STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966524	08/09/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Provision Living At Panama City	6012 Magnolia Beach Road Panama City, FL 32408	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Specific Tag Findings:

0000-Initial Comments
An unannounced complaint survey was conducted at Provision Living Assisted Living Facility in Panama City Beach, Florida on to review CCR 2013008182. Deficient practice was identified during the survey.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on record review and staff interviews the facility failed to provide adequate supervision for residents with behavioral conditions resulting in several, ongoing resident to resident physical altercations involving 4 of 4 sampled residents. (#1, 2, 3 and 4)

The findings include:

Review of resident #1's record was conducted on . The record revealed a nurse progress note dated / at 10:30 AM. The resident was observed walking through the common area and walked up to another resident and slapped her in the head without provocation. When questioned why she hit the resident she stated, "She is stupid." Constantly pacing and walking up to other residents calling them names. The Wellness Director was notified. The nurse progress note dated 12 PM stated the resident continued to be combative hitting staff and residents. Unable to redirect. Psychiatrist was faxed. The Staff Daily Reporting on Residents Condition log was reviewed on . The log revealed entries for resident #1 as follows: 7-3 shift resident #1 hit resident #3 four times; 7-3 shift resident #1 hitting resident #3, taking her stuff, following behind her and telling her she was stupid; / 3-11 shift resident #1 hit resident #3 (slap) in the face; 3-11 shift resident #2 was in resident #1's face at dinner, resident #1 began yelling back and pushed resident #2; 7-3 shift resident #1 hit resident #4 on the shoulder and called her stupid. The record revealed resident #1 had a diagnosis of and was admitted to the facility on /. The record revealed the psychiatrist had not been contacted since concerning resident #1's behavior. Resident #1's primary physician was last contacted on with no mention of her behaviors. The nurse's notes contained no further documentation of the resident to resident altercations since .

An interview was conducted with employee A on at approximately 11:54 AM. She stated resident #1 hit resident #2 one day last month and then resident #2 hit resident #1

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back. She feels resident #1 is a threat to the other residents. She stated the nurse witnessed this incident and she was not sure if the incident was reported tot he Wellness Director.

An interview was conducted with employee I on at approximately 12:14 PM. Employee I stated she observed resident #1 hit resident #4 on . She stated the Wellness Director was made aware of the incident.

An interview was conducted with employee E on at approximately 12:26 PM. Employee E stated resident #1 hits other residents on average about twice a month. She stated about 3 weeks ago resident #1 hit another resident on the shoulder. They separate them, redirect resident #1 and try to watch them closely.

An interview was conducted with employee J on at approximately 1:15 PM. She stated she observed resident #1 hit resident #2 on the left arm yesterday. About 2 weeks ago she hit another resident. She stated there is no way the staff can watch resident #1 all the time. She feels resident #1 is a threat to the other residents safety. She stated she has talked to the Wellness Director about resident #1's behaviors.

An interview was conducted with the Wellness Director on at approximately 2:23 PM. She stated she was aware of the incident that occurred on / when resident #1 hit resident #3 but was not aware of the other resident to resident altercations in and 2013. She stated the staff are supposed to verbally report these types of occurrences to her. She stated they try to keep her away from other residents when she is agitated. She confirmed the physician nor the psychiatrist had been contacted regarding resident #1's behaviors since .

The Job Description of the Wellness Director was reviewed on . Essential duties listed included initiating behavioral planned behavioral interventions when indicated, monitor residents and environment frequently, noting resident's condition and response to treatment, and identify and seek referrals for residents in need of psychosocial or behavioral evaluations.

Class II

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0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on record review and staff interviews the facility failed to ensure residents were free from neglect. The facility failed to address behavioral conditions and neglected to provide adequate supervision of one resident (#1), resulting in several, ongoing physical altercations between residents 1, 2, 3 and 4.

