RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Malaya Prado Maulion
Administrator
Henderson House Assisted Living Facility, Inc.
License # 11932557
907 East Orange Avenue
Eustis, Florida 32726

Dear . Maulion:

This letter reports the findings of a complaint inspection conducted on by representatives of the Agency for Health Care Administration. You are directed to comply with the tangible steps outlined below in order to correct the deficient practices. Listed below are the deficiencies noted in the investigation.

The investigation resulted in findings of noncompliance with the following areas:

A030- Resident Care-Rights and Facility Procedures, Class II- Your Assisted Living Facility failed to protect residents by not reporting an alleged assault to law enforcement or the hot line for investigation. Your Assisted Living Facility failed to seek medical attention when they reported a medical condition from the assault. Your Assisted Living Facility retaliated against a resident by discharging the resident without a 45 day notice when the assault was reported to law enforcement.

A077- Staffing Standards- Administrator, Class II- Your Assisted Living Facility failed to ensure that qualified staff with required training were providing care to residents. The facility failed to maintain appropriate staffing standards regarding the administrator. Your Assisted Living Facility failed to report an allegation of resident to authorities for investigation. This action left residents of the facility at continued risk of . Your Assisted Living Facility failed to report alleged to the resident to the Agency within the required one business day after the event was reported to law enforcement for investigation.

Your facility must comply with the following:

1- The Assisted Living Facility is required to have an updated policy and procedures regarding resident rights, including issuing a 45 day notice of discharge to residents and their responsible parties. The procedure needs to include communicating to the resident and family members on why the discharge is to occur. **This shall be completed by**

2- The Assisted Living Facility is required to retrain all facility staff on the requirements

Alachua Field Office
14101 N W Hwy 441, Suite 800
Alachua, FL 32615-5669
Phone:(386) 462-6201; Fax:(386) 418-5300
AHCA.MyFlorida.com

listed below. This training must be taught by a CORE trained individual other than the current administrator of this facility. The trainer must have successfully completed CORE training, passed the exam and maintained the requirement for 12 hours of continuing education every 2 years.

A-adverse incident reporting,
B-reporting major incidents,
C-facility emergency procedures,

This item shall be completed by

3- The Assisted Living Facility is required to retrain all facility staff on the areas listed below. This training must be completed by a Florida Department of Children and Families (DCF) or Long Term Care Ombudsman Program (LTCOC) approved instructor. If a DCF or LTCOC instructor is not available, the Alachua Field Office must be contacted to approve any alternate instructor.

A-resident rights, including issuing a 45-day notice of discharge to residents.
B-recognizing and reporting , neglect and .

This item shall be completed by

4- All staff are required to attend the trainings and proof of attendance must be kept on file and available for review upon request from the agency.
This must be completed by

5- The administrator is required to update her personnel file to include the following: High school diploma, job application with references, written statement from a health care provider showing that she is free from communicable and a written statement that she is free from ( ). The file must be on site and available for review by the Agency. **This must be completed by**

6- The facility is required to review all staff personnel files and ensure that all staff has a written statement from a health care provider stating that they are free of communicable and a statement that they are free from . **This must be completed by**

7- The facility is required to review all staff personnel files and ensure that all staff employed at the Henderson House Assisted Living Facility has completed all of the necessary training as required. The files are to be on-site and available for review by the Agency. **This must be completed by**

8- The facility is required to ensure all staff providing assistance with the self-administration of medication have completed the required training from a nurse or registered pharmacist and that it is properly documented in staff records. The records are to be on-site and available for review by the Agency. **This must be completed by**

Henderson House
[illegible], 2015

All task are to be completed by August 24, 2015

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

Should you have any questions, please contact Laura Manville, Assisted Living Facility Enforcement Team Manager at 727-552-1955 or Jasmine Hayes, Assisted Living Facility Supervisor at 386-462-6239.

