STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910846	09/30/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Dogwood Inn	108 Wagner Road Bonifay, FL 32425	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= J
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= J
St - A - 0077 - 58a-5.019(1) Fac - Staffing Standards - Administrators S-S= J
St - A - 0079 - 58a-5.019(3) Fac - Staffing Standards - Levels S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= J
St - A - 0165 - 429.23(1-4 & 6-10) Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Specific Tag Findings:

0000-Initial Comments

An unannounced compliant survey (CCR# 2014009764) was conducted on [redacted] in conjunction with a monitoring visit. Deficiencies were found at the time of the survey.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on resident record review, resident interview, staff interview, and facility record review, the facility failed to ensure the safety and well-being for 2 out of 7 (#1 and #2) sampled residents. The facility also failed to provide adequate resident supervision and placed facility residents at ongoing risk for victimization by others.

The Findings:

1. During a record review of Resident #1's record, it was discovered that Resident #1 had been issued a 45 day discharge notice on [redacted] Resident #1 discharged from the facility on [redacted] for noncompliance with several of the facility's rules, to include [redacted] misconduct. Resident #1 was a registered [redacted] Offender with the Florida Department of Law Enforcement (FDLE).

There was a hand written statement in Resident #1's file taken [redacted] at 9:00am and signed by Staff B stating the following:
" On the above date and time, I (Staff B), was asked by another staff to question Resident #2 about if Resident #1 came into her [redacted] night. Resident #2 said "yes". Staff B then asked Resident #2 what Resident #1 did to her and Resident #2 said, "He licked me." Staff B proceeded to ask Resident #2 where Resident #1 had licked her and she stated that Resident #1 had licked her between her legs. Staff B asked Resident #2 what else did Resident #1 do to her and Resident #2 stated "he tried to screw me but his thing was too short and small."

2. On [redacted] at approximately 12:25pm, an interview conducted with Resident #2 revealed that Resident # 1 came into her [redacted] while ago during the night closing the door behind him. She revealed that while Resident #1 was in her [redacted] "licked her between her legs and tried to have [redacted]

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with her." Resident #2 revealed that Resident #1 exposed his penis to her also during the time he was trying to have with her. She denied inviting Resident #1 in her revealed that she did not want to have with Resident #1. When asked how Resident#1's actions made her feel, Resident #2 stated "it did not feel so good." Resident #2 revealed that after the incident occurred an unidentified staff member came into her asked her if she was okay. Resident #2 revealed that she reported it to a staff but could not recall which staff.

Several interviews on (approximately 11:38am & 5:15pm) and (approximately 9:35am) with the Administrator and owner revealed that the facility did not report the incident to local law enforcement and appropriate authorities, though they had a statement from Staff B revealing she had taken a statement from Resident #2 about the incident. The administrator revealed that she believed Resident #2 because the resident did not have history of reporting false allegations. She revealed that was why the facility issued Resident issued Resident #1 a 45 day notice to discharge him from the facility. She revealed that they also informed staff to watch interaction in between the two residents. The Administrator was unable to provide any documentation of the facility's actions or investigations. The Administrator confirmed that the facility had not taken the proper steps to ensure Resident #2's safety and well-being after the incident occurred. The administrator also revealed that the facility had called the local law enforcement several times in the past for Resident #1 for his irate behaviors toward staff and other residents. The Administrator confirmed that there had been no measures put into place after the calls to law enforcement for Resident #1 to protect other residents.

An interview conducted with Staff B on at approximately 12:51pm revealed that when she came in to work on the morning of , she was asked by a staff that no longer works at the facility to interview Resident #2 about an incident that had occurred between Resident #1 and Resident #2. Staff B revealed that doing the interview Resident #2 revealed that Resident #1 came into her licked between her legs before trying to have with her. Staff B revealed that Resident #2 was very timid when she asked her about the situation and did not want to talk about the situation at first. Staff B revealed that to her knowledge Resident #2 does not have history of making false reports or making up stories. Staff B revealed that besides a brief conversation with the administrator a few days following the incident she had not spoken to anyone else about the matter.

3. A review of the facility's staffing scheduled revealed that the facility did not meet minimum staffing requirements per week. The facility had a census of 22 residents at the time of the record review. The total staffing hours for the week of was 252.50. The total staffing hours for the week of was also 246.50. The required staffing hours for 16-25 residents is 253 hours per week per the Assisted Living Facility Regulations.

