STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964952	11/18/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Arden Courts Manorcare Health	5509 Swift Road Sarasota, FL 34231	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0011 - 58a-5.0181(5) Fac - Admissions - Discharge 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:
These are the results of an unannounced Complaint Survey, CCR# 2013010031 which was conducted on at Arden Courts Manorcare Health an Assisted Living Facility (ALF).

The following is a description of non-compliance:

0010-Admissions - Continued Residency 58A-5.0181(4) FAC
Based on record review and interview, the facility Administrator failed to monitor the continued appropriateness of placement of 2 (Residents #1 and #5) of 5 residents in the facility and to discharge the same residents because they no longer met admission criteria.

The findings include:

1. Record review for Resident #1 found that she was admitted to the Assisted Living Facility (ALF) on A few days after her admission the facility's psychiatrist filled out and signed a form for the resident. In that from he indicated that "Resident #1 is unable to determine for himself whether an examination is necessary and there is a substantial likelihood that without care or treatment the person will cause serious bodily harm to others." Furthermore he stated the following, "Patient has repeatedly been assaulting to both residents and staff at the ALF. She has been briefly in and both low dosages. D/C as per POA (husband) did not want her medicated. Rational discussion with POA did little good. Patient on this occasion has again been assaulting and need hospitalization to prevent further injury to elderly residents and staff."

The Administrator stated, during interview conducted on at 10:50 a.m., that the psychiatrist filled out the form just in case the resident becomes aggressive and needed to be but the form was never utilized since residents behavior never escalate.

On the psychiatrist documented still resident was not receiving medication and stated the following, "Given that the has been D/C her aggressive behavior is likely to escalate to pre T-x Levels. I suggest that the husband be called to calm her in the aggressive behavior increases. Continue to give low dosage of risperidole as ordered Any further TX from me will be require to he formally sign a Tx agreement as he (the POA) has been so difficult around the issues of her misbehavior and opposition to any form of psych med."

Contrary to Administrators statement of resident's non-escalated aggressive behavior the following issues were documented in resident's record in reference to her aggressive behavior:
On from 3:00 to 11:00 p.m., resident was very aggressive towards staff and other residents. Specific on at 4:30 p.m., she another resident and caregiver that were in the kitchen. Names not provided. At 8:00 p.m., she went to the garden and hit a caregiver and then scratched her arms with her nails. At 10:00 p.m., she became very aggressive and was kicking, screaming and staff while was spitting on the floor. On at 2:30 p.m., resident pushed another resident that was sitting in her wheel chair and at 3:30 p.m., resident repeatedly scratched he arms of a caregiver in an attempt to harm her. Names not provided.

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On [redacted] at 4:00 p.m., resident became very aggressive and began hitting the nurse and other residents present. No one was harmed. Names not provided.
On [redacted] at 1:51 p.m., resident became very aggressive towards other residents and started spiting on their faces.
On [redacted] at 4:00 a.m., resident was hitting, kicking, slapping, and spitting the staff and other resident that were awake.
On [redacted] from 11:00 p.m. to 7:00 a.m., resident was up all night, went to other resident [redacted] to wake them up, when she was redirected she began hitting the caregiver and nurses.
On [redacted] at 5:30 a.m., resident documented having very aggressive behavior.
On [redacted] at 8:00 p.m., resident began an altercation with another resident and placed her hands around the other resident's throat and attempted to push her over. Nurse separated residents and both residents were not harmed. Name of other resident was not provided. At 8:15 p.m., resident approached the same resident and slapped her in the face.

When the Administrator was questioned on [redacted] at 11:00 a.m. as of why resident was not monitored for appropriateness or discharged due to her aggressive behavior that caused harm to others, she stated that she was unaware of residents multiple aggressive episodes. She said she knew she was difficult but not to the extent that was documented at progress notes.

