STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964069	09/20/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Mandarin	10790 Old St Rd Jacksonville, FL 32257	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= G
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced licensure complaint survey, CCR #2013009886, was conducted on , 2013. Emeritus at Mandarin had deficiencies found at the time of the visit.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on record review and interview, the facility failed to follow their policy and procedures to ensure an environment free from for 1 out of 12 sampled residents (Resident #12).

The findings include:

In an interview with the Administrator on at 1:31 PM, he reported that residents at the facility had been complaining about Resident #1. He reported that he did not have any knowledge that Resident #1 had been aggressive verbally or physically with any residents at the facility.

In an interview with the Assistant Executive Director on at 2:30 PM, he reported that he was unaware of any resident to resident or any issues with Resident #1 becoming aggressive towards any resident or staff at the facility. In a follow up interview with the Assistant Executive director on at 5:12 PM, he reported that he had witnessed the occurrence on where Resident #1 and Resident #12 had been yelling at each other by the dining

In an interview with Resident #12 on at 5:00 PM, she reported that she did not feel safe at the facility. She reported that she had several " altercations " with Resident #1. She reported that " a few weeks ago " Resident #1 had come up to her and had swung her fist at her. She reported that she had called 911 and they had come to the facility. She also reported that she recently had her seating changed in the dining of Resident #1. She reported that during dining " a few weeks ago " , Resident #1 had " got in my face, pointed her finger at me and threatened to kick my ass " . She reported she was scared because Resident #1 is " unstable " and she switched her seat in the dining that her back would not be facing Resident #1. She reported that staff had witnessed the altercation and she told staff she felt afraid. She could not remember which staff she had told, but did report that she had told the Resident Care Director about all of the incidents. She reported that the facility had not addressed any of her concerns. She reported that she had spoken to the Administrator and he did not do anything about Resident #1 threatening her.

A record review for Resident #1 record revealed an admission date of and a diagnosis of and . Her Resident Health Assessment was dated She was coded as independent in ambulation, eating, self-care toileting and transferring and needing supervision in dressing and assistance in bathing. The

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physician signed off at this time stating that she required daily oversight. A review of the resident ' s service notes revealed an entry written by the Resident Care Director dated that read " (Resident #1) was observed in the main dining her finger at another resident, making threatening remarks stating " I ' m done with you and I ' m going to kick your ass later " . Resident was redirected by staff. As she walked out of the main dining continued to point her finger at the other resident making threatening remarks. " Another service note dated read that " another resident had called 911 on (Resident #1) stating that she had " showed me a fist, " The police came and talked to the resident. A voicemail was left for Resident #1 ' s son " .

A review of the facility ' s prevention, identification and reporting policy, revision date found that mental was defined as " willful action or inaction of mental or This includes but is not limited to: coercion, harassment and verbal assault that includes ridiculing, intimidating, yelling or swearing " . The policy read that mandatory reporting should be made immediately to the Executive Director, Resident Care Director or other appropriate supervisory personnel. It also read that " The Executive Director or designee investigates all reports of alleged/suspected or neglect " . The policy read that in allegations of resident to resident " staff are encouraged to report signs and symptoms of resident aggressive behavior either verbal or physical ...immediately separate involved residents begin investigation process as outlined below " . The investigation process in the policy outlined that " The investigation into allegations of neglect or will be documented by the Executive Director or designee using the Event Investigation form. The Executive Director or designee completes an investigation and documents the findings and notify appropriate agencies and authorities."

In an interview with the Executive Director on at 6:00 PM he reported he was unaware of the situation with Resident #1 and Resident #12. He confirmed the facility ' s policy read that he or the assistant executive director would be notified. He reported that the assistant executive director is his designee while is away or on vacation. He confirmed that the facility did not follow their policy in regards to the incident that occurred on and between Resident #1 and Resident #12. He confirmed that the Resident Care Director did make note of the occurrence on Resident #1 ' s resident observation sheet. He reported that the Resident Care Director was on vacation at time of the complaint survey. He reported that there were no event reports for either of these occurrences.

Class II

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC
Based on observation and staff and resident interview, the facility failed to ensure that all existing mechanical appurtenances are in working order and providing a clean and sanitary environment for residents.

The findings include:

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Tour of the facility commenced on at 10:10 AM. Upon tour of the first floor, it was noted that the trash a foul odor emanaing from behind the closed door. Further inspection of the trash that trash bags were overflowing out of the trash chute door and were piled approximately two feet high around the trash chute door. The smell was overpowering, pungent and stung the nostrils.

In an interview with the Assistant Resident Care Coordinator on at approximately 10:10 AM, she confirmed that the smell was overpowering and seeping through the door into the hallway.

In an interview with Resident #3 on at 11:49 AM, she reported that she was frustrated because when she goes to put her trash in the trash chute, it is all backed up and smells. She reported it occurs every week and she has brought it to the administrator ' s attention and he " has done nothing about it " .

In an interview with the administrator on at 11:30 AM, he reported that the trash system they have in place at the facility is not capable of handling " all the trash " . He reported that it has been an " on-going " issue. He reported that the building is old and has an " outdated " system.

In an interview with the Maintenance Director on at 11:31 AM, he reported that the trash gets backed up " at least twice a week " . He reported that the system at the facility cannot handle the amount of trash that gets generated.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Emeritus at Mandarin
10790 Old St. Road
Jacksonville, FL 32257

Re: CCR# 2013009886

Dear Administrator,

This letter reports the findings of a complaint licensure survey conducted on , 2013 by representatives of the Agency for Health Care Administration. Attached is the provider's copy of the State (3020) Form, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's corrective action plan within **specified dates** listed in this report.

The inspection resulted in findings of non-compliance in the following areas:

1) A0030 – Resident Care - Rights and Facility Practices - Class II
The Assisted Living Facility failed to ensure that a resident was free from when it failed to follow its policy and procedure on prevention.

2) A0152- Physical Plant – Safe Living Environment - Class III
The Assisted Living Facility failed to ensure all existing appurtenances were in working order so that refuse could be disposed of properly ensuring a safe, clean environment.

Directed Corrective Actions:

(1) You are being directed to increase supervision for Resident #1 immediately. She must be on 1:1 supervision to ensure that no additional altercations occur between Resident #1 and Resident #12.

(2) The facility must have Resident #1 evaluated for continued appropriateness of residency in the facility in order to determine if she is a threat to other residents. The evaluation must be completed by , 2013.

(3) The incidents involving Residents # 1 and #12 must be thoroughly investigated by 2013. The facility will also thoroughly investigate and document any allegations that occur during your period of correction.

(4) The facility must meet with Resident #12 and her family to address her fear of Resident #1 by 2013.

(5) The facility must also meet with Resident #1 and her family to discuss the incidents and acceptable ways to express anger by , 2013.

(6) You are being directed to review your policy and procedure for Prevention, Identification, and Reporting, revision date , and determine if revisions are necessary by , 2013.

(7) One hundred percent of your staff must be in-serviced on the policy and procedure for prevention, with special emphasis on investigating and reporting requirements. This training must be completed by 2013.

All other deficiencies must be corrected by 2013.

Please be advised that nothing in this DPOC limits the Agencies authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call Catherine Anne Avery, Survey and Certification Support Branch, at 850-412-4505.

Regards,

Robert Dickson, Field Office Manager
Division of Health Quality Assurance