Interviews with the administrator on at approximately 1:25pm & 4:21pm revealed that the census for the periods of remained at 22 residents. She revealed that the facility's employees work 8 hours a day when scheduled to work and are paid for their lunch breaks taken during their shift. The facility's employees work the following shifts: 7:00am-3:00pm, 3:00pm-11:00pm, and 11:00pm-7:00am. She confirmed that the facility had not met the minimum staffing requirement of maintaining a minimum staffing of 253 hours per week for the two above

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periods. She revealed that the owner is at the facility at least 2 hours a day, 5 days a week (Monday-Friday) and could be counted in the coverage for staffing hours, but she was unable to provide evidence to confirm this statement. The facility failed to provide evidence (i.e. timecards or timesheets) to validate any of the above information.

Class I

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on record review, resident interview, and staff interview, the facility failed to provide a safe and decent environment, free from [redacted] for 1 of 7 sampled residents (#2). The facility also did not put measures into place to protect the facility's residents from being potential victims of [redacted].

The findings:

During a record review of Resident #1's record, it was discovered that Resident #1 had been issued a 45 day discharge notice on [redacted]. Resident #1 discharged from the facility on [redacted] for noncompliance with several of the facility's rules, to include [redacted] misconduct. Resident #1 was a registered [redacted] Offender with the Florida Department of Law Enforcement (FDLE).

There was a hand written statement in Resident #1's file taken [redacted] at 9:00am and signed by Staff B stating the following:
"On the above date and time, I (Staff B), was asked by another staff to question Resident #2 about if Resident #1 came into her [redacted] night. Resident #2 said "yes". Staff B then asked Resident #2 what Resident #1 did to her and Resident #2 said, "he licked me." Staff B proceeded to ask Resident #2 where Resident #1 had licked her and she stated that Resident #1 had licked her between her legs. Staff B asked Resident #2 what else did Resident #1 do to her and Resident #2 stated "he tried to screw me but his thing was too short and small."

On [redacted] at approximately 11:38am, an interview was conducted with the Administrator and she revealed that Resident #1 had indeed been discharged due to [redacted] misconduct toward Resident #2. When asked if the facility had reported the allegations to the appropriate authorities the administrator revealed that the facility had not investigated the matter or reported it the required authorities even though the facility had a statement from a staff that revealed Resident #1 attempted to have [redacted] with Resident #2 that was not consensual. During the interview the facility's policies and procedures on [redacted] and [redacted] Reporting " was requested and the Administrator revealed that the facility did not have a policy on how to recognize [redacted] or how to report [redacted]. When asked what was the facility's process for submitting [redacted] the administrator could not provide an answer, she only revealed "the facility leaves it up to the residents to report [redacted] if they choose." She revealed that she considered Resident #2 to be a credible source and believed that the [redacted] misconduct with Resident #1 had occurred. She revealed that is why the facility provided Resident #1 a 45 day notice to vacate the premises; Resident #1 discharged from the facility on [redacted].

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On [redacted] at approximately 12:25pm, an interview conducted with Resident #2 revealed that Resident # 1 came into her [redacted] while ago during the night and closed the door behind him. She revealed that while Resident #1 was in her [redacted] "licked her between her legs and tried to have [redacted] with her." Resident #2 revealed that Resident #1 exposed his penis to her also during the time he was trying to have [redacted] with her. She denied inviting Resident #1 in her [redacted] revealed that she did not want to have [redacted] with Resident #1. When asked how Resident#1's actions made her feel, Resident #2 stated "it did not feel so good." Resident #2 revealed that after the incident occurred an unidentified staff member came into her [redacted] asked her if she was okay. Resident #2 revealed that she reported it to a staff but could not recall which staff.

