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
	AL11963865	A. BUILDING: _____ B. WING _____	04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE SENIOR LIVING	4201 SPRINGTREE DRIVE SUNRISE, FL 33351

(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 2026005182 was conducted at Springtree Senior Living from - . The facility had deficiencies at the time of the survey.	A 000		
A 011	59A-36.006(5) FAC Admissions - Discharge (5) DISCHARGE. If the resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, as determined by the facility administrator or health care practitioner, the resident must be discharged in accordance with Section 429.28, F.S. This Statute or Rule is not met as evidenced by: Based observation, interview and record review, the facility failed to monitor the continued appropriateness of residency for 1 of 1 sampled residents, (Resident #1) whose pattern of behaviors directly threaten the emotional and physical health, safety and security of all within the facility. Cross reference A 0030 for addition information regarding Resident #1. The findings include: Review of Resident #1's medical record revealed he was admitted to the facility on . Resident #1 utilizes , and can ambulate and also uses a motorized wheelchair for mobility. The resident is alert oriented, to person, place and time and is forgetful at times. In an interview with the Administrator and Director of Nursing (DON) on at approximately 10 AM they stated Resident #1 had a history of verbally harassing residents if he has an "issue" with them. They stated the resident would bully	A 011		

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A 011	Continued From page 1	A 011		

other residents but never had any physical altercations prior to . The DON stated that Resident #1 used a motorized scooter for mobility. She stated that Resident#1 would become impatient and drive aggressively around other residents. The Administrator stated that Resident #1 was verbally harassing Resident #3. She stated that Resident #1 uses a rope to assist him to open his room door. Due to the ongoing harassment by Resident #1, Resident#3 was caught cutting the rope from Resident #1's door. The action was caught on video by a camera, placed in the hallway by Administrator. Resident #3 no longer resides at the facility. The Administrator stated there had been 2 other grievances filed by another resident and she provided two grievance forms that were submitted by Resident #2 regarding Resident#1's behavior, harassment.

Review of facility Grievance Form dated indicated the Administrator spoke with Resident #1 and asked him what happened. The resident stated "Resident #2 was in his way, and he was beeping his scooter horn for him to move out of his way. This caused Resident #2 to spill his coffee." The form indicated that Resident #1 apologized, but Resident #2 wanted him to stay away. The Administrator documents she instructs Resident #1 to be patient, "other resident's do not have to move out of his way". Resident #1's response is documented as "Resident #2 was walking too slowly. "The Administrator instructs Resident #2 to keep his distance from Resident #1.

Review of facility 2nd Grievance Form dated revealed Resident #2 has asked repeatedly for Resident #1 to leave him alone. Findings- ? " when I spoke with resident

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A 011	Continued From page 2 he was asked to please keep his distance from Resident #2." Resident #1 acknowledged and agreed with instruction by Administrator. In an interview with Resident #2 on at 1:15 PM, he stated Resident #1 had repeatedly harassed him, yelled profanity and enjoyed startling him. He stated recently he was walking outside with a cup of coffee and Resident#1 was riding his motorized scooter behind him. He stated Resident #1 drove up behind him and pulled at his pants, he was beeping the scooter horn and yelling at him to move out of the way. Resident #2 stated that he lost his balance due to the tugging of his pants and he spilled coffee all over himself. He stated he wasn't injured. He stated he filed a grievance with the Administrator when Resident #1 would not leave him alone, and even after Administrator spoke with Resident #1, he continued to yell and attempt to startle him every time he saw Resident #2. Resident #2 stated he filed a 2nd grievance, he stated he told Resident #1 to leave him alone, and now he stays clear of Resident #1. In an interview conducted with Resident #1 on 12:PM , the resident stated his anger towards the Licensed Practical Nurse (LPN) began on during a scheduled mandatory fire evacuation drill. He stated that he had informed the morning staff that he is not feeling well and would not be participating in the drill. A female (name unknown) and LPN come into his room and LPN yells at him "get up ". The resident stated that he told LPN he needed to go to the bathroom so he got in his wheelchair and tried to wheel himself into bathroom, but the LPN blocks him. He stated the LPN keeps yelling "let's go". The resident goes into the bathroom and "tells LPN to go to the drill and save yourself".	A 011		

