STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967955	07/08/2016
NAME OF PROVIDER OR SUPPLIER **GRACE MANOR ASSISTED LIVING AND MEMORY CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1321 HERBERT ST** **PORT ORANGE, FL 32129**	

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

0000 Initial Comments

An unannounced complaint survey (CCR#2016003496) was conducted at Grace Manor Assisted Living (License #11955) on & . Grace Manor assisted Living had deficiencies at the time of survey.

0010 Admissions - Continued Residencv

Based on observation, record review, and interview, the facility failed to ensure that 1 of 4 sampled residents was appropriate for continued residency (Resident #5). The Administrator failed to assess the appropriateness of Resident #5 ' s residency after he exhibited a significant change by having several instances of inappropriate behavior with female residents in the facility. This lead to the assault of 3 residents (Resident #6, #7, &#9) and placed all 47 female residents in the facility at risk.

The findings include:

1) A review of the admission and discharge log revealed that Resident #5 was admitted to the facility on / . A review of Resident #5 ' s record revealed a Resident Health Assessment (1823) dated . The date on the 1823 appeared to be altered. The 1823 physician signature page was signed by a medical doctor (MD). The rest of the 1823 was filled out in the same handwriting as observed on the last page of the 1823, where the Administrator signed and listed services being provided to Resident #5. The 1823 listed Resident #5 has having with behavioral disturbances and his status listed him as calm. The resident was assessed as not being a danger to self or others, as well as assessing that his needs could be met in an assisted living facility.
In an interview with the Administrator on at 6:55 PM, she reported that she had filled out the 1823 herself, since she did not get one from his previous placement. She acknowledged that the date on the 1823 was altered, but could not identify who altered the date. The Administrator could not give a date, when the resident was assessed by a health care provider. The Resident Health Assessment is to be completed by a health care provider and used as part of the resident ' s assessment to ensure their needs can be met in an Assisted Living Facility.

An interview was conducted with a private duty aid for Resident #8 on at 4:45 PM. She reported that Resident #5 would wander in resident and had a history of being inappropriate. She reported that there were current accusations of Resident #5 having relations with two current residents. She reported that she did not have any other information regarding the allegations.

In an interview with the Assistant Health and Wellness Director (AHWD) on / at 5:04 PM, she reported that residents had complained about Resident #5 and that she reported those concerns to the

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Administrator. When asked what residents had complained about she stated " inappropriate comments " and then reported that Resident #5 had been given a 45 days notice for the inappropriate comments.

In an interview with the Administrator on at 5:21 PM, she stated that Resident #5 was admitted from another Assisted Living Facility. She stated that the other facility reported that Resident #5 was " touchy feely " with staff but not with other residents. She reported that she had received concerns from residents regarding Resident #5. When asked what the concerns were, she stated that he would verbalize " I am a young man and I have needs. What am I supposed to do?" She confirmed she mailed Resident #5 ' s sister a 45 day notice on , due to Resident #5 ' s inappropriate language. She reported that she had no knowledge of any inappropriate contact between Resident #5 and other residents in the facility.

In a telephone interview with the Administrator of Resident #5 ' s previous Assisted Living Facility on at 12:20 PM, he reported that Resident #5 had been a resident at his facility. He reported that Resident #5 had consensual with another resident at the facility and had exposed himself to another resident. He reported that they had to increase his supervision.

In a follow up interview with the AHWD on at 11:34 AM, she stated that Employee E had come to her and reported that she had walked by Resident #5 ' s ' overheard the resident stating " I have a resident in my " . Resident #7 was found by Employee E laying in Resident #5 ' s bed, with her clothes off from the waist down. The AHWD reported that they did not investigate this event, nor did they notify Resident #7 ' s family or physician.

Resident #5 ' s chart also revealed an Advanced Registered Nurse Practitioner (ARNP) note dated . The ARNP note read that " Patient (Resident #5)was found in naked woman (Resident #7), in bed " . The note also listed Resident #5 as having " ' addiction " . There were no other notes in the resident ' s file that reflected the date of the event.

A phone interview was conducted with Resident #5 ' s ARNP on at 11:44 AM. She reported that on she came to the facility. She reported that a nurse at the facility had informed her that Resident #5 was found with Resident #7. She then stated that she went to the AHWD and that the AHWD stated the incident had been reported. The ARNP stated that she told the AHWD that she needed to inform the families for Resident #5 & #7. When asked about Resident #5 ' s diagnosis of " addict " , she reported she could not recall why he had that diagnosis, but confirmed that diagnosis was on her notes from .

In an interview with Resident #7 on at 5:15 PM, she reported that a male resident came into her . When asked if she gave him permission to come into her , she stated that he would just

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come in. When asked if Resident #5 had ever touched her, she states yes and then moved her hand over her and stated that Resident #5 would put his tongue in her mouth. Resident #7 reported that Resident #5 kept asking her to have with him. " He would take my clothes off and ask me to touch him. " Resident #7 then reported that Resident #5 " just took me " . She said he laid on top of her with her clothes off, and staff interrupted by knocking on the door. Resident #7 reported it was " terrible " .

In a follow interview with Administrator on at 12:41 PM, she then confirmed she had knowledge of Resident #7 being found naked with Resident #5. She reported that she became aware of Resident #7 being naked in Resident #5 ' s , the day after the event. She could not recall the actual date of the occurrence, and admitted there was no documentation to show that the event occurred. She stated that she did not report the incident. She confirmed she did not have any investigation or documentation for Resident #5 or Resident #7.

In an interview with Resident #5 ' s physician on at 3:50 PM, he stated he first saw Resident #5 a month after he moved in. He stated that on his visit to the facility, he was told by the facility that Resident #5 had taken a female resident and attempted to have intercourse with her. The physician stated that he informed the AWHD that Resident #5 needed a , evaluation and close monitoring. He was confirmed he was never made aware of any other incidents regarding Resident #5.

2) An interview was conducted with Resident #9 on at 5:30 PM. She reported that Resident #5 lived right by her when he moved in, in 2016. She reported that one day Resident #5 had come into her began touching her arm. She reported Resident #5 then started touching her right and put his hand down her shirt and started looking down her robe. Resident #9 stated that Resident #5 grabbed his crotch and asked if she wanted it. She told Resident #5 no and to get out. Resident #5 responded " think about it, and let me know " . She reported that she informed Employee E, who stated that it " shouldn ' t happen and I ' ll let someone know " .

In an interview with Employee E on at 5:56 PM, she reported that Resident #9 had reported to her that Resident #5 had come into her touched her and looked down her shirt. She reported that she informed the AHWD of the allegation of .

A review of Resident #5 ' s and Resident #9 ' s file revealed no documentation of the event.

In an interview with Resident #9 ' s daughter-in-law on at 5:45 PM, she reported that Resident #5 had been at the facility for about 3 weeks before he started entering her mother-in-law ' s . She reported that Resident #9 reported to her that Resident #5 had touched her . She reported that

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her husband (Resident #9 ' s son) had informed the facility about the event. The daughter-in-law reported that she had purchased a whistle for Resident #9, to blow for her safety. She was told that Resident #5 had been moved, so they had no more concerns.

