RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

Administrator
Gulf Breeze Courtyard
3428 Gulf Breeze Parkway
Gulf Breeze, FL 32561

, 2016

Dear Administrator:

This letter reports the findings of a complaint (CCR# 2016011494) inspection survey conducted on , 2016, by representatives 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 the time frames noted below.

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

-A 0030 - 58a-5.0182(6) Fac; 429.28(1-2) Fs - Resident Care - Rights & Facility Procedures, Class I

The Assisted Living Facility is required to do the following:

1. All facility staff having contact with and providing care to residents must be re-trained on resident rights and recognizing and reporting and neglect. This training must be provided by a representative of the Department of Elder Affairs, an Assisted Living Facility CORE trainer, or the Department of Children and Families or an approved provider of one of the two agencies. The facility must maintain documentation of the completion of this training and documentation of the trainer's qualifications at the facility and must be available for review by the Agency. **This training shall be scheduled by** .

2. The Assisted Living Facility is required to re-train all staff, including the Administrator, on the facility's policy. The in-service must have an agenda. The facility must maintain documentation of the completion of this training which must be kept on file at the facility, and be available for review by the Agency. **This shall be completed by** .

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 me at (850) 412-4540.

Sincerely,

Donah Heiberg, M.S.W.
Field Office Manager

DH/kb

D7JR

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965645	10/05/2016
NAME OF PROVIDER OR SUPPLIER **GULF BREEZE COURTYARD**	STREET ADDRESS, CITY, STATE, ZIP CODE **3428 GULF BREEZE PARKWAY** **GULF BREEZE, FL 32561**	

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

0000 Initial Comments

An unannounced complant survey into allegations (CCR2016011494) was conducted at Gulf Breeze Courtyard Assisted Living Facility (license number 9976) on . Deficiencies were identified at the time of survey.

A Class I deficiency was identified at A0030, Resident Care - Rights and Facility Procedures.

0030 Resident Care - Rights & Facility Procedures

Based on staff interviews and record reviews the facility failed to provide a safe and decent living environment, free from for 1 of 9 sampled residents (#1) and ongoing , denying of dignity, for other residents at the facility. The facility also did not put measures into place to protect the facility's residents from being potential victims of physical and .

The Findings:

On at approximately 9:40AM, an interview was conducted with Employee F, Executive Director (ED) who reported that on the morning of it was brought to her attention by Employee G, Resident Care Director that Employee C, License Practical Nurse (LPN) had witnessed Employee H, Dietary Manager popped resident #1 on the hand with a metal spatula. The Executive Director reported that resident #1 received no from the incident nor received any changes from it. The ED reported that she monitored the resident after this and notified the Department of Children and Families Adult Protective Services. The ED reported that she received no other concerns from staff or resident in regard to employee H abusing the residents.

On , at approximately 9:51AM, an interview was conducted with Employee H, Dietary Manager who reported that he has been working at the facility for 8 years. The Dietary Manager reported that he had nothing else to say, he had wrote a statement and he would repeat the same information.

A record review was conducted of the statement, signed and undated by the Dietary Manager which stated, "I, (Dietary Manager), affirm the following to be true to the best of my recollection. On or about 27th of , approximately 8:00, during the near completion of the breakfast meal tapped resident #1 on the hand. I was totally caught off guard by his presence in the kitchen and more so in that he was eating from the cutting board, so in a manner to dissuade him from the action the event occurred. As it appeared to have no effect upon (resident #1), i.e., he did not withdraw his hand, he did not drop the food, he did not acknowledge or appear to have felt anything, I thought nothing of it and guided him out of the kitchen. I knew it was the wrong reaction as soon as I did it, one because I know

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better, two because I have never done anything like that before to anyone else and residents are constantly walking into the kitchen".

On at approximately 10:00AM, an interview was conducted with employee C, LPN who reported that she was going to the kitchen to get some napkins and noticed that resident #1 was in the kitchen behind the serving line and stated that she did not see any staff, so she called the resident name to get his attention and then employee H appeared and he called resident #1's name and yelled, "what are you doing in here" and snatched the bread out of resident #1's hand and turned and threw the bread in the garbage. The LPN reported that employee H then turned around and hit resident #1 on the left area with a silver metal spatula. The LPN reported that she was stunned; she immediately removed resident #1 out of the kitchen and immediately walked to the front and informed her supervisor the Resident Care Director.