Sincerely,

for
Kristie J. Mennella
Field Office Manager

KJM/vk
Enclosure

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2727 Mahan Drive
Tallahassee, FL 32308
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

A complaint investigation (CCR 2015007590) was conducted on and at Henderson House Assisted Living Facility, 907 East Orange Avenue, Eustis, Florida, 32726. Deficient practice was found at the time of the investigation.

0030 Resident Care - Rights & Facility Procedures

Based on interview and record review, the facility failed to protect 1 of 1 sampled residents (#10) from reported assault by not reporting an alleged assault to law enforcement or the hotline for investigation and not seeking medical attention for Resident #10 after the resident report a medical condition resulting from the assault. The facility also retaliated against 1 of 1 sampled residents (#10) by discharging them without required 45 day notice when the assault was reported. Findings include:

A review of a local police department report revealed on Resident #10 was interviewed by the police. Resident #10 reported that on at approximately 3:00 AM she was assaulted by another resident. Resident #10 stated she reported this assault to the administrator on . Further review of the police report revealed the administrator confirmed she was made aware of the alleged assault on decided not to call the police.

On , a record review revealed, both the law enforcement report and the Florida Department of Children and Families report were generated by sources outside of the facility.

On / at 11:51 AM, in an interview with an investigator from the Florida Department of Children and Families (DCF). The DCF investigator stated that they interviewed the administrator on . According to the investigator, when asked why the administrator did not take Resident #10 to the local medical treatment facility after the resident told the administrator she was assaulted, the administrator stated she did not think she needed too. The administrator finally stated that Resident #10 was taken to the local medical treatment center at the request of Resident #10's daughter.

On at 11:43 AM, in an interview with the administrator she stated that the alleged incident of assault on Resident #10 occurred sometime between the hours of 2:00 AM and 4:00 AM on . The administrator stated that she became aware of the incident on the afternoon of when Resident #10 came and told her about the incident. The administrator stated that Resident #10 came to talk with her and asked if she could talk in private. The administrator stated she told Resident #10 no and that Resident #10 needed to talk with the administrator with staff A present. The administrator further stated that she did not report the incident to a law enforcement or DCF because

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she did not believe the [redacted] assault with Resident #10 occurred. In a continued interview the administrator stated that on [redacted] Resident #10 came to her complaining of a [redacted] discharge. The administrator was asked what action she took to the statement from Resident #10 about the [redacted] discharge and she stated she took no action.

On [redacted] at 11:14 AM, an interview was conducted with Resident #10's daughter. Resident #10's daughter stated she was notified about the alleged [redacted] assault by Resident #10 on the evening on [redacted]. She stated she contacted the facility on [redacted] and asked the administrator why her mother had not been seen by a medical physician after stating she was [redacted] assaulted. She stated the administrator told her that she had plan to take Resident #10 on [redacted], but was too busy and would take her that day ([redacted]). Resident #10's daughter further stated the facility was aware that alleged predator had previously made threats to harm Resident #10.

2. On [redacted] at 9:30 AM, in an interview with a detective from local law enforcement, the detective stated law enforcement was contacted about allegations of an alleged resident on resident [redacted] assault on [redacted] by a local medical facility. Resident #10 was being treated at a local medical facility at the time local law enforcement was contacted. Local law enforcement stated at the end of the examination that law enforcement contacted the facility to have Resident #10 returned to the facility. Law enforcement stated that the facility refused to accept Resident #10 back into the facility. The detective further stated the facility refused to provide Resident #10's medication and that two uniformed officers had to be sent to the facility to retrieve Resident #10's medication.

On [redacted] at 11:43 AM, in an interview with the administrator, the administrator stated that she had " [redacted] refused " to accept Resident #10 back into the facility. The administrator stated that she refused to accept Resident #10 back until law enforcement could provide a [redacted] evaluation. On [redacted] at 11:43 AM, in a continued interview with the administrator, the administrator stated she had not provided Resident #10 or her family with a written discharge notice. During this interview the administrator stated that Resident #10 was taken to the hospital on [redacted] due to the [redacted] discharge.