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A 011	Continued From page 3 Resident #1 stated the LPN starts knocking on the door yelling "Get out of there." The resident stated he comes out of the bathroom and the LPN attempts to move his wheelchair towards the exit door. Resident#1 stated he applies the brakes and complains to LPN that he is not going downstairs in his underwear. Resident #1 stated "I was so mad, I had to get even with the guy". The resident does not inform anyone that he was upset and angry about the LPN actions that occurred on . Review of investigation records/report completed by the facility revealed the following. An incident that occurred on at 6:44 PM. The report indicated that a facility licensed practical nurse (LPN) and Resident #1 were involved in a verbal and physical altercation in the main lobby. The report indicates that at 7:30 PM Resident #1 called 911 and was transported to the hospital for evaluation. The facility Executive Director/ Administrator arrived on site and spoke with police who were investigating. Review of the facility internal investigation written statement from the DON dated on at 5:30 PM indicated the DON went to visit the resident to check on him and he described the events that occurred between him and LPN on , specifically that the LPN tried to embarrass him by having him come out of his room in his underwear. Resident #1 told the DON that he was mad from that day and was "trying to think of a way to get at the LPN". The statement revealed that Resident #1 stated he thought "he should get a baseball bat so he could hit the LPN from behind to take him out." The DON statement further revealed that on when Resident #1 saw LPN walking in the hallway and there were a lot of people around, he decided to get	A 011		

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A 011	Continued From page 4 him and yelled "hey c..ksucker" at him. The argument began and then escalated. Resident #1 was exhibiting aggressive verbal behavior towards the LPN, who engaged in a verbal argument with the resident, which then escalated into physical contact between the resident and LPN. Review of the facility progress notes indicated no precautionary safety monitoring was implemented for Resident #1's verbal and physical behaviors after the incidents involving Resident #2 and after the altercation on with LPN. Review of the facility's "Resident Handbook" given to all residents on admission revealed sections: Behaviors- If you exhibit behaviors that interfere with your safety and health and/or other residents' safety and health, you will be given a 45-day notice. We expect all residents and family members to treat the staff with respect as you are provided the same respect to you. If there is any issue or concern, you can bring it to the attention of the Executive Director and place a grievance to be investigated. These grievances are confidential. If there is any threats or belligerent behavior, you will be asked to leave and or police may be called. There is zero tolerance for this in the building. Respect for Building, Other Residents and Staff- Be thoughtful and considerate of others in the community to include residents, family members and staff with appropriate language, comments or remarks. We ask that residents act appropriately in the general areas, no excessive yelling, disruption of a building activity, disruption with the building daily general routine, any name calling,	A 011		

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A 011	Continued From page 5 disrespectful comments or any verbal threats to other residents, family members or staff. Class II	A 011		
A 030	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 telephone numbers must be posted in close proximity to a telephone accessible by residents	A 030		

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A 030	Continued From page 6	A 030		

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 must be, at a minimum, a readily accessible telephone on each floor of each building where

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A 030	Continued From page 7 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 attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as	A 030		

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A 030	Continued From page 8 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 resident may contact the State Long-Term Care Ombudsman Program for assistance with	A 030		

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A 030	Continued From page 9 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 resident for presenting grievances or for exercising any other resident right. The facility	A 030		

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A 030	Continued From page 10 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 observation, interview and records review, the facility failed to ensure that facility residents lived in an environment free from . The facility's failure to protect residents from escalating verbal and physical behaviors by 1 of 1 sampled residents (Resident #1) who placed other residents and staff at risk of physical and harm and/or injury. The findings include:	A 030		

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A 030	Continued From page 11 Review of Resident #1's medical record revealed he was admitted to the facility on . The resident had medical diagnosis' including , , prostatic hyperplasia, dyslipidemia, , , , , and ambulation. Resident #1 utilizes and is able to ambulate. He utilizes a mobilized wheelchair for mobility. The resident is alert oriented, to person, place and time and is forgetful at times. He is independent for activities of daily living (ADL) care and requires assistance with medication management. Review of investigation records/report completed by the facility revealed the following. An incident that occurred on at 6:44 PM. The report indicated that a facility licensed practical nurse (LPN) and Resident #1 were involved in a verbal and physical altercation in the main lobby. The report indicates that at 7:30 PM Resident #1 called 911 and was transported to the hospital for evaluation. The facility Executive Director/ Administrator arrived on site and spoke with police who were investigating. Review of the hospital record dated revealed Resident #1 was evaluated in the hospital for complaints of injury due to an altercation- , , , and , , Treatment prescribed included Extra Strength for and to follow-up with the physician. Resident #1 was discharged to the facility on . Review of the facility's internal written investigation report indicated an interview with the facility's Sales Director on who stated that on she and the LPN went to Resident	A 030		

