's station that is located on the southwest side of the facility at the beginning of wing 2. Resident #3's room has not been relocated closer to the staff station to ensure ongoing monitoring/supervision.

On the surveyor toured all four wings (sections) of the facility. Observation was made of resident doors which revealed they all have keyed doorknobs and are kept locked at all times. A random check of residents' doors in all four sections by the surveyor revealed the doors were locked and could not be entered without the key. On at 12:09 PM this surveyor knocked several times on Resident #3's door, then turned the knob which revealed it was locked. There was no documentation at the facility indicating how Resident #4 entered Resident #2 and #3's room.

On , the Administrator provided the surveyors with a Majestic Memory Care " , Neglect & , Training" document dated , 3-days after the incident involving

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A 025	Continued From page 11 Resident #2 and #3. Review of the document revealed 18 of 64 staff listed on the facility's background clearing house roster were documented as attending the training session. The elements covered and the staff names/signatures of those in attendance were observed (copy obtained). Review also revealed that the training material provided to the surveyor was a 2-page document labeled " , Neglect & , Training" and gave the definitions of , neglect, and , . The document also gave examples of , indications of , and indications of neglect. In an interview with the Administrator on at 10:45 AM, he stated staff are to complete the Count report form daily on each shift throughout the day and night. He was informed that a review of the facility's "Endorsement Count Report" for the Month of , documented missing headcounts (bed checks) were conducted. Specifically, review of the document for the date of incident ( ) did not document a headcount. As such, supervision of the residents could not be determined. Record review revealed Resident #3 was issued a 45-Day Notice dated . Reason for discharge noted as a 45-day notice to transfer Resident #3 to another facility that can cater to his needs. Majestic Memory Care can no longer take care of the Residents needs due to his behavioral status. However, as of the date of the survey, the Resident remains at the facility. In addition, Resident #3 is still able to move unabated throughout the facility, and has direct contact with other residents, as evidenced by observations made by the surveyors during the	A 025		

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survey. Specifically, observations throughout the survey were made of Resident #3 with no direct supervision in various locations within the facility (i.e. In the dining sitting at a table with 3 other residents, in the activity room with other residents).

A review of the facility's resident census documented during the survey that there are currently 77 residents (excluding Resident #3) in the facility that have exposure to Resident #3. All residents of the facility have a documented and Related (ADRD) diagnosis as the entire facility is a locked-down Memory Care Unit. Observation of all the residents during the survey revealed many require assistance with ADLs; Several Residents requiring additional care were observed with Private Duty Aides (PDAs).

As the facility has not conducted any specific/or related training regarding the incidents with Residents #2 and #4 and have allowed Resident #3 to remain at the facility with minimal monitoring and supervision, and unabated access throughout the facility, one (1) to seventy-seven (77) Residents remain at risk for potential . The facilities document " , Neglect & , Training" also provided information on how to report elder , neglect, and , to an outside agency, (Department of Children and Families, Adult Protective Services, Aging Network, and the Florida Hotline). However, the document did not provide specific training related to the incidents on and .

After Resident #3 exhibited aggressive behaviors on where he physically assaulted Resident #4 inside his room, Resident #3 was

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MAJESTIC MEMORY CARE BY RSR	1200 ARTHUR STREET HOLLYWOOD, FL 33019

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A 025	Continued From page 13 allowed to remain at the facility and in the same room where the aggressive actions took place. In addition, the facility failed to thoroughly investigate the assault on Resident #4 that occurred on [redacted] at 3:30 AM. Such an investigation may have resulted in the facility averting the incident with Resident #2 on [redacted], which also was not thoroughly investigated. Specifically, the facility had information available regarding the potential for [redacted] by Resident #3 and had sufficient time to investigate and put in place measures to prevent a further occurrence and did not. As such, the facility failed to demonstrate actions taken to prevent past, and potential future occurrences. Class I	A 025		