RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2015

Administrator
Henderson House
907 East Orange Avenue
Eustis, FL 32726

Dear Administrator:

This letter reports the findings of a complaint 2015003803 inspection survey conducted on , 2015 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 report.

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

St - A - 0008 - 429.26(4-6) FS; 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0030 - 58a-5.0182(6) FAC; 429.28 FS - Resident Care - Rights & Facility Procedures S-S= G
St - A - 0165 - 429.23(1-4 & 6-10) FS; 58a-5.0241 FAC - Risk Mgmt & QA; Adverse Incident Report S-S= D

Directed Corrective Actions

The Assisted Living Facility is required to:

1. Have the administrator review all current residents to ensure they are appropriate for continued residency in accordance with 58A-5.0181(4), Florida Administrative Code. Residency is determined if residents are appropriate to reside in the facility.

2. Develop a policy and procedure to address staff reporting incidents in the facility. The policy and procedure shall include the identification of a designee to report adverse incidents to the Agency. All employees shall be trained on the aforementioned policy and procedure. Documentation of completed training must be maintained on file in the facility for Agency review.

3. Develop a policy and procedure to establish an admission screening process prior to an admission of new residents. The procedure must include an assessment to determine if prospective residents are a danger to self or others. The policy shall include identification of the person(s) responsible for the intake process and the screening assessments.

4. Train all staff on the recognition of neglect and using a provider approved by the Department of Children and Families or the Long Term Care Ombudsman Council. Documentation of the aforementioned training must be maintained on file in 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.

Should you have any questions, please contact Jasmine Hayes, Health Facility Evaluator Supervisor, Area 3, at (386) 462-6201

Sincerely,

Deborah Allison for

Kriste J. Mennella
Field Office Manager

KJM/amw
Enclosure

Received by Date

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932557	05/06/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
HENDERSON HOUSE	907 E. ORANGE AVENUE EUSTIS, FL 32726	

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

0000 - Initial Comments

On unannounced complaint survey CCR #2015003803 was conducted at Henderson House Assisted Living Facility in Eustis Florida. Discernible deficiencies were identified as a result of this survey. The facility was not in compliance at this time

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record reviews and interviews the facility failed to obtain omitted information from a health assessment (AHCA form 1823) for 3 of 3 (#1, #6 and #10).

Findings:

On a record review was conducted on resident #10's health assessment dated, The required comments for activities of daily living were on page 2 were omitted. The required comments for daily tasks page 3 were omitted. The information regarding if the resident requires assistance with the self-administration or administration of medication on page 4.

On a record review was conducted on resident #1 1823 health assessments dated and resident #6 health assessment dated Resident #1 1823 was missing required comments for ADL's on page 2. required comments for daily tasks on page 3. Page 5 was not completed. Resident #6 health assessment was missing required comments for ADL's on page 2. Required comments for daily tasks on page 3 and Page 5 was left blank.

On at approximately 2:30 PM an interview was conducted with the Administrator regarding the omitted information on resident #1, 6, and 10 1823 health assessment. She stated she did not know the information was missing and she thought page 5 was only filled out if they were extended congregate care resident.

Class III

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

Based on record reviews and interviews the facility failed to ensure the right to live in a safe and decent living environment, free from was protected for 3 of 9 sampled residents (resident #1, #2, and #6) after acknowledging inappropriate behaviors of another resident (resident #10).

Findings:

On at approximately 10:30 AM an interview was conducted with the Administrator in reference to

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resident #10 being in the facility. She stated resident #10 was [redacted] and removed from the facility by the police on [redacted] for lewd battery on an elderly person. On [redacted] at approximately 2:00 PM the Administrator was stated she did not find out about resident #10 touching resident #1 until [redacted] when it was reported to her. When she found out she called Department of Children and Families, and she called family and told them that resident #10 had to be removed but they refused to come and get him. She said that when he touched resident #1 again on [redacted] the police were called and resident #10 was [redacted]

On [redacted] at approximately 12:20 PM an interview was conducted with resident #2. During the interview she stated resident #10 used to stare at her. She reported resident #10 grabbed her [redacted] and touched her back which she did not like. She stated she told staff and staff told resident #10 to stop, which he did. She said this happened approximately 3 months ago.