In an interview with the Administrator and the AHWD on at 6 PM, they both denied knowledge of Resident #5 being inappropriate with Resident #9. They both reported that Resident #5 was moved on occurred because of financial reasons and not due to any behavioral events.

#3) A second review if Resident #5 ' s chart revealed a note dated , written by the AHWD. The note read that she heard a female resident yelling " get out " on the 300 hall. The note then read that Resident #5 was found in Resident #6 ' s . Resident #6 was reported as watching television and that there was no evidence of " contact or inappropriate behavior " . The note went on to read that the sister for Resident #5 was contacted and told she needed to pick him up because his " behavior was alarming " . There is documentation that Resident #6 ' s family was notified. There was no documentation that either resident was undressed.

An interview with Employee D was conducted on at 7 PM. She reported that she had concerns regarding Resident #5. She reported that she had witnessed two separate events in which Resident #5 was kissing on Resident #6. She reported that she had immediately informed the AHWD. Employee D reported that the AHWD told her she would " take care of it " . She reported that the Administrator had a meeting with the staff the week of in which the Administrator instructed staff to lock residents ' doors to prevent Resident #5 from being allowed to enter. Employee D reported that she was concerned about Resident #5, before he was admitted due to his history. Employee D reported that the Administrator was aware of past inappropriate behaviors that Resident #5 exhibited.

In an interview with Employee E on at 7:57 PM, she reported that she found Resident #5 in Resident #6 ' s . Employee E stated that Resident #5 was found naked in bed with Resident #6, who was naked from the waist down. Employee E stated that when she asked Resident #5 what he was doing, he reported " I am a man and I have needs " . Employee E then stated that she went and told the AHWD about the event. She reported that the AHWD completes all documentation for allegations.

In an interview with the AHWD on at 10:25 AM, she reported that Employee E came to her on and reported that the employee heard yelling and that Resident #5 was found in Resident #6 ' s ! Resident #5 was taking his pants down. She reported that she went to go talk to Resident #5, he did not directly answer her questions. The AHWD stated that she had informed the Administrator of the event, on . She reported that she had not informed either resident ' s physician or family. When asked why the note, written by her and dated , did not mention Resident #5 being naked

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or removing his pants, she stated she did not put that information in the notes due to confidentiality. She confirmed there was no other documentation regarding this event. She reported that Resident #5 ' s sister came to pick him up on and did not recall the date that he came back to the facility but reported it was the beginning of 2016. She confirmed that Resident #5 did not have any increased supervision when he came back to the facility. She reported that staff were informed to lock residents ' doors so that Resident #5 could not go into the . She confirmed that residents were locked in their reported that some residents could unlock their doors, while others were not capable.

In an interview with the Administrator on at 12:41 PM, she reported that she was made aware of the event between Resident #5 & #6 on / . She reported that the AHWD reported that Resident #5 was found with his clothes off. She reported that she did not report this event because there was no real evidence that there was contact. She reported that she did have a meeting with staff and told them to lock resident ' s to prohibit Resident #5 from walking into the .

A review of Resident #5 ' s chart revealed no record of the facility obtaining a new 1823 after he exhibited a significant change of reported behavior. The record revealed no documentation that the facility obtained a evaluation as requested by Resident #5 ' s physician. The record showed no indication that Resident #5 was reviewed or re-evaluated for continued residency upon exhibition of behavior.

In an interview with Resident #5 ' s sister on at 3:52 PM, she reported that when Resident #5 first moved back in with her in 2015, she reported that he had behaviors. She reported he would go up and down the street and asking people for . She reported that he was diagnosed with with . She reported that events started to " blow up " at the facility the last few weeks. She reported that the facility called her on to come pick up her brother. She reported that the facility had told her there were 2 incidents where he was caught with one female resident with her pants down and he was on top of her naked. The second incident occurred when he was found with a second female resident, which is why she went to pick him up. Resident #5 ' s sister also reported that she was made aware of two other incidents where he was found hugging and kissing two female residents.

In an interview with Resident #5 on at 6:45 PM, he reported that the staff keep him caged up because they think he ' s a " ' predator. " He reported that the facility was full of women and that they all loved him and wanted to be with him. When asked if he ' s ever touched another female resident he reported " sure. I kiss them and I touch them " . He reported that he had kissed and touched Resident #6 & #7. He reported that there are only 4 male residents here, and that he had " needs " .

A review of the 45 day notice for Resident #5 revealed a date of . The letter read " (Resident #5) no longer meets criteria to remain in our Assisted Living Facility. His inability to control his urges

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and puts other residents at risk. If he returns to the facility he will need 24 hour sitter with him so that he is unable to approach our female residents.
Class I

0025 Resident Care - Supervision

Based on observation, record review, and interview, the facility failed to provide appropriate personal supervision for 1 of 5 sampled residents (Resident #5). By failing to provide appropriate supervision to Resident #5 after he exhibited inappropriate behaviors, the facility placed all female residents at the facility at risk of including Residents #6, #7, & #9 who reported that Resident #5 made advances and contact with them.

The findings include:

1) A review of the admission and discharge log revealed that Resident #5 was admitted to the facility on . A review of Resident #5 ' s record revealed a Resident Health Assessment (1823) dated . The date on the 1823 appeared to be altered. The 1823 physician signature page was signed by a medical doctor (MD). The rest of the 1823 was filled out in the same handwriting as observed on the last page of the 1823, where the Administrator signed and listed services being provided to Resident #5. The 1823 listed Resident #5 has having with behavioral disturbances and his status listed him as calm. The resident was assessed as not being a danger to self or others, as well as assessing that his needs could be met in an assisted living facility. His assessment listed Resident #5 as independent with all activities of daily living.

In an interview with the Administrator on at 6:55 PM, she reported that she had filled out the 1823, since she did not get one from his previous placement. She acknowledged that the date on the 1823 was altered, but could not identify who altered the date. The Administrator could not give a date, when the resident was assessed by a health care provider.

Resident #5 ' s chart also revealed an Advanced Registered Nurse Practitioner (ARNP) note dated . The ARNP note read that " Patient (Resident #5 was found in naked woman (Resident #7), in bed " . The note also listed Resident #5 as having " addiction " .

An interview was conducted with a private duty aid for Resident #8 on at 4:45 PM. She reported that Resident #5 would wander in resident and had a history of being inappropriate. She reported that there were current accusations of having relations with two current residents. She reported that she did not have any other knowledge.

