STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965330	08/26/2015
NAME OF PROVIDER OR SUPPLIER **ARCADIA OAKS ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **1013 EAST GIBSON STREET** **ARCADIA, FL 34266**	

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

0000 Initial Comments

An unannounced complaint survey, CCR #2015006847 was conducted / at Arcadia Oaks Assisted Living, an assisted living facility in Arcadia, Florida.

The complaint contained 2 allegations, of which 2 were substantiated

The following is description of the deficiencies.

0025 Resident Care - Supervision

Based on record review, observation, and interview, the facility failed to provide appropriate supervision to keep residents safe for 1 (Resident #10) of 3 residents reviewed. The facility failed to maintain an updated written record for 1 (Resident #11) of 3 residents reviewed who had a change resulting in the provision of additional services. The facility failed to contact the resident's health care provider concerning hospitalization for 3 (Residents #10, #11, and #12) of 3 residents reviewed. Resident #10 was involved in a resident-to-resident altercation with Resident #12. Facility staff who was present at the beginning of the altercation exited the area, which allowed for Resident #12 to strike Resident #10. This resulted in Resident #10 being transported by emergency medical service ( ) to the hospital. The failure of staff to separate the residents and keep them safe resulted in direct harm.

The findings included:

1. Record review revealed Resident #10 was admitted to the facility on . The record review found no completed health assessment.
An "incident/accident report" dated / documented Resident #10 lost his balance and backward and on the floor. This followed an altercation with Resident #12. Resident #10 was transported to the hospital by . The incident/accident report did not document the physician was notified.
A "Resident Communication Log" completed by staff on reported Resident #10 and Resident #12 were having a verbal confrontation. Resident #10 shoved Resident #12. Resident #12 shoved Resident #10. Resident #10 "had been threatening Resident #12." The log did not identify any steps taken by this staff person to intervene and protect the residents. Resident #12 struck Resident #10. Under the section "Action," it noted the Administrator and a second staff person ran into the dining area to separate the residents. Resident #10 to the floor.
On at 2:30 p.m., the Administrator said there was a staff person in the dining the time of the incident. This staff person observed Resident #10 and Resident #12 in an altercation. She left the dining get help. By the time help got back to the dining , Resident #12 had struck Resident #10. The Administrator said the staff person did the right thing in leaving the resident in the middle of

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the altercation to come and get her.

On at 2:46 p.m. the video of the incident was observed. In the video, Resident #10 and Resident #12 were standing at a table facing each other. The video did not have an audio. A staff person walked across the dining stand between Resident #10 and Resident #12. After a few seconds she moved from being between the residents to standing to the side of Resident #12. This staff person was not observed trying to move either of the residents away from the area of conflict. After a few seconds in that position, the staff person left the area to go into the kitchen. The Administrator and a second staff person were observed rushing from the kitchen into the dining . Just before they reached the table where Resident #12 and Resident #10 were standing, Resident #12 struck Resident #10 several times. Resident #10 staggered backwards. He was caught by staff. Resident #10 then collapsed to the floor.

Review of hospital Discharge Summary for admit of included "The patient got into a physical altercation with another resident at his living facility. The patient was hit in the jaw, knocked to the ground. Shortly thereafter he was found to have global aphasia [severe ability to communication], right-sided , unable to move the right arm or leg per report. It has persisted. The was given TPA [a clot-dissolving drug] administration... after a day he did have some perfused improvement..." He was discharged to a nursing home.

2. Review of an "Incident/Accident Report" dated revealed Resident #12 came to the front desk with a cut to his head and on his ear. It noted Resident #12 was transferred to the hospital by . There was no written record of what happened. There was no written record of the resident returning to the facility or any orders for treatment upon return. The record had no documentation the resident's health care provider was notified.

Record review for Resident #12 found a physician's order for physical and an order for care dated . The record had a "Home Health Communications" dated identifying care to Resident #12's right ear. There was no written record of the occurrence that required home health treating Resident #12.

In an interview on at 12:38 p.m., the Administrator said that Resident #12 returned from the hospital on . The exact time was unknown. Staff recognized that Resident #12's ear needed to be cared for and requested an order for the care. She could not remember the exact details.

3. Record review for Resident #10 found an incident report dated . It noted the resident was transferred to the hospital (as noted above). The record had no documentation the resident's health care provider was notified.

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4. Record review for Resident #11 found an incident report dated / . It noted the resident was transferred to the hospital. The record had no documentation that the resident's health care provider was notified.
An second incident report dated noted the resident was transferred to the hospital. The record had no documentation the resident's health care provider was notified.

5. On at 12:38 p.m. the Administrator said there was no documentation that Resident #10, #11, or #12's health care provider was notified of their hospitalizations on the related dates.