On [redacted] at 9:53 AM, in an interview with Resident #10, Resident #10 stated she had not made any comments about wanting to harm herself or anyone else. Resident #10 stated she did not have any prior behavioral issues at the facility and stated the facility did not give her a 45 day notice of relocation or termination.

On [redacted], in a record review of the facility discharge log, Resident #10 was listed as discharged on [redacted] to the local medical treatment facility. On [redacted], in a record review of Resident #10 ' s file, the file did not contain any notices of discharge. The file did not document any incidents of Resident #10 being a threat to herself or others.

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On at 11:14 a.m. an interview was conducted with Resident #10's daughter. Resident #10's daughter confirmed the facility did not provider her with 45 day notice of relocation or termination prior to refusing to accept Resident #10 back into the facility. She further stated she had to pick Resident #10 up form the police station as Resident #10 did no have a place to go after being discharged from the facility.

Class II

0077 Staffing Standards - Administrators

Based on interviews and record review, the facility administrator failed to maintain facility appropriate staffing standards and training for 3 of 3 employee reviewed (the administrator, Staff C and Staff E), failed to report an allegation of resident to authorities for investigation as well as file a one day Adverse Incident report to the Agency for Health Care Administration (Agency) for 1 of 18 (Resident #10) sampled residents. The administrator also failed to provided 1 of 18 sampled residents with a 45 day notice of discharge or termination prior to discharging the resident (Resident #10). This left residents of the facility at continued risk of .

Findings include:

1. On , a record review was conducted on the administrator's personnel file. The review of the file revealed the administrator was hired on / / . The file did not contain the following items: the administrator's high school diploma or equivalent, a job description, copy of her four (4) hours of training to assist residents with the self administration of medication or documentation from a health care provider stating she was free from ( ).

On at 3:54 PM, in an interview with the administrator she stated that she was unable to locate her high school diploma. The administrator stated it would take several months to obtain it from her home country of the Philippines. The administrator admitted she had not made any attempts to try and get a copy. On at 3:54 PM, in a continued interview with the administrator, the administrator stated that she was not aware that she needed to have a job application or references in her file. In a continued interview with the administrator, she stated she was unable to locate the statement that she was free of communicable and had her annual ( ) test. She further stated that she provides residents assistance with the self-administration of medication. she confirmed she is not a licensed nurse in the State of Florida. The administrator, when asked, was unable to provide a copy of having completed training to provide assistance with the self-administration of medication.

A review of staff E's record revealed staff E did not have the following: a job description, /

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training, training, training for reporting major incidents, training on the facility's emergency procedures, resident rights, control, resident behavior and needs and assistance with activities of daily living.

On at 3:54 PM the administrator was interviewed. The administrator was asked to provide the job description for staff E. The administrator stated she was unable to provide this document. She was asked to could provide the following missing training documentation for staff E: / training, training, reporting major incidents, facility emergency procedures, resident rights, control, resident behavior and needs and assistance with activities of daily living. The administrator stated that she could not provide this information.

A review of staff C's record revealed the following training documentation was not included in the record: / training, training, reporting major incidents, facility emergency procedures, resident rights and recognizing and reporting resident , neglect and .

On at 3:54 PM the administrator was interviewed. She was asked to provide the following missing training documentation for staff AC: / training, training, reporting major incidents, facility emergency procedures, resident rights and recognizing and reporting resident , neglect and . The administrator stated that she could not provide this information.

