STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968835	08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEWOOD ESTATES ASSISTED LIVING FACILITY	**4055 PINEWOOD RD MELBOURNE, FL 32934**

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

0000 - Initial Comments

An unannounced Complaint Investigation #2017008830 was conducted on 8/01/17, 8/10/17, 8/11/17, 8/15/17 and 8/17/17. Pinewood Estates Assisted Living had deficient practice at the time of the visit.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on interviews and record reviews, the facility failed to provide an environment which was safe, free from abuse and neglect and being treated with respect and consideration for personal dignity and privacy. The facility failed to provide notice of a 45 day notice for 1 of 2 discharged residents (#6).

Findings:

On 8/1/17, in a record review of local fire and rescue reports, the following information was documented:
1) An E-mail received from the local county fire and rescue dated revealed that local fire and rescue responded to the facility on The fire and rescue officers found two residents located in the patio. The residents reported that nothing was wrong with them other than not having a place to live. The residents stated they could not live at the facility because they did not have their medication. The facility had moved the residents to the facility on and the residents did not have their medication at that time. The facility would not allow the residents to remain unless they went to the local hospital to get more medication.

2) An E-mail received from the local county fire and rescue dated documented that local fire and rescue responded to the facility on , finding a resident standing at the end of the driveway with the manager and another employee of the assisted living facility. The resident stated she has been kicked out of the facility because she refused to allow a nurse to . The resident stated because of the refusal to allow the nurse to , the facility was making her leave. The manager stated to fire and rescue the resident is a threat and needs to be removed. When the manager was questioned how the resident was a threat, she stated, "The resident could be a threat." The manager denied telling the residents that they could not stay there, but later told fire and rescue she told the residents, "They will not be allowed to stay."

3) An E-mail received from the local county fire and rescue dated documented that local fire and rescue responded to the facility on . When the officers from fire and rescue arrived, they found an assisted living facility staff member yelling in the "face" of a resident and calling her names. The resident started to wander down the street without supervision of staff. The staff returned to the facility, went inside and locked the door. Fire and Rescue contacted local law enforcement. Local law enforcement had to become involved to have the facility take the resident back.

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On 8/10/17 at 10 AM, Staff E stated the Agency for Health Care Administration (AHCA) representatives would not be allowed to review the employee files because they are legal office records. Therefore, it was unable to determine if staff had training in reporting Abuse, Neglect, & Exploitation.

4) On 8/15/17, at 3:59 PM, in an interview with a local home health nurse, the nurse stated that she was uncomfortable with the facility and asked to be removed from her assignment at the facility. The nurse stated the facility required her to provide medical treatment for the residents in the rest room. The nurse stated that Staff E would not give the residents privacy and had to be in the room when treatment was being provided.

5) On 8/10/17, the admission and discharge log did not reflect that Resident #6 had been admitted or discharged from the facility, and reflected that Resident #7 was admitted on and discharged on

On 8/10/17 at 10:02 AM, Staff E stated Resident #6 did leave her belongings at the facility. Staff E stated she had boxed all of them up and put them in storage. Staff E walked the surveyor to the back of the property and opened a horse trailer. Staff E pointed to the front of the trailer and stated that the box containing the resident's belongings were up front. Staff E reported that everything would need to be moved in order to retrieve the items. Horse saddles, farm type equipment, and mattresses blocked the box.

On 8/10/17 at 10:45 AM, Staff E stated Resident #6 had been at the facility for a few hours and was not admitted because she refused to sign the contract. Staff E stated she sent Resident #6 to the hospital because she had in her Staff E stated Resident #6 had come from a local assisted living facility.

On 8/11/17 at 11:59 AM, an interview was conducted with Resident #6 at her current place of residence, which was another licensed location in the area. Resident #6 stated she had previously resided at the facility for Resident #6 stated she had come to this facility from a prior local assisted living facility. Resident #6 stated she is to a Resident #6 stated Staff E would make her carry her to the restroom to empty it after use via her Resident #6 stated the staff would become upset because she would sometimes spill the contents attempting to empty it in the bathroom. Resident #6 stated that she had resided at the facility and went out to the hospital due to She reported that the day she went to the hospital, staff at the facility would not contact a health care provider, so she called her case manager who told her to call 911. Resident #6 stated she called 911, and the fire department took her to the hospital. Resident #6 stated when she got

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to the hospital, she noticed her wallet was missing her credit cards and state identification. Resident #6 stated she was never given a letter of 45-day discharge. No records were provided by the facility to show a 45-day notice had been provided. She reported that she was not allowed back at the facility upon being discharged from the hospital.

On 8/15/17, at 1:48 PM, a local insurance provider stated Resident #6 was moved from a local assisted living facility to the facility in early 2017. The provider stated the resident was transported to the hospital at the end of 2017. The provider stated Resident #6 called her to say she was and the facility would not do anything to help her. The provider stated she instructed Resident #6 to contact 911.

On 8/17/17, 10:25 AM, in an interview with the Administrator from Resident #6's prior assisted living facility, the administrator stated Resident #6 had been discharged from their assisted living facility to the facility around

Class II