RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Hampton Manor
1500 S.E. 24th Road
Ocala, FL 34471

Dear Administrator:

This letter reports the findings of a complaints, 2015007973 and 2015009537, inspection survey conducted on 5 - 6, 2015, by a representative 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 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
The facility failed to adequately provide care and services to meet the needs of the residents by not assisting or supervising the residents with their assessed activities of daily living (ADLs). Your facility failed to properly assess, monitor, supervise and did not promote care and services appropriate to the needs of the resident accepted to your facility for admission, to do with .

St - A - 0079 - 58a-5.019(3) Fac - Staffing Standards - Levels S-S= G
The facility failed to provide enough qualified staff to provide adequate resident direct care and supervision for the residents.

Directed Corrective Actions:

1. The facility is required to develop a comprehensive policy and procedure that addresses any resident who has been identified by their physician/physician extender to need /accident precautions. This policy and procedure must clearly describe interventions that the facility and its staff will perform to mitigate and prevent any resident's identified /accident risks. The facility must implement this policy, procedure immediately after it is developed, and it must inform and educate all the facility direct care staff with the content of this policy and procedure. The facility must keep written proof that all of the direct care staff have been informed and educated on this policy and procedure. The facility is continuously responsible for all of the direct care staff to remain informed and educated on the content of this policy and procedure, at all times during the staff's employment with the facility. This comprehensive policy and

procedure must include maintenance of a facility-wide and up-to-date log identifying residents with special /accident precautions; the facility staff member(s) responsible to implement and supervise the specialized care and service; and, the duration and frequency of specialized care and service each resident is to receive based on their individual physician/physician extender assessment. This must also, address how staff will be trained about resident use of chair alarms and wheelchairs, including instructions and training of staff on the proper use. In addition, include a curriculum and re-education of staff, on what to do if raining, allowing residents to go out in the rain and providing supervision for residents in the rain. **This requirement must be met by the facility on or before , 2015.**

2. The facility is required to develop a comprehensive policy and procedure for immediately evaluating the care and safety needs of residents suspected to have or have been in an accident and who did not have any visible signs of injury. This post /accident policy and procedure must include that at least one facility licensed nurse be responsible to deliver immediate nursing care and service to the identified resident. It must include how residents are re-evaluated post- , including appropriateness for the resident to remain in the facility. This policy and procedure must include resident-specific interventions that include consideration of, but are not limited to: checks, referrals to a higher level of care, determination of a resident significant change, determination of an adverse event and other resident-specific measures to prevent future similar events. In addition, the procedures must address ongoing documentation, including notifying responsible party for the resident and of notification to the health care provider for the resident. **The facility must meet this requirement on or before , 2015**

3. The facility must have a complete record of each resident in the facility, including an updated complete health assessment for each resident (AHCA form 1823) completed by the resident's health care provider. This should also include all documentation of significant changes in the resident's status. The facility must review every resident's health assessment, documented in an AHCA Form 1823, to ensure it is complete and accurately reflects the resident's condition and the examining physician/physician extender's assessment. The facility must apply the resident assessment/records requirements herein for all residents admitted to the facility. **The facility must meet this requirement on or before , 2015.**

4. The facility must evaluate the current system of communication via telephone with the staff on duty. Based on the evaluation, changes to the system will be implemented for the facility and the staff on duty to answer the telephone with incoming calls. Phone calls should be answered within 5 rings. **The facility must meet this requirement on or before , 2015.**

5. In order for the facility to meet its resident care needs, the facility is required to provide increased direct care staff in both of its units, the memory care unit (MCU) and the standard side of the facility. During the daily daytime and evening shifts, continuously from 7am to 11pm, the

Hampton Manor
, 2015

facility must employ and adequately train two (2) additional direct care staff members and must maintain in the facility at least a total three (3) adequately-trained direct care staff members, not including licensed nurses, for the overnight shift, continuously from 11pm to 7am. The additional number of direct care staff members required herein, is based on the facility's established staffing and resident census during this follow-up inspection. The facility is required to dedicate at least one (1) of the newly-hired and trained direct care staff member for service in the facility's MCU during the 7am to 11pm shifts. **This requirement must be met by the facility immediately upon receipt of this DPOC.**

6. For the remainder of the facility's current licensure period, the facility must remain responsible to commensurately increase the staffing load herein, based on an increased census or increased resident care needs, relative to the facility census during this follow-up inspection of 60 residents and its 60 licensed beds capacity. The facility must also notify the Agency in writing of any staffing decrease, which must only be based on commensurate decrease in census for the remaining licensure period. **This requirement must be met by the facility immediately upon receipt of this DPOC.**

7. All the mandated training herein is deemed as supplemental and shall not circumvent any required training or continuing education originally needed to maintain the assisted living facility's State of Florida licensure. **This requirement must be met by the facility immediately upon receipt of this DPOC.**

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 Kriste Mennella at (386) 462-6201.

Sincerely,

Kriste J. Mennella
Field Office Manager

KJM/kf
Enclosure

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

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

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964374	10/06/2015
NAME OF PROVIDER OR SUPPLIER **HAMPTON MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **1500 S.E. 24TH ROAD** **OCALA, FL 34471**	

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

0000 Initial Comments

On , 2015 through , 2015 a complaint survey (CCR #2015007973 & 2015009537) was conducted at Hampton Manor Assisted Living Facility in Ocala, FL. Deficient practice was identified at the time of this survey.