On [redacted] at approximately 1:30pm an interview conducted with the Administrator and the Owner of the facility revealed that they were aware of the [redacted] misconduct that had occurred with Resident #1 and Resident #2. Both the Administrator and the Owner were told that they needed to report the incident to appropriate authorities (law enforcement and the Department of Children and Families (DCF)) as required. A call was not made at the time. The owner revealed in an interview that at the time the facility did not report this matter because it was "alleged" and when they questioned both Resident #2 she did not appear to be hurt or harmed. When asked if the facility had sent Resident #2 out for a medical exam, both the Administrator and the Owner revealed the resident had not been sent out. Both, the Administrator and the Owner revealed that on the night [redacted] of the incident they were called and they only instructed staff to keep Resident #1 and Resident #2 separate from each other and watch them closely. The Owner revealed that is the right of residents to have consensual [redacted] with another resident if they chose, but denied being able to confirm that the [redacted] encounter between Resident#1 and Resident #2 was consensual. The Owner revealed Resident #1 denied that he had behaved inappropriately with Resident #2. However, the Administrator revealed that Resident #1 continued to confirm that Resident tried to have non-consensual [redacted] with her. During the interview the Owner continued to make statements like "She wasn't [redacted] "She wasn't hurt or [redacted] so what's the big deal." The owner went on to state that this type of thing happens all the time in the Assisted Living Facilities (ALF) and in his 35 years in the business he had never seen a resident go to jail for resident on resident [redacted] unless it was [redacted] The Owner revealed that the resident did not want to make fuss of it so we just did not call it in. Resident #2 has a right not to report things and the Owner revealed he believes in honoring his residents' rights. The facility could provide any documentation or statements which confirmed that Resident #2 stated she did not want to report the incident nor did the facility have any proof of an investigation of the matter. The Administrator again revealed that she believed Resident #2 because the resident was did not have a history of making up false allegations. Both the administrator revealed that Resident #1 had a history of [redacted] behaviors and was a Registered [redacted] Offender with FDLE. The facility revealed that they did not interview any other residents or staff about the matter. The facility revealed that Resident #1 had been known to be "drunk and irate at times" and that local law enforcement had been called in the past for his behaviors, though Resident #1 had never been [redacted] The owner described Resident #1 as being a "scary person" when he excessively drank [redacted] The Owner revealed that there is no need to keep asking if they investigated the matter because they did not take the resident to have a medical exam, nor did they investigate the matter, they revealed that they did not call law enforcement or DCF. The owner stated to the surveyor, "You do what you have to and we will go on from there because there is

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nothing that we could have done to prevent the matter." The owner stated that "this not a nursing home and "not documented, didn't happen is not what happens here at the ALF." When asked what measures the facility had put into place to protect other resident from residents with had a history of behaviors, both the Owner revealed the facility does not have any measures in place that the facility simply discharge resident the implement inappropriate behaviors.

When asked to provide documentation on training that is provided to staff on the facility provided a copy of the grievance procedure and resident's rights stating that was what the facility used to train staff on and how to report.
The grievance procedure stated:
"In addition to any other grievances procedures and rights available pursuant to the resident's rights the administrator will be available during complaints with any resident or their family or other personal representative. Likewise, the Administrator is available to discuss changes to facility policies and procedures. Prior to contemporaneously with, or following any such discussion, if the problem is not being addressed satisfactorily, the resident other their representative may submit a written complaint to the administrator. The administrator will respond in writing within ten (10) business days and will then schedule a meeting to resolve the problem with you, and any other appropriate individuals. Completion of a resident satisfaction survey is encouraged to ensure quality care and address resident concerns. Resident may present grievances without interference, coercion, discrimination of reprisal. You may also contact any or all of the following Contact Information: Ombudsman; The advocacy Center for persons with the Florida local advocacy council; The Agency for Health Care Administration (AHCA); and The Florida Hotline.

On at approximately 4:56pm, a 2nd interview with the Administrator and the Owner revealed that they did not see how the facility could have been prevented the incident. They revealed that there was no negative outcome to Resident #1 and no evidence of a scuffle as if she had tried to fight Resident #2 off of her. They revealed that had Resident #2 had some evidence of an assault they would have contacted the appropriate authorities. The owner revealed that if staff hadn't asked Resident #2 about the matter she probably would have not said anything. The owner and administrator was told a 2nd time that they needed to call APS (Adult Protective Services) and local law enforcement. The owner revealed that the incident is in past and he does not see what good calling DCF (Department of Children & Families) would have done. The owner revealed that calling law enforcement would not have done any good either because the facility had called several times in the past for Resident #1 and other resident and law enforcement would not even come out at times.