2. Record review for Resident #5 found the he was admitted to the facility on [redacted] and occupied [redacted] A. Record review for Resident #1 found that prior to his admission to the facility was [redacted] to [redacted] hospital due to aggressive behavior on [redacted] He was [redacted] again due to a very aggressive behavior towards a CNA. When the Administrator asked if she knew residents prior aggressive behavior history and [redacted] prior to admission she did not provide an answer.

Resident #5 had 24 private Home Health care since the day of his admission. Primary care physician notes dated [redacted] and [redacted] reporting aggressive behavior and a possible incident that the resident pushed another resident to the stomach. On [redacted] at 3:00 p.m., resident became very aggressive and broke a glass frame. The same day at 12:15 a.m., he became very aggressive with the Nurse. Same day around 11:00 p.m., resident was very aggressive towards nurses and other staff. On [redacted] at 8:55 a.m. Registered Nurse (RN) reported resident being very aggressive.

Interview with the Resident Aide from Home Health Agency responsible for Resident #5's 24 care, on [redacted] at 11:26 a.m., revealed that Resident #5 is a very aggressive man. She said that on [redacted] he pulled her finger in an attempt to break it. Finger observed to be [redacted] He has hit her twice since this morning and pushed her against the wall 2-3 times in the past. The aide that was working yesterday from 10:00 p.m. to 6:00 a.m. said that she is not coming back. She said that the resident slam her in the face pushed in the chest and stomach ad kicked her legs. The LPN that worked last night was hit in the back. Caregiver present was hit in the back. She also said that he has a tendency to lash at female residents and to push his walker on them. She said that multiple staff left the Agency because it's very hard for them to take care of the resident. She also stated that she notified her supervisor and she will be reviewing the case.

3. The Administrator acknowledged on [redacted] at 2:30 p.m., that she did not re-assess both Residents #1 and #5 and failed to discharge them. She said that she was unaware that when a resident possess threat to others no longer meets admission criteria.

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Class III

0011-Admissions - Discharge 58A-5.0181(5) FAC
Based on record review and interview, the facility failed to discharge 2 (Residents #1 and #5) of 5 sampled residents that no longer met admission criteria.

The findings include:

1. Record review for Resident #1 found that she was admitted to the Assisted Living Facility (ALF) on . . . . . A few days after her admission the facility's psychiatrist filled out and signed a . . . . . form for the resident. In that from he indicated that Resident #1 "Is unable to determine for himself whether an examination is necessary and there is a substantial likelihood that without care or treatment the person will cause serious bodily harm to others." Furthermore he stated the following, "Patient has repeatedly been assaulting to both residents and staff at the ALF. She has been briefly in . . . . and . . . . both low dosages. D/C as per POA (husband) did not want her medicated. Rational discussion with POA did little good. Patient on this occasion has again been assaulting and need hospitalization to prevent further injury to elderly residents and staff."

The Administrator stated, during interview conducted on . . . . at 10:50 a.m., that the psychiatrist filled out the form just in case the resident becomes aggressive and needed to be . . . . but the form was never utilized since residents behavior never escalate.

On . . . . . the psychiatrist documented still resident was not receiving . . . . . medication and stated the following, "Given that the . . . . . has been D/C her aggressive behavior is likely to escalate to pre T-x Levels. I suggest that the husband be called to calm her in the aggressive behavior increases. Continue to give low dosage of risperidole as ordered any further TX from me will be require to he formally sign a TX agreement as he (the POA) has been so difficult around the issues of her misbehavior and opposition to any form of psych med."