Class II

0165 Risk Mgmt & QA: Adverse Incident Report

Based on record review, interview, and observation, the facility failed to file the required Adverse Incident Report. During the development of the conflict between Residents #10 and #12 staff were present and could have exercised control by removing one resident from the area or by continuing to separate the residents. Staff leaving the area resulted in a resident being struck resulting in hospitalization.

The findings included:

Resident #10 was admitted to the facility on . An "incident/accident report" dated stated Resident #10 lost his balance and backward and on the floor. This followed an altercation with Resident #12. He was transported to the hospital by . The incident/accident report did not document the physician was notified. A "Resident Communication Log" completed by staff on stated Resident #10 and Resident #12 were having a verbal confrontation. Resident #10 shoved Resident #12. Resident #12 shoved Resident #10. Resident #10 "had been threatening Resident #12." The observation did not identify steps taken by this staff person to intervene and protect the residents. Resident #12 struck Resident #10. Under the section "Action" it noted the Administrator and a second staff person ran into the dining area to separate the residents. Resident #10 to the floor.
On at 2:30 p.m., the Administrator said there was a staff person in the dining the time of the incident. She observed Resident #10 and Resident #12 in an altercation. She left the dining get someone to help. By the time we got back to the dining #12 had struck Resident #10. The Administrator said that the staff person did the right thing in leaving the resident in the middle of the altercation to come and get me.

On at 2:46 p.m., the video of the incident was observed. Resident #10 and Resident #12 were observed standing at a table facing each other. The video did not have an audio. An unidentified staff

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was observed walking across the dining stand between Resident #10 and Resident #12. After a few seconds she moved from being between the residents to standing to the side of Resident #12. This staff person was not observed trying to move one of the residents away from the area of conflict. After a few seconds in that position the unidentified staff was observed leaving the area to go into the kitchen. The Administrator and a second unidentified staff was observed rushing from the kitchen into the dining . Just before they reached the table where Resident #12 and Resident #10 were standing Resident #12 was observed striking Resident #10 several times. Resident #10 was observed staggering backwards. He was caught by staff. Resident #10 was then observed collapsing to the floor.

On / at 12:38 p.m. the Administrator admitted no adverse incident report was completed concerning the altercation concerning Resident #10 and #12. The Administrator said that the incident was not within the facility's control. Resident #10 was just here for a short time; there was no indication he had aggressive behavior.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Arcadia Oaks Assisted Living
1013 East Gibson Street
Arcadia, FL 34266

Dear Administrator:

This letter reports the findings of a complaint survey (CCR# 2015006847) conducted on 26, 2015, by a representative 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 five business days of receipt of this report.

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

St - A - 0025 - 429.26(7) Fs; 58a-5.0182(1) Fac - Resident Care - Supervision 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:

1. The Assisted Living Facility is required to assess all residents in the facility for abnormal behavioral issues, including aggression. These assessments are to be completed within 48 hours by a Registered Nurse or the resident's primary physician. These assessments will be retained in each resident's file and be updated when the resident experiences a significant change. This must be completed no later than , 2015.

2. The Assisted Living Facility is required to assess all new admissions for abnormal behavioral issues, including aggression before admittance to the facility. These assessments will be retained in each resident's file.

3. The Assisted Living Facility is required to provide training within 48 hours to all staff on dealing with persons with and related as well as dealing with persons who exhibit aggressive behaviors. Documentation of this training must be maintained in each employee's file. This must be completed no later than , 2015.

4. The Assisted Living Facility is required to develop policies and procedures on dealing with residents who display behaviors which are disruptive to the safe operation of the facility, including aggression. These policies and procedures will be developed by no later than , 2015. Documentation of these policies and procedures must be maintained in the facility file.

Fort Myers Field Office
2295 Victoria Avenue,
Fort Myers, FL 33901
Phone:(239) 335-1315; Fax:(239) 338-2372
AHCA.MyFlorida.com

5. The Assisted Living Facility is required to train all facility staff on the above developed policies and procedures within 48 hours after they are developed. Documentation of this training must be maintained in each employee's file. This must be completed no later than , 2015. Training on these policies and procedures will also be included in the facility's training for all new employees. Documentation of this training must be maintained in each new employee's file.

6. The Assisted Living Facility is required to provide training within 48 hours to all staff on dealing with emergency situations within the facility, including dealing with residents during such situations. Documentation of this training must be maintained in each employee's file. This must be completed no later than , , 2015.

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 Laura Manville, Survey and Certification Support Branch, at (727) 552-1955.

Sincerely,

Jon Seehawer, R.N.
Field Office Manager

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D7JR