On at approximately 10:10AM, an interview was conducted with employee G, Resident Care Director/LPN, who reported that employee C reported to her that she had witness employee H hit resident #1 on the hand with a metal spatula. The Resident Care Director reported that upon being told of the information she immediately informed the Executive Director and then proceeded to assess resident's #1 arm. The Resident Care Coordinator reported upon assessing resident #1 arm, she found a red mark about 2 by 3 inches, there was no , or . The Resident Care Director reported that employee H can be rude to the residents, especially if the residents wander in the kitchen.

On at approximately 10:40AM, an interview was conducted employee E who reported that she has heard the cook being rude to the residents when they wander in the kitchen or come to the kitchen to ask for a snack. Employee E reported that she informed one of the former nurses that employee H was rude to the residents, and the nurse informed her, "that just the way employee H is". Employee E reported that she has heard employee H calling some of the resident's derogatory names such as, "mother f____" and "retards".

On at approximately 11:30AM, an interview was conducted with employee I who reported that she has witnessed employee H being abrasive, and rude to the residents who wander in the kitchen. Employee I reported that when she reported this to past administrative staff, she was told, "that just the way employee is".

On at approximately 11:45AM, an interview was conducted with employee B who reported that she has witnessed employee H being rude to residents who wandered in the kitchen, stated that she brushed the rude comments to residents off as his sense of humor, figured that was just the way he communicates with people.

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On at approximately 12:36PM, a second interview was conducted the Executive Director (ED) who reported that she met with employee H and received a statement from employee C and then called the Department of Children and Families. The ED reported that employee H continued to work his schedule and she made contact with her Human Resource Office who informed her to note to employee H's file and re-schedule him for the , resident rights and trainings. The ED reported that employee H was scheduled for trainings on . The ED reported that she met with employee H and informed him that the incident was unacceptable. The ED confirmed that she did not complete a report stating that this incident was a violation of care. The ED reported that the policy does state that this was a violation of care and she deemed the incident as a violation of care. The ED confirmed that she did not notify the resident's court appointed guardian of the , nor did she notify resident's physician. The ED stated that since the Resident Care Director assessed and found the 2 by 3 red marks then the Resident Care Director should have called resident #1's physician. The ED reported that she was not aware of the facility ' Prohibition 7.01' policy because she has not been at the facility for about a month.

The ' Prohibition 7.01', dated / , states:
The facility would not tolerate any form of , neglect, or . A review of 5C Investigation: indicated that (a) inform the Executive Director immediately (within 1 hour of learning) of an incident of alleged or suspected . (b) The Executive Director or the Director of Resident Services will conduct a thorough investigation of reports of alleged resident or neglect to determine if the conduct of the individual is in violation of any standard of care. A written report will be completed and submitted to the Executive Director within forty-eight hours of the reported incident (c) protect the resident or residents involved in a case of suspected from potential additional harm during the investigation procedure. This includes, but is not limited to, suspension of the associate in question, removal of visitor or family member from premises (d) obtain written statements from witnesses (e) if the resident sustains an injury or unknown origin the Director of Resident Care and or the Executive Director will conduct an investigation to include, but not limited to interview of staff present at the time of identification and prior to identification, observation of injury, observation of care provided to resident, and inspection of resident physical environment (f) notify the resident's family and/or responsible party and physician as soon as possible of the incident, and when completed, the results of the investigation. Notification will preferably be in person, and done by the Executive Director (g) if a charge of resident , neglect, or is substantiated, the associate will be terminated promptly.

A record review was conducted of the Resident Bill of Rights which indicated (A) live in a safe and decent living environment, free from and neglect and (B) Be retreated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.

A record review was conducted of employee H's work schedule. According to the Executive Director the

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occurred the morning of , the work schedule revealed that employee H worked the remainder of the day, returned to work on from 6am to 12pm, returned to work on working in the office, worked on 6am to 12pm and from 6am to 11:48am when he resigned his position.

A record review was conducted of resident #1 Resident Health Assessment for Assisted Living Facilities dated / which indicated that resident #1 has advanced and and he is to be supervised for safety.

A record review was conducted of resident #1 tenant information and contacts which indicated that resident #1 had listed an emergency contact. The Resident Health Assessment indicated that resident #1 had a court appointed guardian on .

A record review was conducted of the facility's incident reports and grievance log and there was no documentation recorded of the incident that occurred on in regard to employee H to resident #1. A further review revealed no documentation of any reported in the incident reports and grievance log. The previous had not been addressed nor had any reporting been done, nor had any investigations taken place, allowing the to continue.

Class I