RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

*Better Health Care for all Floridians*

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Emeritus at Ocala East
1601 Southeast 24th Road
Ocala, FL 32671

Dear Administrator:

Re: CCR #2012008446

This letter reports the findings of a complaince licensure survey that was conducted on , 2012 by a representative of this office.

Enclosed is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after , 2012 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call this office at (386) 462-6201.

Sincerely,

Kriste J. Mennella
Field Office Manager

KJM/amw

Enclosure

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Alachua Field Office
14101 N W Hwy 441, Suite 800
Alachua, FL 32615-5669
Phone (386) 462-6201; Fax (386) 418-5300

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 |
|---|---|---|---|
| | AL11911441 | A. BUILDING _____ B. WING _____ | 08/08/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERITUS AT OCALA EAST | 1601 S.E. 24TH ROAD OCALA, FL 32671 |

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| A 000 | Initial Comments | A 000 | | |

On [redacted] an unannounced Assisted Living Facility (ALF) complaint investigation was conducted, for CCR # 2012008446. The facility was found not to be in compliance with Chapter 429, Part I, F.S. and 58A-5, F.A.C.

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|---|---|---|---|---|
| A 030 SS=G | 58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures | A 030 | | |

(6) 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 Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C.
(b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for 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 address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456.
(d) The statewide toll-free telephone number of the Florida [redacted] Hotline " 1(800)9[redacted] or 1(800)962-2873 " shall be posted in full view in a

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| A 030 | Continued From page 1 | A 030 | | |

common area accessible to all residents.
(e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility ' s policies with respect to such issues, for example, as resident responsibilities, the facility ' s and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements.
(f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law.
(g) The facility shall 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 shall not prohibit 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 shall be, at a minimum, an accessible telephone on each floor of each building where residents reside.
(h) Pursuant to Section 429.41, F.S., the use of physical shall be limited to half-bed rails, and only upon the written order of the resident ' s physician, who shall review the order biannually, and the consent of the resident or the resident ' s representative. Any device, including half-bed rails, which the resident chooses to use

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and can remove or avoid without assistance shall not be considered a physical

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 [illegible] 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 achieve 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

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provided in s. 429.27.
(g) Share a [redacted] 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) Access to adequate and appropriate health care 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 shall be set forth in writing. 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

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active in, and to associate with advocacy or special interest groups.

This Statute or Rule is not met as evidenced by:
Based on interviews, observations, and record review, the facility failed to provide 3 of 4 sampled residents (#1, #2, #3) with a safe living environment. The facility also protect 1 of 4 (#2) residents from continuously falling with injury. The facility also failed to ensure 1 of 4 (#2) residents was not physically restrained, in order to prevent the resident from walking.

Findings:

1. Interview with Resident Care Coordinator (RCC) on [redacted] at 11:22 AM revealed the RCC stated that on [redacted] resident #4 kicked resident #2 (his [redacted] in the face and resident #2 was sent to the hospital at approximately 2:30 AM because he had a cut over his right eye. She added resident #2 returned to the facility later that day. According to the RCC, "He (resident #4) was moved out into a [redacted] himself. " The Resident Care Coordinator added, "after the incident with resident #1 (on [redacted] resident #4 was calmer and did not exhibit any other aggressive behavior toward any other residents that we know of. She added "the resident's psychiatrist evaluated him on [redacted] and adjusted his medications, but I didn't feel comfortable with his level of [redacted] so I sent him to the hospital on [redacted] She added, "after we went to the hospital to visit the resident, we decided he was no longer appropriate for Emeritus."

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2. The RCC added, "(resident #4) had another incident on [redacted] when he got into an altercation with another resident. She stated, "they started arguing (resident #3 and resident #4) and resident #4 punched resident #3 in the mouth. According to the RCC the bunch resulted in resident #3's [redacted] became loose. She added resident #3's son was notified and set up a dental appointment for him and the [redacted] was examined. She added, " I don't think the [redacted] was loose enough to be an issue." She further added, "Resident #4 has been seen by [redacted] psychiatrist] since his admission [redacted]

Record review reveals [redacted] and [redacted] are the dates resident #4 was seen by the psychiatrist." She added resident #4 was discharged from Emeritus on [redacted] because of his "behavior." Record review on [redacted] reveals resident #4 was seen by his psychiatrist after his discharge from Emeritus [redacted] and while he was residing at the hospital.