The following issues were documented in resident's record in reference to her aggressive behavior:
On . . . . . from 3:00 to 11:00 p.m., resident was very aggressive towards staff and other residents. Specific on . . . . . at 4:30 p.m., she . . . . . another resident and caregiver that were in the kitchen.
At 8:00 p.m., she went to the garden and hit a caregiver and then scratched her arms with her nails, at 10:00 p.m., she became very aggressive and was kicking, screaming and . . . . . staff while was spitting on the floor.
On . . . . . at 2:30 p.m., resident pushed another resident that was sitting in her wheel chair and at 3:30 p.m., resident repeatedly scratched he arms of a caregiver in an attempt to harm her.
On . . . . . at 4:00 p.m., resident became very aggressive and began hitting the nurse and other residents present. No one was harmed.
On . . . . . at 1:51 p.m., resident became very aggressive towards other residents and started spiting on their faces.
On . . . . . at 4:00 a.m., resident was hitting, kicking, slapping, and spitting the staff and other resident that were awake.
On . . . . . from 11:00 p.m., to 7:00 a.m., resident was up all night, went to other resident . . . . . to wake them up, when she was redirected she began hitting the caregiver and nurses.
On . . . . . at 5:30 a.m., resident documented having a very aggressive behavior.
On . . . . . at 8:00 p.m., resident began an altercation with another resident and placed her hands around the other resident's throat and attempted to push her over. Nurse separated residents and both residents were not harmed. Name of other resident was not provided. At 8:15 p.m., resident approached the same resident and slapped her in the face.

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When the Administrator was questioned on at 11:00 a.m., as of why resident was not monitor for appropriateness or discharged due to her aggressive behavior that caused harm to others, she stated that she was unaware of residents multiple aggressive episodes. She said she knew she was difficult but not to the extent that was documented at progress notes.

2. Record review for Resident #5 found the he was admitted to the facility on and occupied A. Record review for Resident #5 found that prior to his admission to the facility was to hospital due to aggressive behavior on He was again due to a very aggressive behavior towards a CNA.

When administrator asked if she knew residents prior aggressive behavior history and prior to admission she did not provide an answer.

Resident #5 had 24 private Home Health care since the day of his admission. Primary care physician notes dated and reporting aggressive behavior and a possible incident that the resident pushed another resident to the stomach. On at 3:00 p.m., resident became very aggressive and broke a glass frame. The same day at 12:15 a.m., he became very aggressive with the Nurse. Same day around 11:00 p.m., resident was very aggressive towards nurses and other staff. On at 8:55 a.m., Registered Nurse (RN) reported resident being very aggressive.

Interview with the Resident Aid from Home Health Agency responsible for Resident #5's 24 care, on at 11:26 a.m., revealed that Resident #5 is a very aggressive man. She said that on he pulled her finger in an attempt to break it. Finger observed to be . He has hit her twice since this morning and pushed her against the wall 2-3 times in the past. The aid that was working yesterday from 10:00 p.m. to 6:00 a.m., said that she is not coming back. She said that the resident slam her in the face pushed in the chest and stomach ad kicked her legs. The LPN that worked last night was hit in the back. Caregiver present was hit in the back. She also said that he has a tendency to lash at female residents and to push his walker on them. She said that multiple staff left the Agency because it ' s very hard for them to take care of the resident. She also stated that she notified her supervisor and she will be reviewing the case.

3. The Administrator acknowledged on at 2:30 p.m., that she failed to discharge both residents. She said that she was unaware that when a resident is threat to others no longer meets admission criteria.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on record review and interview, the facility failed to provide a safe environment for the residents.

The findings include:

1. Record review for Resident #1 found that she was admitted to the Assisted Living Facility (ALF) on . Few days after her admission the facility's psychiatrist filled out and signed a form for the resident. In that from he indicated that Resident #1 "Is unable to determine for himself whether an examination is necessary and there is a substantial likelihood that without care or treatment the person will cause serious bodily harm to others." Furthermore he stated the following "Patient has repeatedly been assaulting to both residents and staff at the ALF. She has been briefly in and both low dosages. D/C as per POA (husband) did not

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want her medicated. Rational discussion with POA did little good. Patient on this occasion has again been assaulting and need hospitalization to prevent further injury to elderly residents and staff."

The Administrator stated during interview conducted on at 10:50 a.m., that the psychiatrist filled out the form just in case the resident becomes aggressive and needed to be but the form was never utilized since residents behavior never escalate.

