RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Serenades in the Villages
2450 Parr Drive, The Villages
Lady Lake, FL 32162

Dear Administrator:

This letter reports the findings of a complaint 2014010678 inspection survey conducted on , 2014 through , 2014, by representatives of the Agency for Health Care Administration (Agency). Enclosed 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 ten **business days** of receipt of this hand delivered report.

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

St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G

Directed Corrective Actions:

1. The Assisted Living Facility is required to supplement their policy and procedure(s) to include the identification of the need and the implementation of direct supervision of third parties and their interactions with residents based upon demonstrated behaviors. This requirement must be completed within five business days.

The Assisted Living Facility is required to retrain all staff on the facility's policy which addresses Neglect and within ten business days. Documentation of the curriculum and completed training must remain on the premise of the facility for Agency review.

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

Alachua Field Office
14101 N W Hwy 441, Suite 800
Alachua, FL 32615-5669
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Serenades In The Villages
2014

Should you have any questions, please call Jasmine Hayes, Survey and Certification Support Branch, at (386) 462-6201.

Sincerely,

Kristie Mennella
Field Office Manager

KJM/jjh

Enclosure

Received by:

Date:

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

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14101 N W Hwy 441, Suite 800
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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968578	10/31/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Serenades In The Villages	2450 Parr Drive, The Villages Lady Lake, FL 32162	
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= G

Specific Tag Findings:

0000-Initial Comments

On and a complaint inspection (CCR #2014010678) was conducted at Serenades in the Villages, an assisted living facility. Deficient practice was identified at the time of the survey.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observation, record review and interview, the facility failed to provide supervision for 1 of 3 sampled residents after having actual knowledge of potential risk presented to residents or staff by a Power of Attorney (Resident #1).

Findings:

On a review of the facility's surveillance video for at 9:18 PM, showed Resident #1 being led by the hand out of a door, by her POA, into a small a door which opens to the outside the building. Resident #1 was observed trying to pull away from her POA. Resident #1 ' s POA was observed to not let go of her hand and yanking her. Continued observations showed the POA attempted to unlock and exit the door leading out of the building while holding onto Resident #1. Staff D entered the area then exchanged words with the POA. The Staff D left Resident #1 and her POA in the area alone. The POA was observed attempting to kiss the resident while the resident resisted his attempts. The resident's POA opened the door then pulled the Resident #1 out with him.

A review of police report dated revealed on an officer responded to the facility to investigate the incident between Resident #1 and her POA. The officer documented an interview and written statement of Staff D ' s account of events. The officer wrote, " [Resident #1 ' s POA] was at the door attempting the exit but the door would not open. Staff D went to assist [The POA] when she saw [Resident #1] " ' hiding ' " in the corner. Staff D explained to [the POA] why the door would not open so she left to get help when Resident #1 grabbed her hand and stated, " ' Nol, don ' t let me go! ' " The officer further documented Staff D reported the POA was able to exit the building with Resident #1. Further review of the same police report showed the reporting officer interviewed Staff B on regarding the same incident. The officer's documentation revealed Staff B reported, " [Resident #1 stated she did not want to go with him [the POA]. " The reporting officer documented Staff B she asked the POA if he was drunk at the time of the incident and the POA stated, " ' Well yes! But it ' s a good thing! A good celebration! " Continued review of the report revealed Staff B asked Resident #1 if she was scared of the POA, to which Resident #1 replied, " ' yes. ' "

On at 3:33 PM and interview was conducted with the Staff B. Staff B stated on Resident #1 ' s POA was very drunk and that he took Resident #1 to the center of the facility ' s parking lot. She stated Resident #1 was wearing her pajamas and no shoes. The nurse stated Resident #1's POA grabbed the resident and kissed her very inappropriately on the mouth. The nurse then ordered the resident's POA to leave the facility. A review of facility documentation showed on Resident #1 ' s POA signed a, "Negotiated Risk Agreement (NRA) " with the facility. This agreement acknowledged the Reisdent #1 ' s POA as risk and outlined measure to minimize future risk. The agreement was put in in place for 60 days and was contingent on the POA's behavior during that time." The NRA stated, " Serenades are upholding some conditions in order to

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prevent likelihood that the House Rules would be broken again in the future. Violation of the House Rules could also result in accident, including but not limited to mental , , , and other injuries up to and including . . . . . The section of the document entitled Alternative Approaches to Minimize Risk stated:

1. Resident #1's POA will visit the community during the hours of 8:00 am til 6:00 pm
The [POA] is never to be alone with Resident #1 in the apartment or any other secluded area of the community.

2. The [POA] will ask staff for assistance if needed for [Resident #1].

3. The [POA] will not be permitted to visit in the event he should display being under the influence .
The Executive Director reserved the right to intervene should a visit be questionable.

4. [The POA] will ensure [Resident #1] Florida guardianship papers are completed and updated and will provide us with up to date copies by .

5. A companion/overseer will accompany the [POA] should he take [Resident #1] out of the community.

Course of Action Agreed To:

In the event of an emergency [The POA] will be allowed to enter the facility: After 60 days we will re visit this Negotiated Risk Agreement: If there are no incidents or concerns this agreement will no longer be in effect."

A review of the facility's Policy and Procedure for Neglec revealed the procedure stated, "If the community does not employ the suspect, visitation to the community must be supervised by community personnel and in approved, designated areas. The suspect will be prohibited from unsupervised access to the resident."

A review of Resident #1's service notes dated revealed another documented incident between Resident #1 and her POA. The notes stated, "CNA reported to this writer that [Resident #1] was distraught. CNA stated that POA had asked her to help Resident change wet soiled clothing and that he was having a hard time changing her. CNA then stated that she found resident in bed with panties and pants pulled down to her knees. CNA found zero wet soiled items in the . . . . . on resident. Resident presented anger toward CNA and CNA reported that [Resident #1] told her [the] POA hit resident on her head. This writer approached resident in the dining . . . . resident stated " ' Help Me! ' " Writer asked resident what ' s wrong and resident gestured that she was hit in the head and writer gestured that POA (as she pointed to him) pulled on her clothing. " The service notes further stated, " Writer and ED Director assisted resident to the boutique . . . . . resident offered to toilet. Resident gestured that ' He hit me 'swinging her arms at head and pulling on her shirt. And pointing to her area. Resident stated that he hurt her. She did this and again pointing to her area. Writer walked with resident back to dining area. Resident past POA in dining . . . . started hollering at him, stated you did this you hurt me and then stated that he does this to his wife also. Resident sat at the dining table but refused to eat. She was too distraught.

A review of police report, dated , revealed the police responded to the facility to investigate an alleged assault on Resident #1 by her POA. A review of the report revealed the police interviewed the Executive Director (ED). The ED reported Staff B informed her Resident #1 was upset with her POA. The ED reported asking Resident #1 what happened with her POA and Resident #1 started hitting herself in the face and pointing at her area. The ED reported Resident #1 stated, " ' He ' s a bad man, he hurt me. ' " Resident #1 was

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reported to point at her area again.

During an interview with the Executive Director (ED) on at 1:20 PM, she stated the facility did not have grounds to restrict Residents #1's POA at the facility. She further stated she did not believe her POA had any private contact with Resident #1 after the end of the negotiated agreement until .

A phone interview with Staff B on at 1:58 PM revealed Resident #1's POA did enter the by his wife and Resident #1 on other occasions, and resident #1 could be in the he visited his wife without staff present.

Class II