3. Record review dated [redacted] of resident #1's record revealed a service note from [redacted] According to the record, "resident was sent to the hospital due to altercation with another resident; the resident (#1) was 'hit to the floor', by resident (#4); he (resident #1) complained of right hip pain and right foot noted turned out; sent to ER (emergency [redacted] for evaluation and treatment; wife notified but is out of town but will call hospital. "

Record review of a service note dated [redacted] at 2 pm regarding resident #1 revealed, "phone call from hospital; resident has right hip [redacted] and will be admitted."
Record review of a service note dated [redacted] revealed, "resident (#1) is in rehab [named Skilled

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Nursing Facility]; both daughters were in the community today and spoke to me; resident reportedly [illegible] forward and hit forehead and sustained a [illegible] on right hand; wife stated she would call the facility before he returned."

Interview with Resident Aide and Medication Technician (Med Tech) A, who stated the facility had an incident approximately 2 weeks ago when a resident (#4) became combative with another resident (#1). She stated, "I did an incident report on it and I called the family of the resident (#1) who had [illegible] She also stated, "I didn't actually witness the incident; it was after breakfast and I saw him (resident #4) walking down the hall toward (resident #1's) [illegible]; one of the housekeepers called for help; then I saw him (resident #1) laying on the floor and he (resident #1) said, "that man hit me." She added, "the resident was assessed by the shift nurse who called (emergency medical services [illegible] and he was taken to the hospital." She added, "I heard he had a [illegible] hip" and "sometimes the residents get in little quarrels and we can't keep track of where they are all the time." She further stated. "We have 1 resident (#2) that is a high [illegible] risk and we do all we can, we can't do [illegible] and we try to meet all their needs so they are not agitated; we try to keep them active."

Review of resident #1's hospital discharge summary dated [illegible] reflects resident #1 was admitted to the hospital with a Right [illegible] neck [illegible], status post open reduction and External fixation. The report also stated resident #1 had hurt his shoulder, neck, and pelvis. The resident had surgery (closed reduction and internal fixation) on [illegible]. The disposition for resident #1 was listed as "Assault" and the County [illegible] reported the situation for the resident was

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reported as, "Assault,

4. Record review of resident #2's record revealed the following incidents:

---Per first responder resident lost balance in doorway to courtyard at 8 PM last night; noted on left eyebrow, resident sent to (named hospital)

resident was sent to (named hospital) for evaluation and treatment after staff found him on the floor with a bump on his head.

was hit in the head by another resident (#1) with a walking cane because he (resident #2) touched him (resident #1). Advanced Registered Nurse Practitioner (ARNP) in to check the resident who has redness over his left eyebrow.

Late Entry for at 1:05 PM---staff was alerted BY MAINTENANCE that resident was on the floor in his no injuries

resident came out of his to a on right face area..." resident has a history of getting bumps and

kicked in the face by , taken by (emergency medical transport) to hospital, returned with dressing in place over right eye.

---1:24 AM---resident was walking around at a fast pace, staff offered him a walker, resident not able to use, forward and has on forehead and left arm.

lost balance in

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at 7:45 PM over left eye, on elbow and on knees. On at 12:06 AM resident was found on the floor of his on his sheets, old on left elbow, first aid provided.

PM---resident lost his balance in the hallway, forward, noted in his mouth with a (left upper) missing (did not find on floor), on left forehead, nose, and cheek, sent to(named hospital) for evaluation

PM ---resident sent to (named hospital) via ambulance for unresponsiveness, would not open eyes, speak, or respond to touch.

Observation of resident #2 on at 1:15 PM with staff member Med Tech A revealed the resident standing in his his recliner with his right arm stuck through the front of the shirt restricting its movement. The resident was unresponsive to the staff that adjusted his shirt and guided the resident into his recliner. The staff left the 2 minutes later when the resident was observed standing up from his recliner after several failed attempts and proceeded to stagger and almost The resident staggered from corner to corner of his while not responding to questions. The resident was unstable on his feet and stumbled often.