The findings include:

Review of resident #1's record was conducted on . The record revealed a nurse progress note dated // at 10:30 AM. The resident was observed walking through the common area and walked up to another resident and slapped her in the head without provocation. When questioned why she hit the resident she stated, "She is stupid." Constantly pacing and walking up to other residents calling them names. The Wellness Director was notified. The nurse progress note dated 12 PM stated the resident continued to be combative hitting staff and residents. Unable to redirect. Psychiatrist was faxed. The Staff Daily Reporting on Residents Condition log was reviewed on . The log revealed entries for resident #1 as follows: 7-3 shift resident #1 hit resident #3 four times; 7-3 shift resident #1 hitting resident #3, taking her stuff, following behind her and telling her she was stupid; // 3-11 shift resident #1 hit resident #3 (slap) in the face; 3-11 shift resident #2 was in resident #1's face at dinner, resident #1 began yelling back and pushed resident #2; 7-3 shift resident #1 hit resident #4 on the shoulder and called her stupid. The record revealed resident #1 had a diagnosis of and was admitted to the facility on //. The record revealed the psychiatrist had not been contacted since concerning resident #1's behavior. Resident #1's primary physician was last contacted on with no mention of her behaviors. The nurse's notes contained no further documentation of the resident to resident altercations since .

An interview was conducted with employee A on at approximately 11:54 AM. She stated resident #1 hit resident #2 one day last month and then resident #2 hit resident #1 back. She feels resident #1 is a threat to the other residents. She stated the nurse witnessed this incident and she was not sure if the incident was reported tot he Wellness Director.

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An interview was conducted with employee I on at approximately 12:14 PM. Employee I stated she observed resident #1 hit resident #4 on . She stated the Wellness Director was made aware of the incident.

An interview was conducted with employee E on at approximately 12:26 PM. Employee E stated resident #1 hits other residents on average about twice a month. She stated about 3 weeks ago resident #1 hit another resident on the shoulder. They separate them, redirect resident #1 and try to watch them closely.

An interview was conducted with employee J on at approximately 1:15 PM. She stated she observed resident #1 hit resident #2 on the left arm yesterday. About 2 weeks ago she hit another resident. She stated there is no way the staff can watch resident #1 all the time. She feels resident #1 is a threat to the other residents safety. She stated she has talked to the Wellness Director about resident #1's behaviors.

An interview was conducted with the Wellness Director on at approximately 2:23 PM. She stated she was aware of the incident that occurred on / when resident #1 hit resident #3 but was not aware of the other resident to resident altercations in and 2013. She stated the staff are supposed to verbally report these types of occurrences to her. She stated they try to keep her away from other residents when she is agitated. She confirmed the physician nor the psychiatrist had been contacted regarding resident #1's behaviors since .

The Job Description of the Wellness Director was reviewed on . Essential duties listed included initiating behavioral planned behavioral interventions when indicated, monitor residents and environment frequently, noting resident's condition and response to treatment, and identify and seek referrals for residents in need of psychosocial or behavioral evaluations.

The facility policy for Resident Rights was reviewed on . The policy stated residents have the right to be free of physical or from staff, family, and other residents. The staff education titled Resident Rights: , Neglect and , page 3 stated residents have the right to be free from , neglect, and involuntary .

The following is an excerpt from Florida Statute 825.102 that defines neglect:

F.S 825.102 (3)(a) "**Neglect** of an elderly person or adult" means:

1. A caregiver's failure or omission to provide an elderly person or adult with the

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care, supervision, and services necessary to maintain the elderly person's or adult's physical and mental health, including, but not limited to, food, nutrition, clothing, shelter, supervision, medicine, and medical services that a prudent person would consider essential for the well-being of the elderly person or adult; or
2. A caregiver's failure to make a reasonable effort to protect an elderly person or adult from , **neglect**, or by another person.

Neglect of an elderly person or adult may be based on repeated conduct or on a single incident or omission that results in, or could reasonably be expected to result in, serious physical or injury, or a substantial risk of , to an elderly person or adult.

Class II

0077-Staffing Standards - Administrators 58A-5.019(1) FAC
Based on record review and staff interviews the Administrator or alternate person in charge of the facility failed to ensure adequate care and supervision to resident #1 resulting in several, ongoing physical altercations between 4 of 4 sampled residents. (#1, 2, 3 and 4)

The findings include:

Review of resident #1's record was conducted on . The record revealed a nurse progress note dated / at 10:30 AM. The resident was observed walking through the common area and walked up to another resident and slapped her in the head without provocation. When questioned why she hit the resident she stated, "She is stupid." Constantly pacing and walking up to other residents calling them names. The Wellness Director was notified. The nurse progress note dated 12 PM stated the resident continued to be combative hitting staff and residents. Unable to redirect. Psychiatrist was faxed. The Staff Daily Reporting on Residents Condition log was reviewed on . The log revealed entries for resident #1 as follows: 7-3 shift resident #1 hit resident #3