On at approximately 9:35am, an interview with the administrator was conducted and for the 3rd time, the facility was told that they needed to report the allegations to DCF & Local Law Enforcement. The administrator stated that she did not want to report the matter because the resident was okay with so why did she need to report it. At that time the Administrator was told that she had 1 hour to report the incident or that it would be reported by the AHCA surveyor

An interview conducted with Staff B on at approximately 12:51pm revealed that when she

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came in to work on the morning of , she was asked by a staff that no longer works at the facility to interview Resident #2 about an incident that had occurred between Resident #1 and Resident #2. Staff B revealed that doing the interview Resident #2 revealed that Resident #1 came into her licked between her legs before trying to have with her. Staff B revealed that Resident #2 was very timid when she asked her about the situation and did not want to talk about the situation at first. Staff B revealed that to her knowledge Resident #2 does not have history of making false reports or making up stories. Staff B revealed that besides a brief conversation with the administrator a few days following the incident she had not spoken to anyone else about the matter.

Class I

0077-Staffing Standards - Administrators 58A-5.019(1) FAC
Based on record review, resident interview, and staff interview the administrator failed to report allegations of to appropriate authorities involving 2 of 7 sampled residents (#1 & #2) and establish and implement policies and procedures for recognizing and reporting The administrator failed to provide adequate training for 4 of 4 staff records reviewed. (Staff A, Staff C, Staff D, and Staff E). The administrator also did not put measures into place to protect the facility's residents from being potential victims of These failures to establish systems for resident protections, placed residents at imminent threat for potential

The findings:

During a record review of Resident #1's record, it was discovered that Resident #1 had been issued a 45 day discharge notice on . Resident #1 discharged from the facility on for noncompliance with several of the facility's rules, to include misconduct. Resident #1 was a registered Offender with the Florida Department of Law Enforcement (FDLE).

There was a hand written statement in Resident #1's file taken at 9:00am and signed by Staff B stating the following:
" On the above date and time, I (Staff B), was asked by another staff to question Resident #2 about if Resident #1 came into her night. Resident #2 said "yes". Staff B then asked Resident #2 what Resident #1 did to her and Resident #2 said, "He licked me." Staff B proceeded to ask Resident #2 where Resident #1 had licked her and she stated that Resident #1 had licked her between her legs. Staff B asked Resident #2 what else did Resident #1 do to her and Resident #2 stated "he tried to screw me but his thing was too short and small."

On at approximately 12:25pm, an interview conducted with Resident #2 revealed that Resident # 1 came into her while ago during the night and closed the door behind him. She revealed that while Resident #1 was in her "licked her between her legs and tried to have with her." Resident #2 revealed that Resident #1 exposed his penis to her also during the time he was trying to have with her. She denied inviting Resident #1 in her revealed that she did not want to

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have with Resident #1. When asked how Resident#1's actions made her feel, Resident #2 stated "it did not feel so good." Resident #2 revealed that after the incident occurred an unidentified staff member came into her asked her if she was okay. Resident #2 revealed that she reported it to a staff but could not recall which staff.

An interview conducted with Staff B on at approximately 12:51pm revealed that when she came in to work on the morning of , she was asked by a staff that no longer works at the facility to interview Resident #2 about an incident that had occurred between Resident #1 and Resident #2. Staff B revealed that doing the interview Resident #2 revealed that Resident #1 came into her licked between her legs before trying to have with her. Staff B revealed that Resident #2 was very timid when she asked her about the situation and did not want to talk about the situation at first. Staff B revealed that to her knowledge Resident #2 does not have history of making false reports or making up stories. Staff B revealed that besides a brief conversation with the administrator a few days following the incident she had not spoken to anyone else about the matter.

Several interviews on (approximately 11:38am, 1:30pm & 5:15pm) and (Approximately 9:35am) with the Administrator and owner revealed that the facility did not report the incident to local law enforcement and appropriate authorities though they had a statement from Staff B revealing she had taken a statement from Resident #2 about the incident. The Administrator was unable to provide any documentation of the facility's actions or investigations. The Administrator confirmed that the facility had not taken the proper steps to ensure Resident #2's safety and well-being after the incident occurred. The Administrator confirmed that there had been no measures put into place after the calls to law enforcement for Resident #1 to protect other residents. Both, the Administrator and owner revealed that the facility did not have any policies and procedures regarding recognizing and reporting An interview conducted with the Administrator and the Owner of facility revealed that the facility does not have a policy on "recognizing and reporting neglect, and When asked to provide documentation on training that is provided to staff on the facility provided a copy of the grievance procedure and resident's rights only stating that was what the facility used to train staff on and how to report.