Resident #2 was observed on at 3:34 PM in a Geri chair in the common area with a plastic tray locked into place. The resident was asleep with his head cocked to the side located in front of the television. He has a tambourine and bells on the tray. A staff member approached the surveyor (as surveyor was attempting to ascertain if the tray was restraining the resident) and

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| A 030 | Continued From page 9<br>stated, "we had to put him in there (pointing to the Geri chair) cause he wouldn't stay in the chair; he kept getting up and getting up so we put that on it " (she pointed to the locked tray keeping him.) The memory care director appeared at 3:45 PM and moved the resident into the café area with other residents. She took off the resident's locked tray and pushed him up to the table with the other residents.<br><br>Review of the "24 hour book revealed entries for resident #2 revealed the following:<br>2---7 a-3 p---resident stayed in bed all shift, refused all meals.<br>2---7 a-3 p---resident becoming agitated with caregivers when asked to stay seated to prevent<br>12-3 p-11 p---resident getting very agitated in his wheelchair, sat him in recliner<br>2---3 PM ---resident was sent to hospital this morning for a fall-re[illegible] this afternoon<br>PM--resident being very combative not wanting to stay in bed<br>PM---resident still trying to get up to walk will not stay seated.<br>PM entry: " Resident ok, new Geri-chair delivered<br><br>Class: II | A 030 | | |
| A 079 SS=G | 58A-5.019(4) FAC Staffing Standards - Levels<br>(4) STAFFING STANDARDS.<br>(a) Minimum staffing:<br>1. Facilities shall maintain the following minimum staff hours per week:<br>Number of Residents — Staff Hours/Week<br>0-5 — 168<br>6-15 — 212<br>16-25 — 253 | A 079 | | |

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|---|---|
| 26-35 | 294 |
| 36-45 | 335 |
| 46-55 | 375 |
| 56-65 | 416 |
| 66-75 | 457 |
| 76-85 | 498 |
| 86-95 | 539 |

For every 20 residents over 95 add 42 staff hours per week.

2. At least one staff member who has access to facility and resident records in case of an emergency shall be within the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.

3. In facilities with 17 or more residents, there shall be at least one staff member awake at all hours of the day and night.

4. At least one staff member who is trained in First Aid and , as provided under Rule 58A-5.0191, F.A.C., shall be within the facility at all times when residents are in the facility.

5. During periods of temporary absence of the administrator or manager when residents are on the premises, a staff member who is at least . must be designated in writing to be in charge of the facility.

6. Staff whose duties are exclusively building maintenance, clerical, or food preparation shall not be counted toward meeting the minimum staffing hours requirement.

7. The administrator or manager ' s time may be counted for the purpose of meeting the required staffing hours provided the administrator is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility ' s staffing

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schedule.
8. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted.
(b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, shall have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents scheduled and unscheduled service needs, resident contracts, and resident care standards as described in Rule 58A-5.0182, F.A.C.
(c) The facility must maintain a written work schedule which reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules for direct care staff available to residents or representatives, specific to the resident ' s care.
(d) The facility shall be required to provide staff immediately when the Agency determines that the requirements of paragraph (a) are not met. The facility shall also be required to immediately increase staff above the minimum levels established in paragraph (a) if the Agency determines that adequate supervision and care are not being provided to residents, resident care standards described in Rule 58A-5.0182, F.A.C., are not being met, or that the facility is failing to meet the terms of residents ' contracts. The Agency shall consult with the facility administrator and residents regarding any determination that additional staff is required.
1. When additional staff is required above the minimum, the agency shall require the submission, within the time specified in the notification, of a corrective action plan indicating how the increased staffing is to be achieved and resident service needs will be met. The plan shall

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| EMERITUS AT OCALA EAST | 1601 S.E. 24TH ROAD OCALA, FL 32671 |

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be reviewed by the agency to determine if the plan will increase the staff to needed levels and meet resident needs.
2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, modifications may be made in staffing requirements for the facility and the facility shall no longer be required to maintain a plan with the agency.
3. Based on the recommendations of the local fire safety authority, the Agency may require additional staff when the facility fails to meet the fire safety standards described in Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the Agency that fire safety requirements are being met.
(e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios.
(f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of Rule 58A-5.029, 58A-5.030, or 58A-5.031, F.A.C., respectively.