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A	Continued From page 12 #1's room to assist him to evacuate during a mandatory fire evacuation drill in the building. She stated upon arrival at the resident's room she found Resident #1 in bed and refusing to participate in the mandatory drill. The report indicated that the resident was initially noncompliant, refusing to be out of bed. He eventually got out of bed but delayed by spending 5 minutes in the bathroom. Resident #1 insisted on returning to his bed to put on his pants. The Sales Director indicated that the LPN offered to assist the resident, but he declined. LPN made multiple attempts to push the resident in his wheelchair, but Resident #1 kept locking the wheelchair brake. Resident #1 never evacuated his room. In an interview with the Sales Director on at 2:40 PM, she stated that on the facility was conducting a planned evacuation drill to begin around 10 AM. She stated that the facility had alerted both the residents and families about the drill and asked for cooperation to practice total building evacuation. She stated Resident #1 was not observed to participate, so she and LPN went to his room to assist him if needed. She stated that Resident #1 was found in his bed, she informed him that he needed to go downstairs for the drill and the resident stated OK. She returned a few minutes later and found the resident in bed. The LPN instructed Resident #1 that " we need to get going and exit the building". The resident got into his wheelchair and stated he needed to go to the bathroom. The resident remained in the bathroom for 5 minutes, appearing to be delaying. She stated that the LPN raised his voice and knocked on the bathroom door. The resident was wearing only his boxer shorts and T- shirt and he stated he needed to put on his pants before going downstairs.	A 030		

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(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 030	Continued From page 13 Resident#1 and LPN began to yell at each other. Resident #1 was upset that he was being rushed and not allowed to put on his pants even though the LPN had offered to assist him in the elevator. Resident #1 refused to leave the room, LPN attempted to wheel the resident out of the room and the resident kept applying the brake. The drill appeared to be over as other residents were coming to their rooms. Resident #1 never attended the drill and did not go downstairs. The LPN and Sales Director left the room. The Sales Director stated that Resident #1 had a history of aggressive verbal behavior towards other residents. She stated that she was unaware that the resident claimed he had told other staff earlier that he was not feeling well and didn't want to attend the drill. Review of the facility's internal written investigation reports revealed a signed statement by Resident #1, handwritten by the Administrator for the resident on which documented his recollection of events leading up to the incident on . The statement is co-signed by the Director of Nursing (DON). The resident states he informed morning care staff on that he was not feeling well. The LPN comes into his room and starts yelling at him. "I don't feel well, I got into wheelchair and went into the bathroom". The LPN told him not to go into the bathroom and blocked him telling at him "you are going down right now". The resident comes into the bathroom, and the LPN starts knocking on the door to "hurry up". The resident stated he came out of the bathroom and LPN started to take him out of his room in my underwear. Resident #1 tells LPN "you are not going to take me down in my underwear and not going to embarrass me." The resident applies the wheelchair brakes as LPN attempts to pull	A 030		

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	AL11963865	A. BUILDING: _____ B. WING _____	04/06/2026

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A 030	Continued From page 14 wheelchair backwards. The resident stated that he asked to put on his pants and the LPN threw his pants at him. The statement indicates the LPN left the room as the drill had ended. The resident did not report his feelings to anyone. Further review of the document indicates that on Resident #1 is in lobby hallway and sees the LPN and he calls the LPN a "jerk off and a..hole" for embarrassing him. Resident #1 states that he began to call the LPN names and the LPN questions him why he is behaving that way. Resident#1 stated he called him a "f..king jerk off." The resident states the LPN came up to him and started punching him, he felt , and he on the floor. While on the floor Resident#1 asks the Front Desk Receptionist to call 911 and she refused times. The resident stated that the LPN assisted him into his motorized scooter. The resident stated that the LPN said "we can settle this like two men", Resident #1 stated "what the hell are you talking about and told LPN you can start with an , ,. "Resident#1 stated that the LPN did apologize and walked away. The resident stated he called 911. The document was signed by Resident#1 and DON as witness to his statement. In an interview conducted with Resident #1 on 12:15 PM he was observed in bed, wearing pants and T-shirt. His , were on the floor next to the bed along with a wheelchair. The resident stated that the LPN was "a nice guy until he punched him, like a punching bag". Resident #1 stated he was afraid of the LPN, that he would come into his room but had been told by his daughter that the LPN was suspended. Resident #1 stated that the facility video recording showed that he "ran over the LPN". Resident #1 stated his anger towards LPN began on during a scheduled fire drill	A 030		