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In an interview with the Assistant Health and Wellness Director (AHWD) on at 5:04 PM, she reported that residents had complained about Resident #5 and that she reported those concerns to the Administrator. When asked what residents had complained about she stated " inappropriate comments " and then reported that Resident #5 had been given a 45 days notice for the inappropriate comments "

In an interview with the Administrator on at 5:21 PM, she stated that Resident #5 was admitted from another Assisted Living Facility. She stated that the other facility reported that Resident #5 was " touchy feely " with staff but not with other residents. She reported that she had received concerns from residents regarding Resident #5. When asked what the concerns were, she stated that he would verbalize " I am a young man and I have needs. What am I supposed to do?" She confirmed she mailed Resident #5 ' s sister a 45 day notice on , due to Resident #5 ' s inappropriate language. She reported that she had no knowledge of any inappropriate contact between Resident #5 and other residents in the facility.

In a follow up interview with the AHWD on at 11:34 AM, she stated that Employee E had come to her and reported that she walked by Resident #5 ' s ' overheard the resident stating " I have a resident in my " . Resident #7 was found by Employee E laying the Resident #5 ' s bed, with her clothes off from the waist down. The AHWD reported that they did not investigate this event, nor did they notify Resident #7 ' s family or physician.

In an interview with Resident #7 on at 5:15 PM, she reported that a male resident came into her . When asked if she gave him permission to come into her , she stated that he would just come in. When asked if Resident #5 had ever touched her, she states yes and then moved her hand over her and stated that Resident #5 would put his tongue in her mouth. Resident #7 reported that Resident #5 kept asking her to have with him. He would take my clothes off and ask me to touch him. Resident #7 then reported that Resident #5 " just took me " . She said he laid on top of her with her clothes off, and staff interrupted by knocking on the door. Resident #7 reported it was " terrible " .

An interview was conducted on at 1:15PM with Employee K, who confirmed on multiple occasion she was taking care of Resident #7 when Resident #5 would enter the knocking. She would ask him what he is doing coming in the residents ' he stated " He was there to help her " . The aid would inform him that he couldn ' t be in her he would leave.

A phone interview was conducted with Resident #5 ' s ARNP on at 11:44 AM. She reported that on / she came to the facility. She reported that a nurse at the facility had informed her that Resident #5 was found with Resident #7. She then stated that she went to the AHWD and that the

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AHWD stated the incident had been reported. The ARNP stated that she told the AHWD that she needed to inform the families for Resident #5 & #7. When asked about Resident #5 ' s diagnosis of " addict " , she reported she could not recall why he had that diagnosis, but confirmed that diagnosis was on her notes from .

In a follow interview with Administrator on at 12:41 PM, she then confirmed she had knowledge of Resident #7 being found naked with Resident #5. She reported that she became aware of Resident #7 being naked in Resident #5 ' s , the day after the event. She could not recall the actual date of the occurrence, and admitted there was no documentation to show that the event occurred. She stated that she did not report the incident. She confirmed she did not have any investigation or documentation for Resident #5 or Resident #7.

In an interview with Resident #5 ' s physician on at 3:50 PM, he stated he first saw Resident #5 a month after her moved in. He stated that on his visit to the facility, he was told by the facility that Resident #5 had taken a female resident and attempted to have intercourse with her. The physician stated that he informed the AWHD that Resident #5 needed a , evaluation and close monitoring. He was confirmed he was never made aware of any other incidents regarding Resident #5. Resident #5 ' s file was reviewed and found no evidence that Resident #5 received consultation or increased monitoring, as directed by his physician.

2) An interview was conducted with Resident #9 on at 5:30 PM. She reported that Resident #5 lived right by her when he moved in, in 2016. She reported that one day Resident #5 had come into her began touching her arm. She reported Resident #5 then started touching her right and put his hand down her shirt and started looking down her robe. Resident #9 stated that Resident #5 grabbed his crotch and asked if she wanted it. She told Resident #5 no and to get out. Resident #5 responded " think about it, and let me know " . She reported that she informed Employee E, who stated that it " shouldn ' t happen and I ' ll let someone know " .

In an interview with Resident #9 ' s daughter-in-law on at 5:45 PM, she reported that Resident #5 had been at the facility for about 3 weeks before he started entering my mother-in-law ' s . She reported that Resident #9 reported to her that Resident #5 had touched her . She reported that her husband (Resident #9 ' s son) had informed the facility about the event. The daughter-in-law reported that she had purchased a whistle for Resident #9, to blow for her safety. She was told that Resident #5 had been moved, so they had no more concerns.

In an interview with Employee E on at 5:56 PM, she reported that Resident #9 had reported to her that Resident #5 had come into her touched her and looked down her shirt. She

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reported that she informed the AHWD of the allegation of .

In an interview with the Administrator and the AHWD on at 6 PM, they both denied knowledge of Resident #5 being inappropriate with Resident #9. They both reported that Resident #5 was moved on occurred because of financial reasons and not due to any behavioral events.

#3) A second review if Resident #5 ' s chart revealed a note dated , written by the AHWD. The note read that she heard a female resident yelling " get out " on the 300 hall. The note then read that Resident #5 was found in Resident #6 ' s . Resident #6 was reported as watching television and that there was no evidence of " contact or inappropriate behavior " . The note went on to read that the sister for Resident #5 was contacted and told she needed to pick him up because his " behavior was alarming " . There is documentation that Resident #6 ' s family was notified. There was no documentation that either resident was undressed.

In an interview with Employee D on at 7 PM. She reported that she had concerns regarding Resident #5. She reported that she had witnessed two separate events in which Resident #5 was kissing on Resident #6. She reported that she had immediately informed the AHWD. Employee D reported that the AHWD told her she would " take care of it " . She reported that the Administrator had a meeting with the staff the week of in which the Administrator instructed staff to lock residents ' doors to prevent Resident #5 from being allowed to enter. Employee D reported that she was concerned about Resident #5, before he was admitted due to his history. Employee D reported that the Administrator was aware of past inappropriate behaviors that Resident #5 exhibited.

In an interview with Employee E on at 7:57 PM, she reported that she found Resident #5 was found in Resident #6 ' s . Employee E stated that Resident #5 was found naked in bed with Resident #6, who was naked from the waist down. Employee E stated that when she asked Resident #5 what he was doing, he reported " I am a man and I have needs " . Employee E then stated that she went and told the AHWD about the event. She reported that the AHWD completes all documentation relating to investigations.

A review was conducted of Resident #6 ' s chart revealed that she was admitted to the facility on / . She had an 1823 dated that assessed the resident as requiring assistance with ambulation, dressing, and transferring. Resident #6 ' s 1823 listed her diagnosis as s . There was no documentation in this resident ' s chart relating to any events involving Resident #5.

In an interview with the AHWD on at 10:25 AM, she reported that Employee E came to her on and reported that the employee heard yelling and that Resident #5 was found in Resident #6 ' s

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Resident #5 was taking his pants down. She reported that she went to go talk to Resident #5, he did not directly answer her questions. The AHWD stated that she had informed the Administrator of the event, on . She reported that she had not informed either resident ' s physician or family. When asked why the note, written by her and dated , did not mention Resident #5 being naked or removing his pants, she stated she did not put that information in the notes due to confidentiality. She confirmed there was no other documentation regarding this event. She reported that Resident #5 ' s sister came to pick him up on and did not recall the date that he came back to the facility but reported it was the beginning of 2016. She confirmed that Resident #5 did not have any increased supervision when he came back to the facility. She reported that staff were informed to lock residents ' doors so that Resident #5 could not go into the . She confirmed that residents were locked in their reported that some residents could unlock their doors, while others were not capable.