This Statute or Rule is not met as evidenced by:
Based on interview, observation, and record review the facility failed to have enough qualified staff to provide resident supervision to ensure resident safety for 3 of 4 (residents #1, #2, #3) residents.

Findings:

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1. Interview with Resident Care Coordinator (RCC) on [redacted] at 11:22 AM revealed the RCC stated that on [redacted] resident #4 kicked resident #2 (his [redacted] in the face and resident #2 was sent to the hospital at approximately 2:30 AM because he had a cut over his right eye.

2. The RCC added, "(resident #4) had another incident on [redacted] when he got into an altercation with another resident. She stated, "they started arguing (resident #3 and resident #4) and resident #4 punched resident #3 in the mouth. According to the RCC the bunch resulted in resident #3's [redacted] became loose.

3. Record review of the "event management" forms revealed 2 reports dated [redacted] which is actual event date) concerning the incident (resident #4 kicked resident #2 in the face). A second incident generated 2 reports from another incident (dated [redacted] but actual incident occurred [redacted] when resident #4 punched resident #3 in the mouth causing his [redacted] to become loose. A third incident generated another 2 reports on [redacted] actual date of incident) reveals resident #4 punched resident #1 knocking him to the floor and resulting in a broken right hip.

Record review dated [redacted] of resident resident #1 revealed a service note from [redacted] stating, "resident was sent to the hospital due to altercation with another resident; the resident (#1) was 'hit to the floor' by resident (#4); he (resident #1) complained of right hip pain and right foot noted turned out; sent to ER (emergency [redacted] for evaluation and treatment; wife notified, but is out of town, but will call hospital." Record review revealed a service note dated [redacted] at 2 pm

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regarding resident #1 which states, "phone call from hospital; resident has right hip [illegible] and will be admitted."

Interview with Resident Aide and Medication Technician (Med Tech) A who stated the facility had an incident approximately 2 weeks ago when a resident (#4) became combative with another resident (#1). She stated "I didn't actually witness the incident; it was after breakfast and I saw him (resident #4) walking down the hall toward (resident #1's) ; one of the housekeepers called for help; then I saw him (resident #1) laying on the floor and he (resident #1) said "that man hit me." She added "the resident was assessed by the shift nurse and he was taken to the hospital." She added, "sometimes the residents get in little quarrels and we can't keep track of where they are all the time." She added, "We have 1 resident (#2) that is a high [illegible] risk and we do all we can, we can't do [illegible] and we try to meet all their needs so they are not agitated; we try to keep them active." According to Med Tech A, "we have enough staff most of the time to meet the needs of the residents and we have staff that have to do double shifts sometimes."

4. 4. Observation of resident #2 on [illegible] at 1:15 PM with staff member Med Tech A revealed the resident standing in his his recliner with his right arm stuck through the front of the shirt restricting its movement. The resident was unresponsive to the staff that adjusted his shirt and guided the resident into his recliner. The staff left the 2 minutes later when the resident was observed standing up from his recliner after several failed attempts and proceeded to stagger and almost . The resident staggered from corner to corner of his

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while not responding to questions. The resident was unstable on his feet and stumbled often.

Resident #2 was observed on [redacted] at 3:34 PM in a Geri chair in the common area with a plastic tray locked into place. The resident was asleep with his head cocked to the side located in front of the television. He has a tambourine and bells on the tray. A staff member approached the surveyor (as surveyor was attempting to ascertain if the tray was restraining the resident) and stated, " we had to put him in there (pointing to the Geri chair) cause he wouldn't stay in the chair; he kept getting up and getting up so we put that on it" (she pointed to the locked tray keeping him.) The memory care director appeared at 3:45 PM and moved the resident into the café area with other residents. She took off the resident's locked tray and pushed him up to the table with the other residents.