On [redacted] at approximately 1:13 PM an interview was conducted with resident #5. She stated she saw resident #10 with his hand in resident #1 pants and she yelled at him and he stopped. She reported resident #10 was caught in resident #1's [redacted] 4:00 AM. She said staff knew resident #10 was messing with resident #1 and they would get after him all the time.

On [redacted] at approximately 1:30 PM an interview was conducted with care staff B. She stated she had never observed any resident on resident [redacted] She stated she never saw resident #10 touch or [redacted] another resident. She stated none of the residents have ever told her they were touched or abused by resident #10. She stated when another staff member told her what resident #10 did to resident #1 she called DCF and made a report.

On [redacted] at approximately 2:15 PM an interview was conducted with resident #8. She stated that resident #10 wanted to have [redacted] relations with her but she refused. She stated she saw resident #10 touch resident #1 under her clothes. She said she herd resident #10 having [redacted] with resident #6 in her [redacted] door. She said she told staff member B but she would not believe her.

On [redacted] at approximately 11:24 AM an interview was conducted with resident #9. During the interview she stated She saw resident #10 touch resident #1 and #6 fondling and touching their private areas. She said she told staff but could not remember who it was.

On [redacted] at approximately 3:10 PM an interview was conducted with a former employee, staff member J. She stated she remembers resident #10 when she worked at Henderson House. She said staff reported to her Resident #10 was observed grabbing resident #6 between the legs. She said she reported the incident to the Administrator. She also told the Administrator several times that resident #10 was not appropriate for the facility because of his behavior.

A review of a written statement, dated [redacted] by care staff I revealed staff I observed resident #10 rubbing the [redacted] area of resident #1 up and down with his right hand. She told him to stop because that was [redacted] and sent him to his [redacted] She reported the incident to the team leader.

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On a record review of resident #10 observation log was conducted and reveled the resident #10 had inappropriate interactions with female residents as early as and staff was aware of his conduct. The facility allowed his behavior to escalate until he was on with little to no intervention. Further review revealed:

On it was reported to staff that resident #7 saw resident #10 rubbing on resident #6 shoulders.
On its documented: Have too watch resident #10 when he is by little resident #6, he touches her bottom.
On its documented: resident #10 was kept from resident #1 all day.
On its documented: resident #10 was observed touching resident #1 again, he is rubbing on her thigh.
On its documented: resident #10 caught kissing resident #1 on the mouth.
On its documented: resident #10 was rubbing resident #6 thigh this morning. He was making sounds like doing it.
On its documented: staff C talked with resident #10 about touching other residents, he was rubbing on resident #8 arm and she told him to stop.
On its documented: resident #10 was caught trying to touch resident #1.
On its documented: resident #10 was caught rubbing on resident #6 and was trying to touch her

Class II

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on interviews and record reviews the facility failed to file an adverse incident report for an event reported to law enforcement for investigation for 1 of 1 residents (resident #10).

Findings:

On at approximately 10:30 AM an interview was conducted with the Administrator. She was asked if there were any adverse incidents in the last couple months in the facility. She replied, no. When interviewed about resident #10 she reported he was by the police for lewd conduct on an elderly person. She was asked if there was a law enforcement investigation and she said, yes. She was asked did she file an adverse incident report in reference to the law enforcement investigation involving resident #10 and she stated, no.

On a record review was conducted on resident #10. It was observed that the Admissions discharge log shows that resident #10 was removed from the facility by law enforcement do to an Further review revealed on log entry states on police returned to the facility to continue their investigation into the allegations against resident #10.

Class III