0025 Resident Care - Supervision

Based on observations, interviews and record reviews the facility failed to daily observe residents for activities, safety, and physical well-being for 6 of 11 residents reviewed (#1, 3, 6, 7, 8, & 10).

Findings:

On at approximately 10:45 AM resident #1 was observed to be walking around the facility independently without a walker. She had on the left side of her face and chin.

A record review was conducted on resident #1. An incident report dated states at 2:30 PM the resident was found in the hallway yelling with a large amount of on the floor and from the nose. Her 1823 health assessment dated states her special precautions are precautions. Resident #1 had a physicians order dated which states: patient needs walker for mobility, rolling walker with seat will help with balance and mobility.

On at approximately 10:28 AM an interview was conducted with nurse H in reference to resident #1 being observed all day on not using her walker for assistance during ambulation. He stated yes resident #1 is supposed to use her walker when ambulating. She needs constant reminders to use her walker but she refuses.

On at approximately 11:22 AM an interview was conducted with family member C of resident #3. C stated her mother was given a chair alarm by hospice and she has got to constantly remind staff to put it on her mothers wheelchair. It was observed that the chair alarm was not on the wheelchair of resident #3 during this interview.

On at approximately 1:50 PM an interview was conducted with with family member L in reference to her mother, resident #3. She stated her mom in her 2014 and broke both her knee caps. She stated when her mother in her had to call her on the phone from her 7:00 PM because she was on the floor and needed help. L stated she immediately called the facility to inform them her mother needed assistance because she in her , but L could not get a hold of any one at the facility. L stated she arrived at the facility at 7:30 PM and found her mother

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sitting on the floor. When she attempted to move her she cried out in pain and emergency personnel were called to take her to the hospital. L stated she called 5 different numbers for the facility before she arrived and could not get a hold of anyone.

On at approximately 12:45 PM it was observed that resident #6 who is in a wheelchair was asking for help to use the she did not know where to find staff or her . The only available staff were in the dining up after the noon meal and had to be advised of resident #6 need for assistance. It was further observed that resident #7 who is in a wheelchair was pushed out of the dining area into a common area and left while the resident aide went and assisted resident #6. Resident #7 was observed to sit in the common area for more then 10 minutes with food stuff on her face and hands before being taken to be cleaned-up by staff.

On at approximately 1:02 PM resident #8 was observed in the back hallway removing the couch cushions from the couch and trying to place them on another couch. No staff were observed in the area. The resident was observed to have a scab on each knee and a scab on her chin. She was ambulating independently at the time of the observation.

A record review of resident #8 was conducted. An incident report dated revealed the resident was found in the courtyard face down on the sidewalk at 12:30 PM. Resident #8's 1823 health assessment dated states her special precautions is prone to falling unless assisted and supervised.

On at approximately 1:22 PM these observations were shared with the Administrator. The Administrator stated she could use 1 designated server to clean-up the dining area while resident aides assisted residents with their needs.

On at approximately 1:37 PM an interview was conducted with family member K in the dining area. K is the wife to resident #10 who ambulates in a wheelchair. She stated this past Labor Day her husband was found outside in the court yard lying on the ground soaking wet from the rain at 4:30 PM and they did not notify her until 6:50 PM that evening. K said there is not enough staff around to supervise these residents.

On at approximately 1:37 PM during the interview with K it was observed that there were 10 memory residents in the dining area and no staff members were present. It was observed that resident #1 was ambulating without a walker and got into a small altercation with resident #9. The two residents were yelling and slapping each other on the arms. K interceded and separated the two residents before they harmed themselves.

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On at approximately 4:25 PM an interview was conducted with the Administrator regarding resident #10 being found outside in the courtyard lying on the ground getting soaking wet in the rain. The Administrator stated it did happen and an incident report was done the same day. He was found outside as described and he was observed by the facility nurse M who called his hospice nurse to have him assessed. She did not know why he was outside in the rain, but they have installed locks on the door and staff is suppose to lock them when it starts raining.

On at approximately 9:55 AM an interview was conducted with the Administrator in reference to resident #8 and the special precautions listed on her 1823 health assessment. The Administrator stated resident #8 uses a walker and needs constant reminders to use it. The Administrator was advised that resident was observed on throughout the day ambulating without a walker, and she stated that was true.

In conclusion this survey was conducted over a two day time period and even though the facility met the minimum staffing hours, there were several observations made during the survey where memory residents were not adequately supervised. Record reviews also show a pattern of inadequate supervision of residents who have . The facility is laid out in a square pattern with four hallways and a large out door courtyard in the center. Residents walk these hallways and courtyard unsupervised which has allowed for unobserved to occur as described.

Class II

0079 Staffing Standards - Levels

Based on observations, interviews and record reviews the facility failed to have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents ' scheduled and unscheduled service needs, resident contracts, and resident care. Nor are there enough staff to daily observe residents for activities, safety, and physical well-being for 6 of 11 residents reviewed (#1, 3, 6, 7, 8, & 10).

Findings:

On at approximately 10:45 AM resident #1 was observed to be walking around the facility independently without a walker. She had on the left side of her face and chin.

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