AGENCY FOR HEALTH CARE ADMINISTRATION

PRINTED: 10/09/2013
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911767	**09/30/2013**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Gulf Coast Village Assisted Li	**1333 Santa Barbara Blvd** **Cape Coral, FL 33991**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)

List of Tags Cited:
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D

Specific Tag Findings:
A Complaint Survey, CCR# 2013008958 was conducted at Gulf Coast Village Assisted Living, an Assisted Living Facility (ALF), on

Three of the five allegations were substantiated resulting in tags A0025 and A0030 cited.

The following is a description of non-compliance:

0025-Resident Care - Supervision 58A-5.0182(1) FAC

Based on resident records reviewed, staff and resident interviews, the facility failed to provide 2 (Residents #1 and #2) of 3 residents with appropriate supervision resulting in a second incident of inappropriate behavior.

The findings include:

A review of an incident report dated was for an incident with Resident #1 and Resident #2 that happened on was conducted. This report showed the incident at 3:10 p.m. a nurse and Certified Nursing Assistant (CNA) were looking for Resident #1. They found him in Resident #2's Both residents were half clothed. They were separated. The Witness Statement from Staff E showed a volunteer (later identified as Staff F by the manager) told her to look in Resident #2's she saw Resident #1 in her few days ago. On an "Unusual Occurrence Incident Report" was completed at 7:30 p.m. The CNA found Resident #1 in Resident #2's He was wearing his boxers and she was wearing a shirt. This report showed her behavior before the event as calm and after the event she was increased agitation. Her general condition showed she was stable before and after the event.

Interviews were conducted with the manager and DON on at approximately 9:30 a.m. They both stated these two residents are consenting adults and the act was consensual. An interview was conducted with Resident #2 at 11:35 a.m. She stated she did not have a encounter with Resident #1. She did not spend a week or more at her daughter's house last month. She stated she has "Short term memory" problems. She does not know the year, who the president of The United States is, the town she lives in or the place she lives. She does know where her and she lives in Florida. An interview was conducted with Staff G at 11:45 a.m. She stated Resident #2 is able to make decisions if she wants consensual She also stated if a resident does not know the town, year, or president, they might not be able to make consensual A review of Resident #2's health assessment dated shows there is no diagnosis of short term memory, or However, there is a diagnosis of nonspecific Her record shows she is taking 9.5 mg patch daily. An interview was conducted with the manager on at 2:45 p.m. She stated Resident #2 is taking due to She also stated she will talk with Resident #2's daughter for daily decisions and does not ask Resident #2 on issues concerning medical or important decisions.

A review of the nurse s notes shows the two incidents. A review of the monthly summaries completed by nurses show Resident #2 is alert and since Interviews were conducted with the manager and DON on

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at 10:15 a.m. They stated both residents are consensual to have The incident on did not have a report written. Interview with the manager on at 12:45 p.m. stated this report was not completed until she was doing the investigation on for the incident. She told the nurse to write up an incident report of the incident. She stated she asked the nurse why she did not write up an incident and she said she did not think it was an incident. The manager told her in the future this is considered an incident and needs to be written up as one.

An interview was conducted with Staff B on at 3:05 p.m. He stated he heard a rumor of an incident that happened a few days before and that is why they were watching Resident #1. He called the manager and Resident #2's family member family when the incident on occurred. They kept both residents separated and kept watching both

An interview was conducted with Staff F on at 3:12 p.m. She was walking down the hall and the door of Resident #2's open. She saw Resident #1 and #2 standing in her . She went in and asked what was going on. Resident #2 told her she invited Resident #1 in the look at some toys. She said both residents where dressed and acting appropriate but asked Resident #1 to leave the which time he did. She was not involved with the incident.

An interview with Staff E was conducted on at 3:20 p.m. by phone. She stated she was not able to find Resident #1 on She asked a volunteer (later identified as Staff F) and the volunteer told her to look in Resident #2's She found them in the naked. She notified the nurse and they separated them and kept an eye on both of them all night. She was not aware of any incidents prior of them being together in her The next day she made sure to keep them separated. She was not involved with the incident.

An interview with Staff A was conducted on at 3:35 p.m. by phone. She was involved with the incident. She stated when she found the two residents together she didn't know what to do and called her supervisor (the manager). Sue was not available so she called (nurse manager) Staff D. Staff D told her to keep residents apart and that is what she did. At this time if another situation like this happens she will write up an incident report.

A review of the "Assisted Living 24 Hour Report" sheet dated showed Resident #1 was found in another resident's undressed on top of her in bed." On the 24 hour report informs the staff to watch Resident #1 - "He was trying to use his to get into 129." belongs to Resident #2.

The incident on involved Residents #1 and #2. This information was documented in the 24 hour report notifying staff of this incident, however, there was no incident report written. On the incident happened again with Residents #1 and #2. While staff was aware of the first incident and was told to keep them separated these two residents were able to get together in Resident #2's was found half clothed. The staff did not provide them with the correct supervision that was required to keep another incident from occurring.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS

Based on resident records reviewed, staff and resident interviews, the facility failed to provide 2 (Residents #1 and #2) of 3 residents with a safe environment resulting in both resident involved in two incidents of a nature.