On the psychiatrist documented still resident was not receiving medication and stated the following "Given that the has been D/C her aggressive behavior is likely to escalate to pre T-x Levels. I suggest that the husband be called to calm her in the aggressive behavior increases. Continue to give low dosage of risperidole as ordered Any further TX from me will be require to he formally sign a TX agreement as he (the POA) has been so difficult around the issues of her misbehavior and opposition to any form of psych med."

Contrary to Administrators statement of resident's non-escalated aggressive behavior the following issues were documented in resident's record in reference to her aggressive behavior:
On from 3:00 to 11:00 p.m., resident was very aggressive towards staff and other residents. Specific on at 4:30 p.m., she another resident and caregiver that were in the kitchen. Names not provided.
At 8:00 p.m., she went to the garden and hit a caregiver and then scratched her arms with her nails. At 10:00 p.m., she became very aggressive and was kicking, screaming and staff while was spitting on the floor.
On at 2:30 p.m., resident pushed another resident that was sitting in her wheel chair and at 3:30 p.m., resident repeatedly scratched he arms of a caregiver in an attempt to harm her. Names not provided.
On at 4:00 p.m., resident became very aggressive and began hitting the nurse and other residents present. No one was harmed. Names not provided.
On at 1:51 p.m., resident became very aggressive towards other residents and started spiting on their faces.
On at 4:00 a.m., resident was hitting, kicking, slapping, and spitting the staff and other resident that were awake.
On from 11:00 p.m. to 7:00 a.m., resident was up all night, went to other resident to wake them up, when she was redirected she began hitting the caregiver and nurses.
On at 5:30 a.m., resident documented having very aggressive behavior.
On at 8:00 p.m., resident began an altercation with another resident and placed her hands around the other resident's throat and attempted to push her over. Nurse separated residents and both residents were not harmed. Name of other resident was not provided. At 8:15 p.m., resident approached the same resident and slapped her in the face.

When the Administrator was questioned on at 11:00 a.m., as of why resident was not monitor for appropriateness or discharged due to her aggressive behavior that caused harm to others, she stated that she was unaware of residents multiple aggressive episodes. She said she knew she was difficult but not to the extent that was documented at progress notes.

2. Record review for Resident #5 found the he was admitted to the facility on and occupied A. Record review for Resident #5 found that prior to his admission to the facility was to hospital due to aggressive behavior on . He was again due to a very aggressive behavior towards a CNA.

When the Administrator asked if she knew residents prior aggressive behavior history and prior to

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admission she did not provide an answer. Resident #5 had 24 private Home Health care since the day of his admission. Primary care physician notes dated [redacted] and [redacted] reporting aggressive behavior and a possible incident that the resident pushed another resident to the stomach. On [redacted] at 3:00 p.m., resident became very aggressive and broke a glass frame. The same day at 12:15 a.m., he became very aggressive with the Nurse. Same day around 11:00 p.m., resident was very aggressive towards nurses and other staff. On [redacted] at 8:55 a.m., RN reported resident being very aggressive.

Interview with the Resident Aid from Home Health Agency responsible for Resident #5's 24 care, on [redacted] at 11:26 a.m., revealed that Resident #5 is a very aggressive man. She said that on [redacted] he pulled her finger in an attempt to break it. Finger observed to be [redacted] He has hit her twice since this morning and pushed her against the wall 2-3 times in the past. The aid that was working yesterday from 10:00 p.m. to 6:00 a.m., said that she is not coming back. She said that the resident slam her in the face pushed in the chest and stomach ad kicked her legs. The LPN that worked last night was hit in the back. Caregiver present was hit in the back. She also said that he has a tendency to lash at female residents and to push his walker on them. She said that multiple staff left the Agency because it's very hard for them to take care of the resident. She also stated that she notified her supervisor and she will be reviewing the case.

The lack of appropriate supervision for both residents lead to an unsafe environment for the rest of the residents.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Arden Courts Manorcare Health
5509 Swift Road
Sarasota, FL 34231

Re: CCR #2013010031

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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2295 Victoria Avenue,
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Phone (239) 335-1315; Fax (239) 338-2372