The grievance procedure stated:

"In addition to any other grievances procedures and rights available pursuant to the resident ' s rights the administrator will be available during complaints with any resident or their family or other personal representative. Likewise, the Administrator is available to discuss changes to facility policies and procedures. Prior to contemporaneously with, or following any such discussion, if the problem is not being addressed satisfactorily, the resident other their representative may submit a written compliant to the administrator. The administrator will respond in writing within ten (10) business days and will then schedule a meeting to resolve the problem with you, and any other appropriate individuals. Completion of a resident satisfaction survey is encouraged to ensure quality care and address resident concerns. Resident may present grievances without , interference, coercion, discrimination of reprisal. You may also contact any or all of the following Contact Information: Ombudsman; The advocacy Center for persons with the Florida local advocacy council; The Agency for Health Care Administration (AHCA); and The Florida Hotline."

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A total of 4 employees training records were reviewed. All 4 staff (Staff A, Staff C, Staff D, and Staff E) had training certificates for recognizing and reporting neglect, and . Though 4 of 4 staff had certificates that they had been trained on "recognizing and reporting neglect, and but none of the information provided confirmed that the training was adequate and included all required components. The facility's training did not indicate to staff how to recognize and report neglect, and . The facility did not have a policy or procedure on "recognizing and reporting neglect, and .

Class I

0079-Staffing Standards - Levels 58A-5.019(3) FAC
Based on review of the facility's records and interview, the facility failed to maintain the minimum staffing hours per week as required for the periods of and .

The Findings:

A review of the facility's staffing scheduled revealed that the facility did not meet minimum staffing requirements per week. The facility had a census of 22 residents at the time of the record review. The total staffing hours for the week of was 252.50. The total staffing hours for the week of was also 246.50. The required staffing hours for 16-25 residents is 253 hours per week per the Assisted Living Facility Regulations.

Interviews with the administrator on at approximately 1:25pm & 4:21pm revealed that the census for the periods of remained at 22 residents. She revealed that the facility's employees work 8 hours a day when scheduled to work and are paid for their lunch breaks taken during their shift. The facility's employees work the following shifts: 7:00am-3:00pm, 3:00pm-11:00pm, and 11:00pm-7:00am. She confirmed that the facility had not met the minimum staffing requirement of maintaining a minimum staffing of 253 hours per week for the two above periods. She revealed that the owner is at the facility at least 2 hours a day, 5 days a week (Monday-Friday) and could be counted in the coverage for staffing hours, but she was unable to provide evidence to confirm this statement.

Without the hours of the Administrator and the two cooks (Staff A & Staff B), the facility hours for the period of was 132. For the period of without the hours of the Administrator and the two cooks (Staff A & Staff B), the facility hours were 128. The facility failed to provide evidence (i.e. timecards or timesheets) to validate that the Administrator, the Owner, or 2 staff with duties of cooking were actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care. The Owner was the only staff that was not on the staffing schedule.

Class III

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0081-Training - Staff In-Service 58A-5.0191(2) FAC

Based on record review and staff interview, the facility failed to provide 4 of 4 sampled staff (Staff A, Staff C, Staff D, and Staff E) appropriate training on recognizing and reporting resident neglect, and . The facility did not have a policy or procedure on recognizing and reporting resident , neglect and either. Failure to recognize potential and when to investigate/ report such events places facility residents at risk for .

The findings:

During an investigation of allegations of a total of 4 employees training records were reviewed. All 4 staff (Staff A, Staff C, Staff D, and Staff E) had training certificates for recognizing and reporting , neglect, and . Though 4 of 4 staff had certificates that they had been training on "recognizing and reporting , neglect, and none of the information provided confirmed that the training was adequate and included all required components. The facility's training did not indicate to staff how to recognize and report , neglect, and . The facility did not have a policy or procedure on "recognizing and reporting , neglect, and .