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A 030	Continued From page 15 /evacuation that was mandatory. He stated that he informs the morning staff that he is not feeling well and will not be participating in the drill. A female (name unknown) and LPN come into his room and LPN yells at him " Get up ". The resident stated that he told LPN he needed to go to the bathroom so he gets in his wheelchair and tries to wheel himself into bathroom, but the LPN blocks him. He stated the LPN keeps telling him " let's go". The resident goes into the bathroom and "tells LPN to go down to the drill and save yourself". Resident #1 stated the LPN starts knocking on the door "Get out of there." The resident stated he comes out of the bathroom and the LPN attempts to move his wheelchair towards the exit door. Resident stated he applies brakes and complains that he is not going downstairs in his underwear. Resident #1 stated he rolls over to the bed to begin to put his pants on and LPN hears other residents returning from the drill, so he leaves the room. Resident #1 stated "I was so mad, I had to get even with the guy". Resident#1 does not inform anyone that he was upset and angry about the actions that occurred on . Resident #1 stated that on , he is in his motorized scooter and sees the LPN in the hallway, near the main lobby and yells at him" Hey c..ksucker, you are taking advantage of sick persons", " you have showed your true colors", "I'm not afraid of you". Resident #1 confronts LPN again in the lobby area minutes later, calling the LPN names and cursing. Resident #1 stated he and the LPN are arguing and the LPN punches him in the . The resident stated he ducks and out of the scooter to the floor. He stated he told the Front Desk Receptionist to call 911 four-five times and she did not. He stated his , and rate were elevated and he was shaking. He called 911 himself and and police arrived.	A 030		

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A 030	Continued From page 16 He stated he goes to the hospital for evaluation, and no injuries were found. The resident stated he returned to the facility that same night. In a telephone interview with the Front Desk Receptionist on at 4:40 PM she stated that around 4 PM on , she observed LPN walking in the hallway near the front desk. Resident #1 yelled at the LPN " you are a c..ksucker". Later in evening around dinner time, she stated she was in the dining room and heard arguing coming from the lobby area. She stated the LPN and Resident #1 were in a verbal argument about events that occurred during a facility evacuation drill on . She recalls she overheard that LPN state to Resident #1 "if you have an issue, take it up with the Administrator." She stated that they continued to argue, their voices were loud and both were angry. She stated Resident #1 was upset with LPN that during the drill he wanted to bring Resident #1 downstairs in his underwear. She stated she tried to diffuse the argument saying, "leave it alone", "let it be" and "this is so stupid" but they didn't respond to her. She stated that Resident #1 moved his over the scooter control knob, which moved the scooter forward, striking the LPN. She stated the LPN went into "fight or flight" mode, afraid for his safety, he grabbed on the scooter armrest and his arms/ body swung. She stated she observed the LPN grabbing the of Resident #1's and pushed him forward to get away. She stated Resident #1 yelled "you hit me", she stated she didn't see the LPN hit the resident. She stated Resident #1 slid forward and out of the scooter to the floor. She stated the LPN attempted to assist Resident#1 into the scooter, but the resident was yelling and refused assistance at first. She stated Resident #1 asked her to call 911 four- five times, but the LPN	A 030		

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A 030	Continued From page 17	A 030		

stated, " he is not injured and doesn't need 911." She stated Resident #1 remained very angry. The LPN did assist him into the scooter. She stated that Resident#1 sat in the lobby for 15 minutes telling other residents that the LPN was wrong and he was upset about events during drill on . She stated the LPN and resident continued to argue and the LPN was trying to get his point across to the resident. She stated Resident #1 called 911 himself and and police arrived. She stated she had observed Resident #1 driving the scooter aggressively and didn't care about other residents' safety. She stated after the incident on , Resident #1 positioned himself in front of her at the desk and stared at her, trying to pick a fight with her for not calling 911 when he asked.