In an interview with Resident #6 ' s son on at 8 AM, he reported that he went to visit his mother 3 or 4 days after . He reported that when he was at the facility, the AHWD told him that Resident #5 was found in his mom ' s , exposing himself. The son was told no contact was made. He stated that the AHWD reported that Resident #5 has been removed from the facility and was not going to return. He stated that he was pleased with the facility ' s response to remove Resident #5. Resident #6 ' s son at the time of the interview, was not aware that Resident #5 was back living in the facility as of the beginning of 2016.

In an interview with the Administrator on at 12:41 PM, she reported that she was made aware of the event between Resident #5 & #6 on / . She reported that the AHWD reported that Resident #5 was found with his clothes off. She reported that she did not report this event because there was no real evidence that there was contact. She reported that she did have a meeting with staff and told them to lock resident ' s to prohibit Resident #5 from walking into the .

In an interview with Resident #6 ' s physician on at 10:433 AM, he confirmed he was never notified of any events, in nature, regarding this resident.

In an interview with Resident #5 ' s sister on at 3:52 PM, she reported that when Resident #5 first moved back in her sister in 2015, she reported that he had behaviors. She reported he would go up and down the street and asking people for . She reported that he was diagnosed with with . She reported that events started to " blow up " at the facility the last few weeks. She reported that the facility called her on to come pick up her brother. She reported that the facility had told her there were 2 incidents where he was caught with one female resident with her pants down and he was on top of her naked. The second incident occurred when he was found with a second female resident, which is why she went to pick him up. Resident #5 ' s sister also reported that she was

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made aware of two other incidents where he was found hugging and kissing two female residents.

In an interview with Resident #5 on at 6:45 PM, he reported that the staff keep him caged up because they think he ' s a " predator. " He reported that the facility was full of women and that they all loved him and wanted to be with him. When asked if he ' s ever touched another female resident he reported " sure. I kiss them and I touch them " . He reported that he had kissed and touched Resident #6 & #7. He reported that there are only 4 male residents here, and that he had " needs " .

A review of the 45 day notice for Resident #5 revealed a date of . The letter read " (Resident #5) no longer meets criteria to remain in our Assisted Living Facility. His inability to control his urges and puts other residents at risk. If he returns to the facility, he will need 24 hour sitter with him so that he is unable to approach our female residents.

Class I

0030 Resident Care - Rights & Facility Procedures

Based on record review, observation, and interview, the facility failed to ensure that 4 of 5 sampled residents lived in an environment free from (Residents #6, #7, #8, & #9). The Administrator failed to address or investigate allegations of and allowed one resident (Resident #5) to remain in the facility after allegations that he had " assaulted 3 female residents (Residents #6, #7, & #9). The Administrator failed to investigate allegations by Resident #8 of possible misconduct by another resident. The lack of investigation and follow through on allegations of put all 53 residents in facility at risk of . In addition, the facility failed to make available the telephone numbers for lodging complaints against the facility or its staff.
The findings include:

1) During the initial tour on at 4:20 PM, no telephone numbers for lodging complaints against the facility or staff were observed. In an interview on at 5:30 PM, The Administrator confirmed that the long term care ombudsman, Agency consumer hotline and the Florida Hotline numbers were not posted in the facility.

2) A review of the admission and discharge log revealed that Resident #5 was admitted to the facility on / . A review of Resident #5 ' s record revealed a Resident Health Assessment (1823) dated . The date on the 1823 appeared to be altered. The 1823 physician signature page was signed by a medical doctor (MD). The rest of the 1823 was filled out in the same handwriting as observed on the last page of the 1823, where the Administrator signed and listed services being provided to Resident #5. The 1823 listed Resident #5 has having with behavioral disturbances and his

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status listed him as calm. The resident was assessed as not being a danger to self or others, as well as assessing that his needs could be met in an assisted living facility.

Resident #5 ' s chart also revealed an Advanced Registered Nurse Practitioner (ARNP) note dated . The ARNP note read that " Patient (Resident #5 was found in naked woman (Resident #7), in bed " . The note also listed Resident #5 as having " addiction " .

An interview was conducted with a private duty aid for Resident #8 on at 4:45 PM. She reported that Resident #5 would wander in resident and had a history of being inappropriate. She reported that there were current accusations of having relations with two current residents. She reported that she did not have any other knowledge.

In an interview with the Assistant Health and Wellness Director (AHWD) on at 5:04 PM, she reported that residents had complained about Resident #5 and that she reported those concerns to the Administrator. When asked what residents had complained about she stated " inappropriate comments " and then reported that Resident #5 had been given a 45 days notice for the inappropriate comments " .

In an interview with the Administrator on at 5:21 PM, she stated that Resident #5 was admitted from another Assisted Living Facility. She stated that the other facility reported that Resident #5 was " touchy feely " with staff but not with other residents. She reported that she had received concerns from residents regarding Resident #5. When asked what the concerns were, she stated that he would verbalize " I am a young man and I have needs. What am I supposed to do?" She confirmed she mailed Resident #5 ' s sister a 45 day notice on , due to Resident #5 ' s inappropriate language. She reported that she had no knowledge of any inappropriate contact between Resident #5 and other residents in the facility.

In a follow up interview with the AHWD on at 11:34 AM, she stated that Employee E had come to her and reported that she had walked by Resident #5 ' s overheard the resident stating " I have a resident in my " . Resident #7 was found by Employee E laying the Resident #5 ' s bed, with her clothes off from the waist down. The AHWD reported that they did not investigate this event, nor did they notify Resident #7 ' s family or physician.

A review of Resident #7 ' s record revealed that she was admitted to the facility on / . Her 1823 listed her diagnosis as and . She was assessed as requiring assistance with dressing, bathing, walking, toileting, and transferring. Resident #7 ' s record revealed no indication of the events that occurred between Resident #5 & Resident #7. The facility neglected to have Resident #7 assessed or evaluated for injury or psychological harm and neglected to notify Resident #7 ' s physician and family.

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In an interview with Resident #7 on at 5:15 PM, she reported that a male resident came into her . When asked if she gave him permission to come into her , she stated that he would just come in. When asked if Resident #5 had ever touched her, she states yes and then moved her hand over her and stated that Resident #5 would put his tongue in her mouth. Resident #7 reported that Resident #5 kept asking her to have with him. He would take my clothes off and ask me to touch him. Resident #7 then reported that Resident #5 " just took me " . She said he laid on top of her with her clothes off, and staff interrupted by knocking on the door. Resident #7 reported it was " terrible " .