2. On at 11:34 AM, the administrator was interviewed. She asked about the time line for the alleged assault of Resident #10. The administrator stated Resident #10 came to speak with her at 4:00 PM on . The administrator stated that Resident #10 told her Resident #11 came into her 2:00 AM and 4:00 AM and assaulted her. The administrator stated that on Resident #10 came to her complaining of a discharge. The administrator was asked what action she took after the Resident #10 reported she had a discharge. She stated she took no action. She then stated she transported Resident #10 to the hospital on at the request of Resident #10's daughter. In a continued interview the administrator stated that she filed the adverse incident with the agency on (six days after becoming aware of the incident and four days after an investigation was initiated by law enforcement). At 3:54 PM on the same day, the administrator stated she understood about reporting an adverse incident within 24 hours. The administrator could not provide a reason for not reporting the incident and leaving the residents at risk. The administrator could not state why she failed to contact law enforcement about the assault.

A review of the facility's policy and procedure for reporting Incidents and Filing of an Adverse Incident Report revealed the facility defined an incident as, "any accident injury, skin treat resident altercation,

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medication error, (suspected actual) or unusual circumstance of change. Further review of this policy and procedure revealed the facility included events reported to law enforcement as Adverse Incidents. The policy and procedure further states, "Training and review of Policy and Procedures will be done to prevent further incidents and improve safety and care at the ALF." "Training on Reporting and Identifying , Neglect and will be done on staff during initial training and annually thereafter. Completed training documents will be maintained on file in the facility."

On in a record review of the adverse incident provided by the facility was signed by the facility administrator on and date stamped on . The cover sheet of the adverse incident report indicated that the adverse incident was Resident #10 having discharge.

A review of local police report confirmed the police responded to the facility on to investigate the alleged assault (after they were notified by a third party).

3. On at 9:30 AM, in an interview with a detective from local law enforcement, the detective stated that the facility refused to accept Resident #10 back into the facility after the facility dropped Resident #10 off at the hospital. The detective further stated the facility refused to provide Resident #10's medication and that two uniformed officers had to be sent to the facility to retrieve Resident #10's medication.

On at 11:34 AM, the administrator was interviewed, the administrator stated she had not provided a written 45 day discharge to Resident #10 or the family of Resident #10. At 3:54 PM of the same day, the administrator was interviewed. She stated that when she was contacted by local law enforcement she refused to accept Resident #10 back to the facility until local law enforcement provided a copy of a evaluation.

On a record review of the discharge log, the log indicated that Resident #10 was discharged to the hospital on .

Class II

0078 Staffing Standards - Staff

Based on interviews and record reviews the facility failed to obtain a written statement from a health care provider showing the staff was free from communicable for 2 of 3 staff (administrator and staff C). The facility failed to obtain a written statement that staff was free from ( ) for 2 of 3

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staff (administrator and staff C). The facility failed to provide a written job description for 2 of 3 staff (administrator and staff E).

Findings include:

On . A record review of the administrator's personnel file revealed she was hired on /// . Further review of the administrator's record review of the administrator's personnel file, it failed to contain a written statement showing that the administrator was free from communicable and a written statement that the administrator was free from ( ). In a continued record review of the administrators personnel file, it failed to contain a written job description.

On . A review of staff C's personnel file revealed she applied for employment on . On . in a record review of staff C personnel file, it failed to contain a written statement showing that staff C was free from communicable and a written statement that staff C was free from .

On . A record review of staff E's personnel file revealed she was hired on . On in a record review of staff E personnel file, it failed to contain a written job description.

On . at 3:54 PM, in an interview with the administrator, the administrator stated that she was unable to provide a written statement from a health care provider showing that she was free from communicable or a written statement that the administrator was free from . In a continued interview the administrator stated that she was unable to provide a written job description for her position. The administrator further stated that she was unable to provide a written job description for staff E.

On the new facility administator was interviewed. She stated Staff C's was hired on /// .
Class III

0081 Training - Staff In-Service

Based on record review and interviews the facility failed to provide in-service training regarding reporting major incidents, facility emergency procedures, resident rights, for 2 of 3 staff (C and E). The facility failed to provide in-service training for recognizing and reporting resident , neglect and , control, resident behavior and needs and providing assistance with activities of daily living and for 1 of 3 staff (staff E).