Review of the "24 hour book revealed entry's for resident #2 revealed the following:
2---7 a-3 p---resident stayed in bed all shift, refused all meals.
2---7 a-3 p---resident becoming agitated with caregivers when asked to stay seated to prevent
12-3 p-11 p---resident getting very agitated in his wheelchair, sat him in recliner
2---3 PM ---resident was sent to hospital this morning for a turned this afternoon
--6:45-3 PM--resident being very combative not wanting to stay in bed
---2-11 PM---resident still trying to get up to walk will not stay seated.
--3 PM entry: " Resident ok, new Geri-chair delivered
Record review of resident #2's record revealed

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the following incidents:

:---Per first responder resident lost balance in doorway to courtyard at 8 PM last night; noted on left eyebrow, resident sent to (named hospital)

resident was sent to (named hospital) for evaluation and treatment after staff found him on the floor with a bump on his head.

was hit in the head by another resident (#1) with a walking cane because he (resident #2) touched him (resident #1). Advanced Registered Nurse Practitioner (ARNP) in to check the resident who has redness over his left eyebrow.

Late Entry for at 1:05 PM---staff was alerted BY MAINTENANCE that resident was on the floor in his , no injuries

resident came out of his to a on right face area..." resident has a history of getting bumps and

6/26/12-- kicked in the face by roommate, by (emergency medical transport) to hospital, returned with dressing in place over right eye.

AM---resident was walking around at a fast pace, staff offered him a walker, resident not able to use, fell and has bruise forehead and left arm.

7/16/12-- lost balance in room 7:45 PM bruise left eye, skin elbow and bruising knees. On 7/1 12:06 AM resident was found on the floor of his

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| A 079 | Continued From page 17<br>[redacted] on his sheets, old [redacted] on left elbow, first aid provided.<br><br>[redacted] PM---resident lost his balance in the hallway, [redacted] forward, [redacted] noted in his mouth with a [redacted] (left upper) missing (did not find [redacted] on floor), [redacted] on left forehead, nose, and cheek, sent to(named hospital) for evaluation<br><br>[redacted] PM ---resident sent to (named hospital) via ambulance for unresponsiveness, would not open eyes, speak, or respond to touch.<br><br>Class: II | A 079 | | |
| AZ819 SS=B | 408.810(9) FS Minimum Licensure Req - Financial Viability<br><br>408.810, F.S.<br>In addition to the licensure requirements specified in this part, authorizing statutes, and applicable rules, each applicant and licensee must comply with the requirements of this section in order to obtain and maintain a license.<br><br>(9) A controlling interest may not withhold from the agency any evidence of financial instability, including, but not limited to, checks returned due to insufficient funds, delinquent accounts, nonpayment of withholding taxes, unpaid utility expenses, nonpayment for essential services, or adverse court action concerning the financial viability of the provider or any other provider licensed under this part that is under the control of the controlling interest. Any person who violates this subsection commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continuing violation is a separate offense. | AZ819 | | |

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This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to file an Adverse Incident Report when one (#4) resident had an altercation with another resident, when the facility had knowledge that the resident was aggressive towards other residents.

Findings:

Record review of the "event management" forms revealed 2 reports dated which is actual event date) concerning the incident (resident #4 kicked resident #2 in the face). A second incident generated 2 reports from another incident (dated but actual incident occurred when resident #4 punched resident #3 in the mouth causing his to become loose. A third incident generated another 2 reports on actual date of incident) reveals resident #4 punched resident #1 knocking him to the floor and resulting in a broken right hip.

Administrator stated on at 2:04 PM, " this is all I could find in the folder " when she revealed the " AHCA Initial Adverse Incident " report for resident #4 revealing an " altercation between two residents resulting in of the hip. " The report is dated and the incident is reported to have occurred at 9:00 AM.

The facility did not provide an Adverse Incident Report for the altercation on when resident #4 punched resident #3 in the mouth causing his to become loose.

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