A phone interview was conducted with Resident #5 ' s ARNP on at 11:44 AM. She reported that on she came to the facility. She reported that a nurse at the facility had informed her that Resident #5 was found with Resident #7. She then stated that she went to the AHWD and that the AHWD stated the incident had been reported. The ARNP stated that she told the AHWD that she needed to inform the families for Resident #5 & #7. When asked about Resident #5 ' s diagnosis of " addict " , she reported she could not recall why he had that diagnosis, but confirmed that diagnosis was on her notes from .

In a follow interview with Administrator on at 12:41 PM, she then confirmed she had knowledge of Resident #7 being found naked with Resident #5. She reported that she became aware of Resident #7 being naked in Resident #5 ' s , the day after the event. She could not recall the actual date of the occurrence, and admitted there was no documentation to show that the event occurred. She stated that she did not report the incident. She confirmed she did not have any investigation or documentation for Resident #5 or Resident #7.

In an interview with Resident #5 ' s physician on at 3:50 PM, he stated he first saw Resident #5 a month after her moved in. He stated that on his visit to the facility, he was told by the facility that Resident #5 had taken a female resident and attempted to have intercourse with her. The physician stated that he informed the AWHD that Resident #5 needed a evaluation and close monitoring. He was confirmed he was never made aware of any other incidents regarding Resident #5.

3) An interview was conducted with Resident #9 on at 5:30 PM. She reported that Resident #5 lived right by her when he moved in, in 2016. She reported that one day Resident #5 had come into her began touching her arm. She reported Resident #5 then started touching her right and put his hand down her shirt and started looking down her robe. Resident #9 stated that Resident #5 grabbed his crotch and asked if she wanted it. She told Resident #5 no and to get out. Resident #5 responded " think about it, and let me know " . She reported that she informed Employee E, who stated that it " shouldn ' t happen and I ' ll let someone know " .

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A review of Resident #9 ' s chart revealed an admission date of . The resident was coded as requiring supervision of all activities of daily living. Diagnosis included . Resident #9 ' s record revealed no indication of the events that occurred between Resident #5 & Resident #9. The facility neglected to have Resident #9 assessed or evaluated for injury or harm and neglected to notify Resident #9 ' s physician.

In an interview with Employee E on at 5:56 PM, she reported that Resident #9 had reported to her that Resident #5 had come into her touched her and looked down her shirt. She reported that she informed the AHWD of the allegation of .

In an interview with Resident #9 ' s daughter-in-law on at 5:45 PM, she reported that Resident #5 had been at the facility for about 3 weeks before he started entering my mother-in-law ' s . She reported that Resident #9 reported to her that Resident #5 had touched her . She reported that her husband (Resident #9 ' s son) had informed the facility about the event. The daughter-in-law reported that she had purchased a whistle for Resident #9, to blow for her safety. She was told that Resident #5 had been moved, so they had no more concerns.

In an interview with the Administrator and the AHWD on at 6 PM, they both denied knowledge of Resident #5 being inappropriate with Resident #9. They both reported that Resident #5 was moved on occurred because of financial reasons and not due to any behavioral events.

4) A second review if Resident #5 ' s chart revealed a note dated , written by the AHWD. The note read that she heard a female resident yelling " get out " on the 300 hall. The note then read that Resident #5 was found in Resident #6 ' s . Resident #6 was reported as watching television and that there was no evidence of " contact or inappropriate behavior " . The note went on to read that the sister for Resident #5 was contacted and told she needed to pick him up because his " behavior was alarming " . There is documentation that Resident #6 ' s family was notified. There was no documentation that either resident was undressed.

In an interview with Employee D on at 7 PM. She reported that she had concerns regarding Resident #5. She reported that she had witnessed two separate events in which Resident #5 was kissing on Resident #6. She reported that she had immediately informed the AHWD. Employee D reported that the AHWD told her she would " take care of it " . She reported that the Administrator had a meeting with the staff the week of in which the Administrator instructed staff to lock residents ' doors to prevent Resident #5 from being allowed to enter. Employee D reported that she was concerned about Resident #5, before he was admitted due to his history. Employee D reported that the Administrator was aware of past inappropriate behaviors that Resident #5 exhibited.

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In an interview with Employee E on at 7:57 PM, she reported that she found Resident #5 in Resident #6 ' s . Employee E stated that Resident #5 was found naked in bed with Resident #6, who was naked from the waist down. Employee E stated that when she asked Resident #5 what he was doing, he reported " I am a man and I have needs " . Employee E then stated that she went and told the AHWD about the event. She reported that the AHWD completes all documentation regarding allegations.

An attempt to interview Resident #6 on at 9:45 AM. The resident was not alert and oriented and was not able to be interviewed.

In an interview with the AHWD on at 10:25 AM, she reported that Employee E came to her on and reported that the employee heard yelling and that Resident #5 was found in Resident #6 ' s Resident #5 was taking his pants down. She reported that she went to go talk to Resident #5, he did not directly answer her questions. The AHWD stated that she had informed the Administrator of the event, on . She reported that she had not informed either resident ' s physician or family. When asked why the note, written by her and dated , did not mention Resident #5 being naked or removing his pants, she stated she did not put that information in the notes due to confidentiality. She confirmed there was no other documentation regarding this event. She confirmed that she did not report this event to any family members or physicians. She reported that Resident #5 ' s sister came to pick him up on and did not recall the date that he came back to the facility but reported it was the beginning of 2016. She confirmed that Resident #5 did not have any increased supervision when he came back to the facility. She reported that staff were informed to lock residents ' doors so that Resident #5 could not go into the . She confirmed that residents were locked in their reported that some residents could unlock their doors, while others were not capable.

A review was conducted of Resident #6 ' s chart revealed that she was admitted to the facility on . She had an 1823 dated that assessed the resident as requiring assistance with ambulation, dressing, and transferring. Resident #6 ' s 1823 listed her diagnosis as s . Resident #6 ' s record revealed no indication of the events that occurred between Resident #5 & Resident #6. The facility neglected to have Resident #6 assessed or evaluated for injury or psychological harm and neglected to notify Resident #6 ' s physician or family after allegations of

In an interview with Resident #6 ' s son on at 8 AM, he reported that he went to visit his mother 3 or 4 days after . He reported that when he was at the facility, the AHWD told him that Resident #5 was found in his mom ' s , exposing himself. The son was told no contact was made. He stated that the AHWD reported that Resident #5 has been removed from the facility and was not going to

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return. He stated that he was pleased with the facility ' s response to remove Resident #5. Resident #6 ' s son had no knowledge at the time of interview that Resident #5 was back living in the facility since the beginning of 2016.

In an interview with the Administrator on at 12:41 PM, she reported that she was made aware of the event between Resident #5 & #6 on . She reported that the AHWD reported that Resident #5 was found with his clothes off. She reported that she did not report this event because there was no real evidence that there was contact. She reported that she did have a meeting with staff and told them to lock resident ' s to prohibit Resident #5 from walking into the .