Findings include:

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On a record review of staff C's personnel record revealed staff C applied for employment on . Staff C's file does not indicate an actual hire date. The following in-service training items were missing from staff C's file: reporting major incidents, facility emergency procedures, resident rights and recognizing and reporting resident , neglect and .

On at 3:54 PM in an interview with the administrator, the administrator was provided with the list of missing items and asked to provide a copy. The administrator stated that she was unable to provide a copy of the missing items for staff C.

On the new facility administrator was interviewed. She stated Staff C's was hired on .

On in a record review of staff E's personnel record, staff E was hired on . Staff E 's record does not include the following in-service trainings: reporting major incidents, facility emergency procedures, resident rights, recognizing and reporting , neglect and , control, resident behavior and needs and assistance with activities of daily living.

On at 3:54 PM, in a continued interview with the administrator, the administrator was provided with the list of missing in-service items for staff E. The administrator stated that she could not provide the missing items for staff E.

On a record review was conducted of the directed plan of corrective action (DPOC) which was provided to the facility on . The DPOC required by , to train all staff on the recognition of , neglect and .

On a continued record review was conducted on the directed plan of corrective action (DPOC) which was provided to the facility on . The DPOC required by , to develop a policy and procedure to address staff reporting incidents in the facility. The DPOC required that the policy and procedure shall include a designee to report adverse incidents to the agency. The DPOC required all employees be trained on the aforementioned policy regarding reporting adverse incidents.

Class III

0082 Training - /

Based on record review and interviews the facility failed to provide / training for 2 of 3 staff (staff C and staff E).

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Findings include:

On . . in a record review of staff C's personnel file, it indicates that staff C applied for employment on . The facility was unable to provide a start date.

On . , in a record review of staff C's personnel file, staff C's file did not include documentation that staff C had completed training regarding / .

On . . at 4:31 PM the new administrator was hired. She stated Staff C was hired on / .

On . . in a record review of staff E's personnel file, it indicates that staff E was hired on .

On . . , in a record review of staff E's personnel file, staff E's file did not include documentation that staff E had completed training regarding / .

On . . in an interview at 3:54 PM with the administrator, the administrator was provided the opportunity to show documentation of the / training for staff C and E. The administrator stated that she was unable to provide that documentation.

Class III

0084 Trainina - Assis Self-Admin Meds & Med Mamt

Based on interviews and record review, the facility failed to ensure that 1 of 3 sampled staff (administrator) had been properly trained prior to providing assistance with self-administration of medications.
Findings include;
On during a record review of the administrator 's file, there was no documentation indicating that the administrator had completed her training for assistance with self-administration of medication.
Additional review of the file revealed that she had was hired on / / .
On at 3:54 PM, during an interview with the administrator, the administrator stated that she does provide assistance with the self-administration of medication. The administrator stated that she is not a registered nurse in the State of Florida. The administrator was unable to provide a copy of having completed training to provide assistance with the self-administration of medication.
Class III

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0090 Training -

Based on record review and interviews the facility failed to provide documentation that 2 of 3 staff (staff C and E) completed the necessary training related to the facilities policies regarding

Findings include:
On , in a record review of staff C's personnel file, staff C's personnel file did not include documentation that staff C had completed a review of the procedures for for the facility. Staff C's personnel file indicates that she applied for employment on . The facility was unable to provide a start date.

On , in a record review of staff E's personnel file, staff E's personnel file did not include documentation that staff E had completed a review of the procedures for for the facility. Staff E's personnel record indicates a start date of .

On , at 3:54 PM in an interview with the administrator, the administrator was provided the opportunity to provide the documentation of staff C and E having completed the training regarding the facility procedures regarding . The administrator stated that she did not have the documentation.