The findings include:

A review of an incident report dated [redacted] was for an incident with Resident #1 and Resident #2 that happened on [redacted] was conducted. This report showed the incident at 3:10 p.m. a nurse and Certified Nursing Assistant (CNA) were looking for Resident #1. They found him in Resident #2's [redacted] Both residents were half clothed. They were separated. The Witness Statement from Staff E showed a volunteer (later identified as Staff F by the manager) told her to look in Resident #2's [redacted] she saw Resident #1 in her [redacted] few days ago. On [redacted] an "Unusual Occurrence Incident Report" was completed at 7:30 p.m. The CNA found Resident #1 in Resident #2's [redacted] He was wearing his boxers and she was wearing a shirt. This report showed her behavior before the event as calm and after the event she was increased agitation. Her general condition showed she was stable before and after the event.

Interviews were conducted with the manager and DON on [redacted] at approximately 9:30 a.m. They both stated these two residents are consenting adults and the [redacted] act was consensual. An interview was conducted with Resident #2 on [redacted] at 11:35 a.m. She stated she did not have a [redacted] encounter with Resident #1. She did not spend a week or more at her daughter's house last month. She stated she has "Short term memory" problems. She does not know the year, who the president of The United States is, the town she lives in or the place she lives. She does know where her [redacted] and she lives in Florida. An interview was conducted with Staff G on [redacted] at 11:45 a.m. She stated Resident #2 is able to make decisions if she wants consensual [redacted] She also stated if a resident does not know the town, year, or president, they might not be able to make consensual [redacted] A review of Resident #2's health assessment dated [redacted] shows there is no diagnosis of short term memory, [redacted] or [redacted] However, there is a diagnosis of [redacted] nonspecific [redacted] Her record shows she is taking [redacted] 9.5 mg patch daily. An interview was conducted with the manager on [redacted] at 2:45 p.m. She stated Resident #2 is taking [redacted] due to [redacted] She also stated she will talk with Resident #2's daughter for daily decisions and does not ask Resident #2 on issues concerning medical or important decisions.

A review of the nurse s notes shows the two incidents. A review of the monthly summaries completed by nurses show Resident #2 is alert and [redacted] since [redacted] Interviews were conducted with the manager and DON on [redacted] at 10:15 a.m. They stated both residents are consensual to have [redacted] The incident on [redacted] did not have a report written. Interview with the manager on [redacted] at 12:45 p.m. stated this report was not completed until she was doing the investigation on [redacted] for the [redacted] incident. She told the nurse to write up an incident report of the [redacted] incident. She stated she asked the nurse why she did not write up an incident and she said she did not think it was an incident. The manager told her in the future this is considered an incident and needs to be written up as one.

An interview was conducted with Staff B on [redacted] at 3:05 p.m. He stated he heard a rumor of an incident that happened a few days before and that is why they were watching Resident #1. He called the manager and Resident #2's family member family when the incident on [redacted] occurred. They kept both residents separated and kept watching both [redacted]

An interview was conducted with Staff F on [redacted] at 3:12 p.m. She was walking down the hall and the door of Resident #2's [redacted] open. She saw Resident #1 and #2 standing in her [redacted] She went in and asked what was going on. Resident #2 told her she invited Resident #1 in the [redacted] look at some toys. She said both residents where dressed and acting appropriate but asked Resident #1 to leave the [redacted] which time he did. She was not involved with the [redacted] incident.

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An interview with Staff E was conducted on at 3:20 p.m. by phone. She stated she was not able to find Resident #1 on . She asked a volunteer (later identified as Staff F) and the volunteer told her to look in Resident #2's . She found them in the naked. She notified the nurse and they separated them and kept an eye on both of them all night. She was not aware of any incidents prior of them being together in her . The next day she made sure to keep them separated. She was not involved with the incident.

An interview with Staff A was conducted on at 3:35 p.m. by phone. She was involved with the incident. She stated when she found the two residents together she didn't know what to do and called her supervisor (the manager). Sue was not available so she called (nurse manager) Staff D. Staff D told her to keep residents apart and that is what she did. At this time if another situation like this happens she will write up an incident report.

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The incident on involved Residents #1 and #2. This information was documented in the 24 hour report notifying staff of this incident, however, there was no incident report written. On the incident happened again with Residents #1 and #2. While staff was aware of the first incident and was told to keep them separated these two residents were able to get together in Resident #2's was found half clothed. The facility did not provide Residents #1 and #2 with a safe environment free from neglect. The staff were informed of the first incident and failed to adequately supervise them resulting in a second incident.

Class III

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Gulf Coast Village Assisted Li
1333 Santa Barbara Blvd
Cape Coral, FL 33991

Re: CCR #2013008958

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on . 2013 by a representative 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.

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 (239) 335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

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Enclosure: State Form

Headquarters
2727 Mahan Drive
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Fort Myers, FL 33901
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