In an interview with Resident #6 ' s physician on at 10:433 AM, he confirmed he was never notified of any events, in nature, regarding this resident.

In an interview with Resident #5 ' s sister on at 3:52 PM, she reported that when Resident #5 first moved back in with her in 2015, she reported that he had behaviors. She reported he would go up and down the street and asking people for . She reported that he was diagnosed with with . She reported that events started to " blow up " at the facility the last few weeks. She reported that the facility called her on to come pick up her brother. She reported that the facility had told her there were 2 incidents where he was caught with one female resident with her pants down and he was on top of her naked. The second incident occurred when he was found with a second female resident, which is why she went to pick him up. Resident #5 ' s sister also reported that she was made aware of two other incidents where he was found hugging and kissing two female residents.

In an interview with Resident #5 on at 6:45 PM, he reported that the staff keep him caged up because they think he ' s a " predator. " He reported that the facility was full of women and that they all loved him and wanted to be with him. When asked if he ' s ever touched another female resident he reported " sure. I kiss them and I touch them " . He reported that he had kissed and touched Resident #6 & #7. He reported that there are only 4 male residents here, and that he had " needs " .

A review of the 45 day notice for Resident #5 revealed a date of . The letter read " (Resident #5) no longer meets criteria to remain in our Assisted Living Facility. His inability to control his urges and puts other residents at risk. If he returns to the facility, he will need 24 hour sitter with him so that he is unable to approach our female residents.

5) In an interview with Resident #8 ' s wife on at 3:47 PM, she reported that a female resident (Resident #10) would come into her husband ' s . She reported that Resident #10 would come in and watch her husband pee and rub " on him " . Resident #8 ' s wife reported that her husband is and cannot give consent. She reported that she had told the AHWD about the Resident #10

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coming into her husband ' s " about a dozen times " . The wife reported that this morning ( ), Resident #10 was found in Resident #8 ' s on the toilet with nothing on below her waist. Resident #8 ' s wife stated that when she reported the inappropriate touching and situation to the Administrator, she was told " I don ' t have a problem, you do " .

In an interview was conducted with the Administrator on at 5:26 PM. She reported that the wife of Resident #8 accused Resident #10 of " being a predator " . She reported that there is no documentation of any investigation or documentation of the reported occurrences in the resident or facility files. She reported that she did not investigate the allegations because Resident #10 has and often wonders into other residents ' . She reported that only the wife witnessed the alleged events, and not staff, so no investigation was completed.

A review of the grievance log for the facility revealed no documentation regarding grievances related to Resident #5 or #10.

In an interview with the Administrator on at 10:58 AM, she reported that all staff receive training in online. She reported that she was unaware of the facility ' s policy on or if there was training on chain-of command in reporting. She stated she would look to see what policies the facility had.

A review of the facility ' s " , fraud, and wrongdoing " policy (undated) read that " The Administrator will investigate any reports of , fraud, or other wrongdoing " . It went on further to read " if a report of , fraud, or other wrongdoing is received: a) The Administrator is notified immediately. B) Any urgent medical or safety issues are addressed immediately. C) The Administrator or other designated representative initiates an investigation ....All appropriate parties are notified of the outcome of the investigation " .
There was no indication or evidence to show that the facility took action to immediately address urgent safety issues that Resident #5 exhibited to other residents. The facility failed to notify family members and health care providers of allegations. The facility did not put any safeguards in place, to ensure residents safety.

A review of the online training curriculum that all staff at the facility receive on and neglect revealed that staff were trained in how to report . The curriculum read " If you suspect or neglect of a resident, don ' t hesitate to report it. Don ' t assume that someone else will take care of it or that the person being abused is capable of getting help if he or she really needs it, Follow the reporting procedures outlined in your organization ' s policies. "

In an interview with Employee I on at 4:30 PM, they confirmed that they had received on-line

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training in , neglect, and . They confirmed that for any allegations or observed or neglect, they would immediately tell the Administrator and the AHWD. They reported that they did not receive training on the facility ' s chain of command.

In an interview with Employee J on at 3:45 PM, they confirmed that they had received on-line training in , neglect, and . They confirmed that for any allegations or observed or neglect, they would immediately tell the Administrator and the AHWD. They reported that they did not receive training on the facility ' s chain of command.

In an interview with Employee H on at 12:37PM , they confirmed that they had received on-line training in , neglect, and . They confirmed that for any allegations or observed or neglect, they would immediately tell the Administrator and the AHWD. They reported that they did not receive training on the facility ' s chain of command.

In an interview with Employee on K at 1:15 PM they confirmed that they had received on-line training in , neglect, and . They confirmed that for any allegations or observed or neglect, they would immediately tell the Administrator and the AHWD. They reported that they did not receive training on the facility ' s chain of command.

In an interview with Employee B on at 9:45 AM, they confirmed that they had received on-line training in , neglect, and . They confirmed that for any allegations or observed or neglect, they would immediately tell the Administrator and the AHWD. They reported that they did not receive training on the facility ' s chain of command.

Class I

0077 Staffing Standards - Administrators

Based on observation, record review, and interview, the Administrator failed to ensure appropriate care to all residents by failing to investigate and report allegations of for 4 of 5 sampled residents (Resident #6, #7, #8, & #9). By failing to follow the facility ' s policy and neglecting to investigate and report allegations of , all 53 residents at the facility were put at risk.

The findings include:

1) During the initial tour on at 4:20 PM, no telephone numbers for lodging complaints against the facility or staff were observed. In an interview on at 5:30 PM, The Administrator confirmed that the long term care ombudsman, Agency consumer hotline and the Florida Hotline numbers were not

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posted in the facility.

2) A review of the admission and discharge log revealed that Resident #5 was admitted to the facility on / . A review of Resident #5 ' s record revealed a Resident Health Assessment (1823) dated . The date on the 1823 appeared to be altered. The 1823 physician signature page was signed by a medical doctor (MD). The rest of the 1823 was filled out in the same handwriting as observed on the last page of the 1823, where the Administrator signed and listed services being provided to Resident #5. The 1823 listed Resident #5 has having with behavioral disturbances and his status listed him as calm. The resident was assessed as not being a danger to self or others, as well as assessing that his needs could be met in an assisted living facility.
In an interview with the Administrator on at 6:55 PM, she reported that she had filled out the 1823, since she did not get one from his previous placement. She acknowledged that the date on the 1823 was altered, but could not identify who altered the date. The Administrator could not give a date, when the resident was assessed by a health care provider.

Resident #5 ' s chart also revealed an Advanced Registered Nurse Practitioner (ARNP) note dated . The ARNP note read that " Patient (Resident #5 was found in naked woman (Resident #7), in bed " . The note also listed Resident #5 as having " ' addiction " .

An interview was conducted with a private duty aid for Resident #8 on / at 4:45 PM. She reported that Resident #5 would wander in resident and had a history of being inappropriate. She reported that there were current accusations of having relations with two current residents. She reported that she did not have any other knowledge.