On at 4:31 PM the new administrator was interviewed. The new administrator stated staff C was hired on /

Class III

0091 Training - Documentation & Monitoring

Based on record review and interviews the facility failed to documentation for trainings that included the title of the training, subject matter, agenda, hours, trainers name with a trainer's signature for 1 of 3 staff (staff E).

Findings include:

On a record review of staff E's personnel file revealed the file to include training certificates for the following items: /, elopement, emergency preparedness and evacuation training, incident report training, resident rights training, recognizing and reporting , neglect and and training. The certificates did not include an agenda, the number of hours of the training and

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signature.

On . . . at 3:54 PM, in an interview with the administrator, the administrator reviewed the certificates that were in question. The administrator stated that the trainings were signed by a former employee who signed them in error. The administrator admitted that the instructor was not CORE trained. The administrator could not provide an explanation as to why this happened.

Class III

0125 Fiscal - Suretv Bonds

Based on interviews and record review, the facility failed to maintain a surety bond for 5 of 5 residents (Resident #4, #5, #8, #14 and #18), whom the facility is serving as direct payee for social security benefits.

Findings include:

On . . . at 11:43 AM, in an interview with the administrator, she stated that the facility was the direct payee for social security benefits for 5 residents (Resident #4, #5, #8, #14, and #18).

On . . . at 11:43 AM, in a continued interview with the administrator, she stated that the facility did not have a surety bond in place. When asked why, the administrator stated that, "We have not gotten around to it. "

On , in a record review, the facility was able to provide documentation that they were the direct payee for Residents #4, #14 and #18. While reviewing the records, the administrator stated that they had misplaced the records for Resident #5 and #8.

Class III

0160 Records - Facilitv

Based on record review and interviews the facility failed to maintain an up-to-date admission and discharge log.

Findings include:

On . . . at 10:25 AM, in an interview with staff A, she stated that the current facility census is 31

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residents.

On a record review of the census provided by staff A confirmed that the facility had 31 residents listed.

On in a record review, staff A provided a copy of the current facility admission and discharge log. The admission and discharge log shows that the facility has over 80 residents. The review of the admission and discharge log has a number of residents listed more than one time with different admission dates but no discharge dates.

On at 5:08 PM, in an interview with the administrator, the administrator stated that she could not provide any explanation of why the discharge log did not match the census.

Class III

0165 Risk Mgmt & QA: Adverse Incident Report

Based on record review and interviews the facility failed to file the required adverse incident report to the agency for an alleged assault involving two residents (Resident #10 and #11) reported to law enforcement for investigation, within one day business day.

Findings include:

On in an interview at 9:30 AM with local law enforcement, it was confirmed that local law enforcement was investigating an alleged assault at the facility. The Detective from local law enforcement indicated that law enforcement received the information from the local medical facility when Resident #10 disclosed the incident.

On at 9:30 AM, in a continued interview with local law enforcement, the Detective stated that the incident is alleged to have occurred between the hours of 2:00 AM and 4:00 AM on at the facility. The Detective from local law enforcement stated that he made contact with the facility on the evening of regarding the alleged assault.

On at 11:43 AM in an interview with the administrator, the administrator stated that Resident #10 reported the alleged assault the afternoon of .

On at 11:43 AM in a continued interview with the administrator, the administrator stated that she had filed the adverse incident report with AHCA on . When asked, the administrator could not

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NAME OF PROVIDER OR SUPPLIER **HENDERSON HOUSE**	STREET ADDRESS, CITY, STATE, ZIP CODE **907 E. ORANGE AVENUE** **EUSTIS, FL 32726**	

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

provide an explanation about the delay.

On in a record review the facility was requested to provide a copy of the adverse incident report which was submitted to the Agency regarding the alleged assault. The facility provided an adverse incident report which was signed by the administrator on , date stamped on . The cover sheet of the adverse incident report indicated that the adverse incident was the resident having discharge.

Class III