STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910275	C 11/06/2017
NAME OF PROVIDER OR SUPPLIER **GOOD SAMARITAN RETIREMENT HM**	STREET ADDRESS, CITY, STATE, ZIP CODE **507 S.E. 1ST AVENUE** **WILLISTON, FL 32696**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

On , an unannounced complaint survey (CCR#2017013545, 2017013493) was conducted at Good Samaritan Retirement Home in Williston (Licence #25). Deficiencies were identified as a result of the survey. The facility was not in compliance at this time. On This statement of deficiencies is amended to include an additional citation at A-0030 (Resident Rights).

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on interview and record review, the facility failed to contact resident's health care provider when the resident exhibited a significant change in condition, to contact resident's family and failed to maintain/update written record as it relates to significant change in condition for 2 of 2 residents reviewed (Resident #1 and Resident #2).

Findings:

On Resident #1 sustained a outside the building. As a result she sustained a head injury.
On Resident #2 was found .

On at 9:45 AM, an interview was conducted with the facility Manager in reference to of Resident #1. The manager was asked why she did not send Resident #1 to the hospital when she found her in the condition outside the facility. The manager stated that she did not seek medical attention for Resident #1 because the resident refused and did not want to go to the hospital. Manager stated she did not contact resident's medical provider or her emergency contact person, which is her daughter about the resident refusing to go to the hospital or for sustaining the hematoma on her head.

On at 11:30 AM, interview conducted with the facility Manager who stated there is no written documentation indicating change in condition, notification to health care provider, or notification of emergency contact person regarding Resident #1's and changes in condition.

Records Review of Resident #1's observation log contained no documentation of resident having a change in condition including problems with breathing, gasping for air, or . There was no documentation of notification of any concerns to the Health Care Provider.

The record review showed Resident #1 had an Emergency instructions from Shands Emergency at 3:07 PM with diagnosis of and . Follow-up instructions indicated for Resident #1 to schedule an appointment as soon as possible for a visit in 1 day with Family Medicine in Newberry. Resident's observation log has no documentation of the incident,

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Emergency or follow-up visit to primary physician.

Record review of Resident #1's incident/accident report, dated at 8:30 PM, revealed resident condition was normal, with no other noted specifications documented. Description of damage indicated "saw resident with on her right forehead and bumped, applied first aid, ice compress. Patient refused to go to the hospital;" and indicated that physician was notified and actions taken to prevent reassurance is to closely monitor resident specially when going out to smoke. No follow-up actions documented. No family contacted per incident report. (Photo obtained)

Record review of Resident #1's Incident/Accident report dated , report was undated with no documentation of the location of the incident and no conditions were documented by facility. The description revealed that the caregiver found her with a cut on her chin, sent to hospital in Williston for treatment. Report indicated Resident #1 said she , incident was unwitnessed. (Photo of report obtained)

Interview conducted with the facility Manager on at 12:15 PM, revealed the manager stated no documentation of any change in condition exists concerning Resident #1's condition requiring medical attention on and . There was no documentation showing the facility contacted the primary care physician or the resident's emergency contact person regarding both hospital visits. The manager stated that Family Medicine in Newberry was Resident #1's primary care physicians. The Manager confirmed the facility did not notify Family Medicine of Resident #1's transfer to hospital or the Emergency .

On , a record review of the Incident Report for the facility revealed there was no adverse incident report filed for Resident #1 when the resident was sent to the hospital via Emergency Management Services on and .

During interview on at 12:45 PM, Resident #1's daughter, who is emergency contact, stated that she never received a call from Good Samaritan concerning her mother's or being transported to the hospital. She stated that she spoke with her mother on and thought that she didn't sound right. Resident's daughter stated that she spoke with the Manager and told her that her mother sounded off. She asked the Manager if her mother was okay. The Manager assured Resident #1's daughter that her mother was fine. Resident #1's daughter was never told that her mother had and hit her head. She was informed by the hospital that Resident #1 was not going to survive due to in her .

On at 1:30 PM, an interview was conducted with the facility Manager, who stated that on at 8:30 PM she pulled up to the facility and discovered Resident #1 walking around outside

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because she wanted to smoke a cigarette. Manager stated it was dark and getting late so she escorted Resident #1 back into the facility. She stated, when she reached a lit area, she observed a bump on the right side of Resident #1's forehead with a small amount of dry . She stated that Resident #1 said she in the parking lot and did not wish to go to the hospital. The Manager stated Resident #1 was and responsive. The Manager stated that Staff B and Staff C helped clean Resident #1's wounds and then placed her within the memory unit to be monitored better and to prevent her from wandering out of the facility. The Manager stated she did not contact Emergency Medical Service ( ) because Resident #1 was and responsive. The facility Manager stated that Resident #1 was monitored on an hourly basis by Staff C from 9:00 PM until 11:00 PM, then Staff G from 11:00 PM until resident was discovered unresponsive. The Manager stated that at about 1:38 AM she was notified by staff and she called 911 for assistance.