On at approximately 11:38am, an interview was conducted with the Administrator. During the interview the facility's policies and procedures on "recognizing and reporting , neglect, and was requested and the Administrator revealed that the facility did not have a policy on recognizing and reporting , neglect, and . When asked what the facility's process was for submitting the administrator could not provide an answer, she only revealed "the facility leaves it up to the residents to report if they choose."

On at approximately 1:30pm an interview conducted with the Administrator and the Owner of facility revealed that the facility does not have a policy on "recognizing and reporting , neglect, and ." When asked to provide documentation on training that is provided to staff on the facility provided a copy of the grievance procedure and resident's rights only stating that was what the facility used to train staff on and how to report.
The grievance procedure stated:
"In addition to any other grievances procedures and rights available pursuant to the resident's rights the administrator will be available during complaints with any resident or their family or other personal representative. Likewise, the Administrator is available to discuss changes to facility policies and procedures. Prior to contemporaneously with, or following any such discussion, if the problem is not being addressed satisfactorily, the resident other their representative may submit a written complaint to the administrator. The administrator will respond in writing within ten (10) business days and will then schedule a meeting to resolve the problem with you, and any other appropriate individuals. Completion of a resident satisfaction survey is encouraged to ensure quality care and address resident concerns. Resident may present grievances without interference, coercion, discrimination of reprisal. You may also contact any or all of the following Contact Information: Ombudsman; The advocacy Center for persons with the Florida local advocacy council; The Agency for Health Care

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Administration (AHCA); and The Florida Hotline.

Class I

0165-Risk Mgmt & QA; Adverse Incident Report 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC
Based on facility record review, resident interview, and staff interview the facility failed to report alleged to the Department of Children and Family Services (DCF) and submit adverse incident reports including filing a report with local law enforcement as required for 2 of 7 sampled residents (#1 &#2).

The findings:

During a record review of Resident #1's record, it was discovered that Resident #1 had been issued a 45 day discharge notice on Resident #1 discharged from the facility on for noncompliance with several of the facility's rules, to include misconduct. Resident #1 was a registered Offender with the Florida Department of Law Enforcement (FDLE).

There was a hand written statement in Resident #1's file taken at 9:00am and signed by Staff B stating the following:
"On the above date and time, I (Staff B), was asked by another staff to question Resident #2 about if Resident #1 came into her night. Resident #2 said "yes". Staff B then asked Resident #2 what Resident #1 did to her and Resident #2 said, "He licked me." Staff B proceeded to ask Resident #2 where Resident #1 had licked her and she stated that Resident #1 had licked her between her legs. Staff B asked Resident #2 what else did Resident #1 do to her and Resident #2 stated "he tried to screw me but his thing was too short and small."

On at approximately 11:38am, an interview was conducted with the Administrator and she revealed that Resident #1 had indeed been discharged due to misconduct toward Resident #2. When asked if the facility had reported the allegations to the appropriate authorities the administrator revealed that the facility had not investigated the matter or reported it the required authorities even though the facility had a statement from a staff that revealed Resident #1 attempted to have with Resident #2 that was not consensual. During the interview the facility's policies and procedures on and Reporting " was requested and the Administrator revealed that the facility did not have a policy on how to recognize or how to report When asked what the facility's process was for submitting the administrator could not provide an answer, she only revealed "the facility leaves it up to the residents to report if they choose."

On at approximately 12:25pm, an interview conducted with Resident #2 revealed that Resident # 1 came into her while ago during the night and closed the door behind him. She revealed that while Resident #1 was in her "licked her between her legs and tried to have with her." Resident #2 revealed that Resident #1 exposed his penis to her also during the time he was trying to have with her. She denied inviting Resident #1 in her revealed that she did not want to have with Resident #1. When asked how Resident#1's actions made her feel, Resident #2 stated

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910846	09/30/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Dogwood Inn	108 Wagner Road Bonifay, FL 32425	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

"it did not feel so good." Resident #2 revealed that after the incident occurred an unidentified staff member came into her [redacted] asked her if she was okay. Resident #2 revealed that she reported it to a staff but could not recall which staff.