In an interview with LPN on 10:30 AM he stated that he had worked at the facility for three years. He stated that during the morning on the facility had a scheduled mandatory fire drill/evacuation drill. He was assigned to get residents out of the building. He went to assist with Resident #1 since he didn't want to participate. He stated that he instructed the resident, "let's go, let's go", he stated he didn't say anything negative or curse at the resident and he never forced him to leave his room. The LPN stated that on , he saw Resident #1 in the hallway and the resident began calling him names, cursing at him. The LPN stated that he had known the resident for 3 years, had great conversations with him and was surprised to be called nasty, offensive names. He stated when he asked the resident "what are you talking about?" Resident #1 told him "you didn't want to leave during drill." The LPN stated he was unaware that Resident #1 was so upset about their interaction on . The LPN stated that he was unaware

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A 030	Continued From page 18 if the resident contacted the Administrator. He stated that he apologized to the resident, and walked away. Approximately minutes later he returned to the lobby area and found Resident #1 sitting in his motorized scooter. Resident #1 began to curse and point at the LPN. Again, the LPN asked the resident what he was angry about and asked him if they should contact the Administrator to discuss his concerns, the LPN stated the resident refused and continued to curse him. The LPN stated he continued to try to explain to Resident#1 that he was just doing the job asked of him during the drill on . The LPN stated Resident #1 could not see any logic and used curse words. The LPN stated he was standing next to the scooter and Resident #1 was seated in the scooter, the resident moves the scooter backwards then forward, colliding with the LPN. The LPN states he stumbled into chairs and tried to stop the scooter from moving toward him. When the scooter stops, Resident #1 slides off the scooter. The LPN states he attempts to right the resident but lowers him to the floor. The LPN stated that Resident #1 initially stopped cursing and asks the receptionist to call 911. The LPN states he told the resident based on his nursing experience, he was not injured, he had no _, and no . The LPN stated Resident #1 stated "you hit me times". The LPN stated he left the lobby and returned to find the police and personnel interviewing the resident. The LPN stated he called the Administrator and upon her arrival at the facility, the security video recording was reviewed by the police. (See photographic evidence). The LPN stated he has been a nurse for 15 years and never had any resident allegations of or physical altercation. The LPN stated that he was attempting to explain to Resident#1 his evacuation responsibility, but the resident didn't	A 030		

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A 030	Continued From page 19 want to hear it. The LPN stated he asked Resident #1 approximately times, " lets' call management to discuss" but the LPN didn't believe it would escalate to become physical contact. The LPN stated he was unaware of any previous harassment grievances about Resident #1 until the Administrator was discussing her concerns about Resident #1 with police on . Review of the facility internal written investigation statement from the Director of Nursing (DON) dated on at 5:30 PM indicated the DON went to visit Resident #1 to check on him and he described the events that occurred between him and LPN on , specifically that the LPN tried to embarrass him by having have him come out of his room in his underwear. The resident told the DON that he was mad from that day and was trying to think of a way to get at the LPN. The statement revealed that Resident #1 stated he thought "he should get a baseball bat so he could hit the LPN from behind to take him out." The DON statement further revealed that on when Resident #1 saw LPN walking in the hallway and there were a lot of people around, he decided to get him and yelled " hey c..ksucker" at him. The argument began and then escalated. In an interview with the Administrator and Director of Nursing (DON) on at approximately 10 AM they stated Resident #1 had a history of verbally harassing residents if he has an "issue" with them. They stated the resident would bully other residents but never had any physical altercations prior to . The DON stated that Resident #1 used a motorized scooter for mobility. She stated that Resident#1 would become impatient and drive aggressively around	A 030		

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A 030	Continued From page 20	A 030		

other residents.The DON stated that during her conversation with Resident #1 regarding the incident on the resident did not inform her that he had repositioned the scooter and drove it into the LPN. The Administrator stated that Resident #1 was verbally harassing Resident #3. She stated that Resident #1 uses a rope to assist him to open his room door. Due to the ongoing harassment by Resident #1, Resident#3 was caught cutting the rope from Resident #1's door. The action was caught on video by a camera, placed in the hallway by Administrator. Resident #3 no longer resides at the facility. The Administrator stated there had been 2 other grievances filed by another resident and she provided two grievance forms that were submitted by Resident #2 regarding Resident#1's behavior, harassment. The Administrator provided two grievance forms for review that were submitted by Resident #2 regarding Resident#1's behavior, harassment.