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four times; [redacted] 7-3 shift resident #1 hitting resident #3, taking her stuff, following behind her and telling her she was stupid; [redacted] 3-11 shift resident #1 hit resident #3 (slap) in the face; [redacted] 3-11 shift resident #2 was in resident #1's face at dinner, resident #1 began yelling back and pushed resident #2; [redacted] 7-3 shift resident #1 hit resident #4 on the shoulder and called her stupid. The record revealed resident #1 had a diagnosis of [redacted] and was admitted to the facility on [redacted]. The record revealed the psychiatrist had not been contacted since [redacted] concerning resident #1's behavior. Resident #1's primary physician was last contacted on [redacted] with no mention of her behaviors. The nurse's notes contained no further documentation of the resident to resident altercations since [redacted].

An interview was conducted with employee A on [redacted] at approximately 11:54 AM. She stated resident #1 hit resident #2 one day last month and then resident #2 hit resident #1 back. She feels resident #1 is a threat to the other residents. She stated the nurse witnessed this incident and she was not sure if the incident was reported tot he Wellness Director.

An interview was conducted with employee I on [redacted] at approximately 12:14 PM. Employee I stated she observed resident #1 hit resident #4 on [redacted]. She stated the Wellness Director was made aware of the incident.

An interview was conducted with employee E on [redacted] at approximately 12:26 PM. Employee E stated resident #1 hits other residents on average about twice a month. She stated about 3 weeks ago resident #1 hit another resident on the shoulder. They separate them, redirect resident #1 and try to watch them closely.

An interview was conducted with employee J on [redacted] at approximately 1:15 PM. She stated she observed resident #1 hit resident #2 on the left arm yesterday. About 2 weeks ago she hit another resident. She stated there is no way the staff can watch resident #1 all the time. She feels resident #1 is a threat to the other residents safety. She stated she has talked to the Wellness Director about resident #1's behaviors.

An interview was conducted with the Wellness Director on [redacted] at approximately 2:23 PM. She stated she was aware of the incident that occurred on [redacted] when resident #1 hit resident #3 but was not aware of the other resident to resident altercations in [redacted] and 2013. She stated the staff are supposed to verbally report these types of occurrences to her. She stated they try to keep her away from other residents when she is agitated. She confirmed the physician nor the psychiatrist had been contacted regarding resident #1's

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behaviors since .

The Job Description of the Wellness Director was reviewed on . Essential duties listed included initiating behavioral planned behavioral interventions when indicated, monitor residents and environment frequently, noting resident's condition and response to treatment, and identify and seek referrals for residents in need of psychosocial or behavioral evaluations.

A telephone interview was conducted with the facility Administrator on at approximately 3:26 PM. The Administrator stated she had no knowledge of resident #1 hitting or pushing other residents on any of the dates listed in the Staff Daily Reporting on Residents Condition log. She stated she was aware that at times resident #1 had open handed hit other residents but would not even call it a slap and there were no injuries. She stated the Wellness Director is in charge when she is out of the facility and she has been on vacation since / . The Wellness Director produced a document dated / stating the Wellness Director was in charge of the facility in the Administrator's absence. The document was signed by the Administrator.

Class II

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Provision Living At Panama City
6012 Magnolia Beach Road
Panama City, FL 32408

Dear Administrator:

Re: CCR #2013008182

This letter reports the findings of a state licensure survey that was conducted on , 2013 by representative(s) of this office. Attached is the provider's copy of the State (5000-3547) 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 , 2013 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

As a result of the findings of this survey, you must develop a plan on how nursing or physicians will re-assess residents who are demonstrating psychosocial difficulties, including behaviors that are threatening to themselves or others. This plan shall include information on how you will provide adequate supervision to those residents, as well as other facility residents, to ensure safety for all facility residents. Your plan must also include staff inservicing for all facility staff no later than 2013. Please submit evidence of the policy and staff inservicing to this office as soon as it is completed.

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(s). Should you have any questions please call me at 850-412-4540.

Sincerely,

Donah Heiberg
Field Office Manager

DH/dh
Enclosure

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

Tallahassee Field Office
2727 Mahan Drive, Mail Stop #46
Tallahassee, FL 32308
Phone 850-412-4540; Fax (850) 922-9162