On [redacted] at approximately 1:30pm an interview conducted with the Administrator and the Owner of the facility revealed that they were aware of the [redacted] misconduct that had occurred with Resident #1 and Resident #2. Both the Administrator and the Owner were told that they needed to report the incident to appropriate authorities (law enforcement and the Department of Children and Families (DCF)) as required. A call was not made at the time. The owner revealed in an interview that at the time the facility did not report this matter because it was "alleged" and when they questioned both Resident #2 she did not appear to be hurt or harmed. The facility could provide any documentation or statements which confirmed that Resident #2 stated she did not want to report the incident nor did the facility have any proof of an investigation of the matter. The facility revealed that they did not interview any other residents or staff about the matter.

On [redacted] at approximately 4:56pm, a 2nd interview with the Administrator and the Owner revealed that they did not see how the facility could have been prevented the incident. They revealed that there was no negative outcome to Resident #1 and no evidence of a scuffle as if she had tried to fight Resident #2 off of her. They revealed that had Resident #2 had some evidence of an assault they would have contacted the appropriate authorities. The owner revealed that if staff hadn ' t asked Resident #2 about the matter she probably would have not said anything. The owner and administrator was told a 2nd time that they needed to call APS and local law enforcement. The owner revealed that the incident is in past and he does not see what good calling DCF would have done. The owner revealed that calling law enforcement would not have done any good either because the facility had called several times in the past for Resident #1 and other resident and law enforcement would not even come out at times.

On [redacted] at approximately 9:35am, an interview with the administrator was conducted and for the 3rd time, the facility was told that they needed to report the allegations to DCF & Local Law Enforcement. The administrator stated that she did not want to report the matter because the resident was okay with so why did she need to report it. At that time the Administrator was told that she had 1 hour to report the incident or that it would be reported by the AHCA surveyor. The facility had to be asked 3 times to report the allegations to the appropriate authorities.

An interview conducted with Staff B on [redacted] at approximately 12:51pm revealed that when she came in to work on the morning of [redacted], she was asked by a staff that no longer works at the facility to interview Resident #2 about an incident that had occurred between Resident #1 and Resident #2. Staff B revealed that doing the interview Resident #2 revealed that Resident #1 came into her [redacted] licked between her legs before trying to have [redacted] with her. Staff B revealed that Resident #2 was very timid when she asked her about the situation and did not want to talk about the situation at first.

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Staff B revealed that to her knowledge Resident #2 does not have history of making false reports or making up stories. Staff B revealed that besides a brief conversation with the administrator a few days following the incident she had not spoken to anyone else about the matter.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK

3, 2014

Administrator
Dogwood Inn
108 Wagner Road
Bonifay, FL 32425

Dear Administrator:

This letter reports the findings of a complaint (2014009764) inspection survey conducted by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within the time frames noted below.

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

- A025 - Resident Care, Supervision
- A030 - Resident Care, Rights
- A077 - Staffing Standards, Administrators
- A081 - Staff In-Service Training

The Assisted Living Facility is required to do the following:
1. Develop a policy for supervision of residents. This shall include procedures for residents with special care and supervision needs, including risk factors (such as but not limited to sexualized , alcohol use or drug use). This policy must be developed no later 10, 2014. Staff shall be trained on this policy no later 10, 2014. You shall maintain evidence that all staff working within the facility have been trained prior to beginning any shift 10, 2014 or later.
2. Develop a policy for reporting incidents to appropriate authorities. This includes reporting suspected/ alleged criminal behavior to law enforcement immediately; reporting adverse incidents to AHCA per Florida Statute and abuse/ exploitation to the Department of Children & Families in accordance with Florida Statute. This policy must be developed no later 10, 2014. Staff shall be trained on this policy no later 10, 2014. You shall maintain evidence that all staff working within the facility have been trained prior to beginning any shift 10, 2014 or later.
3. Hire a consultant to establish abuse prevention ciriculuum. This consultant should be hired (with documented proof of a contractual agreement) no later 10, 2014. The training should be provided to all facility staff no later 3, 2014. You shall maintain evidence that all staff working within the facility have been trained prior to beginning any shift 3, 2014 or later.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law. Should you have any questions, please call me at 850-412-4540.

Sincerely,

Donald Helberg
Field Office Manager

DH/dh

Tallahassee Field Office
2727 Mahan Drive, Mail Stop #46
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