STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966084	06/22/2017
NAME OF PROVIDER OR SUPPLIER **TITUSVILLE TOWERS**	STREET ADDRESS, CITY, STATE, ZIP CODE **405 INDIAN RIVER AVENUE** **TITUSVILLE, FL 32796**	

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

0000 - Initial Comments

Complaint investigation #2017004114 was conducted in conjunction with the re-licensure survey with Extended Congregate Care survey on . Titusville Towers, license #10346, had a deficiency relating to the complaint.

Z821 - Reporting Requirements; Electronic Submission - 59A-35.110 FAC

Based on resident record review, incident report review and interview the facility failed to file an adverse incident report required pursuant to Sections 429.23(3) and (4), F.S. and Rule 58A-5.0241, F.A.C for incidents involving 3 of 5 sampled residents. (#12, #13, #16).

Findings:
1. In an interview at 4:30 pm on , with Staff H, who worked with the residents as the housing authority case manager stated, "James mostly stayed in his . He was a loner. Sometimes he would come down and play the piano in the lobby. Close to , his behavior changed and he was tossing items around in the lobby where other residents were sitting. He was being treated for a ." According to Staff H, "on at 4:30 pm it was noticed that he was missing for a few hours. Sometimes when he went out for a while, he went to the Budget Inn across the street." She said they called the Budget Inn and he was not there. Around 24 hours had passed since he had his medications. They tried calling his emergency contact numbers and found they had all been disconnected. On at 1 PM, the Titusville Police were called. He was listed as a missing person. The police spent 2 hours searching for Resident #13. The resident who lived in the apartment under Resident #13 complained that his ceiling was leaking. They checked the apartment and found the sinks were all clogged with "a black substance" and the vanity sink had been partially torn off the wall. There was water all over. It appeared resident #13 had taken most of his clothing with him. On around 4:30PM, Resident #13 was found checking in at the Budget Inn. Staff H said they did not have a copy of the police report that was filed when Resident #13 was missing. A note in his record dated documented, "He did not give 30 days' notice. He paid rent for 13 days. 1 thru 13." A second handwritten note dated "D/C in PCC per (manager)."

Review of the admission and discharge log revealed that resident #13 was discharged on to "No forward address given" with the reason documented, as "he wanted to leave."

Review of the record for resident #13 revealed he had been admitted on with a diagnosis of Parkinson's . He required assistance with self-administration of medications.

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2. In an interview with resident #16 on at 3:20 PM, she described incidents she had with resident #12 that started in . Resident #12 had pushed her walker backwards when she was trying to get on the elevator. She started to lose her balance but regained it without falling. Then she said resident #12 hit her. On in the lobby, resident #12 was following her at a high speed in her wheelchair. Resident #16 said she could barely get away, the wheelchair was moving right at her very quickly. She ducked into a back hallway to escape and called for help from the dining staff. Resident #12 also tried to record her using her cell phone and asked "Why did you tell all those lies to my preacher/" Resident #16 said she told her "I don't even know who you are." Resident #12 responded with, "I'm going to get you." Resident #16 said the facility staff and management called the police and helped her go to court to obtain a restraining order. She said the staff escorted her to and from the dining day to make sure she was safe and did not encounter resident #12. She expressed satisfaction with staff and their response to the threats she was feeling. She did not require medical attention and was not harmed. She was having nightmares and was very fearful when Resident #12 was still living there. She went to court and got a restraining order against resident #12.

Review of the admission and discharge log revealed that resident #12 was discharged on to another Assisted Living Facility with a reason documented as "change of scenery for resident."

Review of the record for resident #12 revealed she had been admitted on and had diagnoses of , and . There was documentation that facility sent notices of intent to discharge with more than 45 days' notice. Facility assisted resident in finding a new ALF. There was no documentation of her grievances or incidents/alterations with resident #16.

On at 4:45pm, the manager stated the facility had no adverse reports from 2017.

When asked about the incident with resident #13, the manager said, "I called the police about Resident #13, but he often went to the hotel with a friend for a couple of days. He had been not wanting to be here. He didn't want me to find him or bother him. I care for the residents, that's why I called the police." When asked about the incidents, police involvement and restraining order with Residents #12 & #16, she said she did not file an adverse report at that time either.

The manager stated on at 8:20 PM, "No, I didn't do adverse reports for either of them."
Unclassified