In an interview with the Assistant Health and Wellness Director (AHWD) on at 5:04 PM, she reported that residents had complained about Resident #5 and that she reported those concerns to the Administrator. When asked what residents had complained about she stated " inappropriate comments " and then reported that Resident #5 had been given a 45 days notice for the inappropriate comments "

In an interview with the Administrator on at 5:21 PM, she stated that Resident #5 was admitted from another Assisted Living Facility. She stated that the other facility reported that Resident #5 was " touchy feely " with staff but not with other residents. She reported that she had received concerns from residents regarding Resident #5. When asked what the concerns were, she stated that he would verbalize " I am a young man and I have needs. What am I supposed to do?" She confirmed she mailed Resident #5 ' s sister a 45 day notice on , due to Resident #5 ' s inappropriate language. She reported that she had no knowledge of any inappropriate contact between Resident #5 and other residents in the facility.

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In a follow up interview with the AHWD on at 11:34 AM, she stated that Employee E had come to her and reported that she walked by Resident #5 ' s overheard the resident stating " I have a resident in my " . Resident #7 was found by Employee E laying the Resident #5 ' s bed, with her clothes off from the waist down. The AHWD reported that they did not investigate this event, nor did they notify Resident #7 ' s family or physician.

A review of Resident #7 ' s record revealed that she was admitted to the facility on / . Her 1823 listed her diagnosis as and . She was assessed as requiring assistance with dressing, bathing, walking, toileting, and transferring.

In an interview with Resident #7 on at 5:15 PM, she reported that a male resident came into her . When asked if she gave him permission to come into her , she stated that he would just come in. When asked if Resident #5 had ever touched her, she states yes and then moved her hand over her and stated that Resident #5 would put his tongue in her mouth. Resident #7 reported that Resident #5 kept asking her to have with him. He would take my clothes off and ask me to touch him. Resident #7 then reported that Resident #5 " just took me " . She said he laid on top of her with her clothes off, and staff interrupted by knocking on the door. Resident #7 reported it was " terrible " .

A phone interview was conducted with Resident #5 ' s ARNP on at 11:44 AM. She reported that on she came to the facility. She reported that a nurse at the facility had informed her that Resident #5 was found with Resident #7. She then stated that she went to the AHWD and that the AHWD stated the incident had been reported. The ARNP stated that she told the AHWD that she needed to inform the families for Resident #5 & #7. When asked about Resident #5 ' s diagnosis of " addict " , she reported she could not recall why he had that diagnosis, but confirmed that diagnosis was on her notes from .

In a follow interview with Administrator on at 12:41 PM, she then confirmed she had knowledge of Resident #7 being found naked with Resident #5. She reported that she became aware of Resident #7 being naked in Resident #5 ' s , the day after the event. She could not recall the actual date of the occurrence, and admitted there was no documentation to show that the event occurred. She stated that she did not report the incident. She confirmed she did not have any investigation or documentation for Resident #5 or Resident #7.

In an interview with Resident #5 ' s physician on at 3:50 PM, he stated he first saw Resident #5 a month after her moved in. He stated that on his visit to the facility, he was told by the facility that Resident #5 had taken a female resident and attempted to have intercourse with her. The physician stated that he informed the AWHD that Resident #5 needed a evaluation and close

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monitoring. He was confirmed he was never made aware of any other incidents regarding Resident #5.

3) An interview was conducted with Resident #9 on at 5:30 PM. She reported that Resident #5 lived right by her when he moved in, in 2016. She reported that one day Resident #5 had come into her began touching her arm. She reported Resident #5 then started touching her right and put his hand down her shirt and started looking down her robe. Resident #9 stated that Resident #5 grabbed his crotch and asked if she wanted it. She told Resident #5 no and to get out. Resident #5 responded " think about it, and let me know " . She reported that she informed Employee E, who stated that it " shouldn ' t happen and I ' ll let someone know " .

A review of Resident #9 ' s chart revealed an admission date of / . The resident was assessed as requiring supervision of all activities of daily living. Diagnosis included . There was no documentation in the resident ' s record regarding any events involving other residents, including Resident #5.

In an interview with Employee E on at 5:56 PM, she reported that Resident #9 had reported to her that Resident #5 had come into her touched her and looked down her shirt. She reported that she informed the AHWD of the allegation of .
In an interview with Resident #9 ' s daughter-in-law on at 5:45 PM, she reported that Resident #5 had been at the facility for about 3 weeks before he started entering my mother-in-law ' s . She reported that Resident #9 reported to her that Resident #5 had touched her . She reported that her husband (Resident #9 ' s son) had informed the facility about the event. The daughter-in-law reported that she had purchased a whistle for Resident #9, to blow for her safety. She was told that Resident #5 had been moved, so they had no more concerns.

In an interview with the Administrator and the AHWD on at 6 PM, they both denied knowledge of Resident #5 being inappropriate with Resident #9. They both reported that Resident #5 was moved on occurred because of financial reasons and not due to any behavioral events.

4) A second review if Resident #5 ' s chart revealed a note dated , written by the AHWD. The note read that she heard a female resident yelling " get out " on the 300 hall. The note then read that Resident #5 was found in Resident #6 ' s . Resident #6 was reported as watching television and that there was no evidence of " contact or inappropriate behavior " . The note went on to read that the sister for Resident #5 was contacted and told she needed to pick him up because his " behavior was alarming " . There is documentation that Resident #6 ' s family was notified. There was no documentation that either resident was undressed.

In an interview with Employee D on at 7 PM. She reported that she had concerns regarding

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	AL11967955	07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE MANOR ASSISTED LIVING AND MEMORY CARE	1321 HERBERT ST PORT ORANGE, FL 32129

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

Resident #5. She reported that she had witnessed two separate events in which Resident #5 was kissing on Resident #6. She reported that she had immediately informed the AHWD. Employee D reported that the AHWD told her she would " take care of it " . She reported that the Administrator had a meeting with the staff the week of in which the Administrator instructed staff to lock residents ' doors to prevent Resident #5 from being allowed to enter. Employee D reported that she was concerned about Resident #5, before he was admitted due to his history. Employee D reported that the Administrator was aware of past inappropriate behaviors that Resident #5 exhibited.

In an interview with Employee E on at 7:57 PM, she reported that she found Resident #5 in Resident #6 ' s . Employee E stated that Resident #5 was found naked in bed with Resident #6, who was naked from the waist down. Employee E stated that when she asked Resident #5 what he was doing, he reported " I am a man and I have needs " . Employee E then stated that she went and told the AHWD about the event. She reported that the AHWD completes all documentation relating to investigations.

A review was conducted of Resident #6 ' s chart revealed that she was admitted to the facility on / . She had an 1823 dated / that assessed the resident as requiring assistance with ambulation, dressing, and transferring. Resident #6 ' s 1823 listed her diagnosis as s . There was no documentation in this resident ' s chart relating to any events involving Resident #5.
An attempt was made to interview Resident #6 on at 9:45 AM. The resident was not alert and oriented and was not able to be interviewed.