Review of a written grievance letter dated - addressed to the Administrator, indicated "you must speak with Resident #1. He is constantly harassing me and wont' stop. He caused me twice to drop hot coffee all over me. I told him to stop but he's done it twice more since then. Signed Resident #2.

Review of facility Grievance Form dated indicated the Administrator spoke with Resident #1 and asked him what happened. The resident stated "Resident #2 was in his way and he was beeping him to move out of his way. This caused Resident #2 to spill his coffee." The form indicated that Resident #1 apologized, but Resident #2 wanted him to stay away. Administrator documents she instructs Resident #1 to be patient, other resident's do not have to

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A 030	Continued From page 21	A 030		

move out of his way. Resident #1's response is documented as " Resident #2 was walking too slowly. "The Administrator instructs Resident #2 to keep his distance from Resident #1.

Review of 2nd written grievance letter dated revealed "Resident #1 refuses to stop harassing me. I was on way to the elevator and passed him. He started yelling and trying to startle me. I had coffee in my ; it did not spill. Told him to stay away from me and he replied" Stay away from me". This has to stop. Signed by Resident #2.

Review of facility Grievance Form dated revealed Resident #2 has asked repeatedly for Resident #1 to leave him alone. Findings- ? when I spoke with resident he was asked to please keep his distance from Resident #2. Resident #1 acknowledged and agreed with instruction by Administrator.

In an interview with Resident #2 on at 1:15 PM, he stated Resident #1 had repeatedly harassed him, yelled profanity and enjoyed startling him. He stated recently he was walking outside with a cup of coffee and Resident#1 was riding his motorized scooter behind him. He stated Resident #1 drove up behind him and pulled at his pants, he was beeping the scooter horn and yelling at him to move out of the way. Resident #2 stated that he lost his balance due to the tugging of his pants and he spilled coffee all over himself. He stated he wasn't injured. He stated he filed a grievance with the Administrator when Resident #1 would not leave him alone, and even after Administrator spoke with Resident #1, he continued to yell and attempt to startle him every time he saw Resident #2. Resident #2 stated he filed a 2nd grievance, he stated he told

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A 030	Continued From page 22 Resident #1 to leave him alone, and now he stays clear of Resident #1. In an interview conducted with Resident #1 on 12:15 PM, he was asked about the incident between himself and Resident #2. Resident #1 stated he was driving his scooter outside on the sidewalk (date unknown) and Resident #2 would not move off the sidewalk to let him by. Resident #1 beeped the horn and yelled at Resident #2 " get out of my way". Resident #2 was startled and spilled coffee on himself. Resident #1 stated he was "rushing to get to McDonalds to get a breakfast sandwich before the menu closed." Review of the facility's Resident Handbook given to all residents on admission revealed under sections: Behaviors If you exhibit behaviors that interfere with your safety and health and/or other residents' safety and health, you will be given a 45-day notice. We expect all residents and family members to treat the staff with respect as you are given the same respect to you. If there is any issue or concern, you can bring it to the attention of the Executive Director and place a grievance to be investigated. These grievances are confidential. If there is any threats or belligerent behavior, you will be asked to leave and or police may be called. There is zero tolerance for this in the building. Respect for Building, Other Residents and Staff Be thoughtful and considerate of others in the community to include residents, family members and staff with appropriate language, comments or remarks. We ask that residents act appropriately in the general areas, no excessive yelling, disruption of a building activity, disruption with the building daily general routine, any name calling,	A 030		

Agency for Health Care Administration

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A 030	Continued From page 23 disrespectful comments or any verbal threats to other residents, family members or staff. If a situation occurs in general areas, you will be asked to stop or leave by a manager. If these events continue, or becomes physical you may be given you may be subject to a 45-day notice to leave the community. Inappropriate behavior will not be tolerated; there is zero tolerance with this concern. Review of the facility progress notes indicated no precautionary safety monitoring was implemented for Resident #1's verbal and physical behaviors after the incidents involving Resident #2 and after the altercation on with LPN. ClassII	A 030		