In an interview with the AHWD on at 10:25 AM, she reported that Employee E came to her on and reported that the employee heard yelling and that Resident #5 was found in Resident #6 ' s Resident #5 was taking his pants down. She reported that she went to go talk to Resident #5, he did not directly answer her questions. The AHWD stated that she had informed the Administrator of the event, on . She reported that she had not informed either resident ' s physician or family. When asked why the note, written by her and dated , did not mention Resident #5 being naked or removing his pants, she stated she did not put that information in the notes due to confidentiality. She confirmed there was no other documentation regarding this event. She reported that Resident #5 ' s sister came to pick him up on and did not recall the date that he came back to the facility but reported it was the beginning of 2016. She confirmed that Resident #5 did not have any increased supervision when he came back to the facility. She reported that staff were informed to lock residents ' doors so that Resident #5 could not go into the . She confirmed that residents were locked in their reported that some residents could unlock their doors, while others were not capable.

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In an interview with Resident #6 ' s son on at 8 AM, he reported that he went to visit his mother 3 or 4 days after . He reported that when he was at the facility, the AHWD told him that Resident #5 was found in his mom ' s , exposing himself. The son was told no contact was made. He stated that the AHWD reported that Resident #5 has been removed from the facility and was not going to return. He stated that he was pleased with the facility ' s response to remove Resident #5. Resident #6 ' s son at the time of the interview, was not aware that Resident #5 was back living in the facility since the beginning of 2016.

In an interview with the Administrator on at 12:41 PM, she reported that she was made aware of the event between Resident #5 & #6 on / . She reported that the AHWD reported that Resident #5 was found with his clothes off. She reported that she did not report this event because there was no real evidence that there was contact. She reported that she did have a meeting with staff and told them to lock resident ' s to prohibit Resident #5 from walking into the .

In an interview with Resident #6 ' s physician on at 10:433 AM, he confirmed he was never notified of any events, in nature, regarding this resident.

In an interview with Resident #5 ' s sister on at 3:52 PM, she reported that when Resident #5 first moved back in with her in 2015, she reported that he had behaviors. She reported he would go up and down the street and asking people for . She reported that he was diagnosed with with . She reported that events started to " blow up " at the facility the last few weeks. She reported that the facility called her on to come pick up her brother. She reported that the facility had told her there were 2 incidents where he was caught with one female resident with her pants down and he was on top of her naked. The second incident occurred when he was found with a second female resident, which is why she went to pick him up. Resident #5 ' s sister also reported that she was made aware of two other incidents where he was found hugging and kissing two female residents.

In an interview with Resident #5 on at 6:45 PM, he reported that the staff keep him caged up because they think he ' s a " " predator. " He reported that the facility was full of women and that they all loved him and wanted to be with him. When asked if he ' s ever touched another female resident he reported " sure. I kiss them and I touch them " . He reported that he had kissed and touched Resident #6 & #7. He reported that there are only 4 male residents here, and that he had " needs " .

A review of the 45 day notice for Resident #5 revealed a date of . The letter read " (Resident #5) no longer meets criteria to remain in our Assisted Living Facility. His inability to control his urges and puts other residents at risk. If he returns to the facility, he will need 24 hour sitter with him so that he is unable to approach our female residents.

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5) In an interview with Resident #8 ' s wife on at 3:47 PM, she reported that a female resident (Resident #10) would come into her husband ' s . She reported that Resident #10 would come in and watch her husband pee and rub " on him " . Resident #8 ' s wife reported that her husband is and cannot give consent. She reported that she had told the AHWD about the Resident #10 coming into her husband ' s " about a dozen times " . The wife reported that this morning ( ), Resident #10 was found in Resident #8 ' s on the toilet with nothing on below her waist. Resident #8 ' s wife stated that when she reported the inappropriate touching and situation to the Administrator, she was told " I don ' t have a problem, you do " .

In an interview was conducted with the Administrator on at 5:26 PM. She reported that the wife of Resident #8 accused Resident #10 of " being a predator " . She reported that there is no documentation of any investigation or documentation of the reported occurrences in the resident or facility files. She reported that she did not investigate the allegations because Resident #10 has and often wonders into other residents ' . She reported that only the wife witnessed the alleged events, and not staff, so no investigation was completed.

A review of the grievance log for the facility revealed no documentation regarding grievances related to Resident #5 or #10.

In an interview with the Administrator on at 10:58 AM, she reported that all staff receive training in online. She reported that she was unaware of the facility ' s policy on or if there was training on chain-of command in reporting. She stated she would look to see what policies the facility had.

A review of the facility ' s " , fraud, and wrongdoing " policy (undated) read that " The Administrator will investigate any reports of , fraud, or other wrongdoing " . It went on further to read " if a report of , fraud, or other wrongdoing is received: a) The Administrator is notified immediately. B) Any urgent medical or safety issues are addressed immediately. C) The Administrator or other designated representative initiates an investigation ....All appropriate parties are notified of the outcome of the investigation " .

A review of the online training curriculum that all staff at the facility receive on and neglect revealed that staff were trained in how to report . The curriculum read " If you suspect or neglect of a resident, don ' t hesitate to report it. Don ' t assume that someone else will take care of it or that the person being abused is capable of getting help if he or she really needs it, Follow the reporting procedures outlined in your organization ' s policies. "

In an interview with Employee I on at 4:30 PM, they confirmed that they had received on-line

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training in , neglect, and . They confirmed that for any allegations or observed or neglect, they would immediately tell the Administrator and the AHWD. They reported that they did not receive training on the facility ' s chain of command.

In an interview with Employee J on at 3:45 PM, they confirmed that they had received on-line training in , neglect, and . They confirmed that for any allegations or observed or neglect, they would immediately tell the Administrator and the AHWD. They reported that they did not receive training on the facility ' s chain of command.

In an interview with Employee H on at 12:37PM , they confirmed that they had received on-line training in , neglect, and . They confirmed that for any allegations or observed or neglect, they would immediately tell the Administrator and the AHWD. They reported that they did not receive training on the facility ' s chain of command.

In an interview with Employee on K at 1:15 PM they confirmed that they had received on-line training in , neglect, and . They confirmed that for any allegations or observed or neglect, they would immediately tell the Administrator and the AHWD. They reported that they did not receive training on the facility ' s chain of command.

In an interview with Employee B on at 9:45 AM, they confirmed that they had received on-line training in , neglect, and . They confirmed that for any allegations or observed or neglect, they would immediately tell the Administrator and the AHWD. They reported that they did not receive training on the facility ' s chain of command.

Class I

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Grace Manor Assisted Living And Memory Care
1321 Herbert Street
Port Orange, FL 32129

RE: CCR #2016003496

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on 8, 2016 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit.

Thank you for the assistance provided to the surveyor. Should you have any questions please call this office at -4201.

Sincerely,

Jana Meyering, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

AF/JM/sm
Enclosure

XG90

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