An incident on in the memory care unit. The incident involved Resident #2, and Residents # 11, #12 and #13. The memory unit was left unsupervised by staff, against protocol, and at approximately 1:06 PM a physical confrontation took place between Resident #2 (,), who had a diagnosed of late stage , and Resident #11 (,), diagnosed with , . The incident between Resident #2 and #11 started as verbal confrontation over a cup cake, which turned physical.

On at 4:30 PM, review/observation of the video clip of the incident which occurred on between Residents #2 and #11 showed Resident #11 hitting Resident #2 with his fist causing him to to the floor. Resident #11 was observed to hit Resident #2 approximately 55 times making contact with his face and trunk area. This act of aggression started at 1:06 PM and lasted for about two minutes then ended when the facility manager, the cook, and the maintenance man walked into the area at 1:08 PM separating the residents. The video showed Resident #12 and #13 attempting to stop the fight but they were unsuccessful in doing so. Resident #2 sustained injuries from Resident # 11 which required emergency medical treatment.

On at 5:15 PM, the facility Manager stated she did not notify Residents #2's primary care physician or Resident #2's son about the incident.

On , a record review of the Incident Report for the facility revealed there was no adverse incident report filed for Resident #2 when the resident was sent to the hospital via Emergency Management Services on .

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

Based on video observations the facility failed to provide a safe living environment and prevent resident-to-resident for 1 (resident #2).of 4 residents. For Resident #2.
Findings:
On an incident of resident on resident aggression occurred in the memory care unit. The incident involved Resident #2, and Residents #11, #12 and #13. The memory unit was left unsupervised by staff, against protocol, and at approximately 1:06 PM a physical confrontation took place between Resident #2 ( ), who had a diagnosed of late stage , and Resident #11 ( ), diagnosed with . The incident between Resident #2 and #11 started as verbal confrontation over a cup cake, which turned physical.

On at 4:30 PM, an observation of the facility video recording was conducted of the incident that occurred on at approximately 1:06.34 PM between Resident #2 and #11. The video shows Resident #11 getting up off a couch (after a verbal exchange) and hitting Resident #2 with his fist in the face, causing him to to the floor. Resident #2 then got up off the floor and confronted Resident #11. Resident #2 was seen pointing his finger and shaking his hand at Resident #11. Resident #11 was observed to hit Resident #2 a second time knocking him to the floor. Once Resident #2 was on the floor the second time, Resident #11 got on top of Resident #2 and continued to hit him approximately 55 times with closed fist making contact with his face and trunk area of Resident #2 body. This act of aggression started at 1:06 PM and lasted for about two minutes then ended when Resident #11 seemed to get tired because Resident #12 and #13 were attempting to stop the . Resident #13 is seen going to the memory care door and a few second later at approximately 1:08.45 PM staff are seen coming into the memory care to assist Resident #2. Resident #2 sustained injuries from Resident #11 that required emergency medical treatment.

During this incident, there were no staff noted on the video supervising the residents.

Class I

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview, the facility failed to document observations on resident record and to report the observation to the residents health care provider for 2 of 2 residents reviewed (Resident #1 and Resident #2)

Findings:

On , Resident #1 sustained a outside the building. As a result she sustained a head injury.

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Medical attention was not sought for Resident #1. On Resident #2 was found in the memory care unit and transported to the hospital. Resident #1 subsequently as a result of her injuries.

During interview on at 9:45 AM, the facility Manager stated that she did not seek medical attention for Resident #1 because she refused and did not want to go to the hospital. Manager stated she did not contact resident's medical provider or her emergency contact person, which is her daughter.

On at 1:30 PM, an interview was conducted with the facility Manager who stated that on at 8:30 PM she pulled up to the facility and discovered Resident #1 walking around outside because she wanted to smoke a cigarette. Manager stated it was dark and getting late so she escorted Resident #1 back into the facility. She stated, when she reached a lit area, she observed a bump on the right side of Resident #1's forehead with a small amount of dry She stated that Resident #1 said she in the parking lot and did not wish to go to the hospital. The Manager stated Resident #1 was and responsive. The Manager stated that Staff B and Staff C helped clean Resident #1's wounds and then placed her within the memory unit to be monitored better and to prevent her from wandering out of the facility. The Manager stated she did not contact Emergency Medical Service ( ) or the Department of Children and Families (DCF) because Resident #1 was and responsive.

On at 1:45 PM, an interview was conducted with the facility Manager who stated that Resident #1 was monitored on an hourly basis by Staff C from 9:00 PM until 11:00 PM, then Staff G from 11:00 PM until resident was discovered unresponsive. The Manager stated that at about 1:38 AM she was notified by staff and she call 911 for assistance.

During interview on at 2:30 PM, Resident #4 stated that he had been at the facility for about 2 years. He stated that the facility is very short on staff and at night there is only one staff working at the facility. He stated that he was the "Supervisor" and watches the residents of the memory unit every Friday from 1-3 pm because there is no staff available to watch them. He stated that he also knows the PIN code to get in and out of the secured unit, which is a restricted area. Resident #4 stated that he was on the unit the day that there was a battery incident, that resulted in a resident having a hip back in early .

During interview on at 3:15 PM, Resident #9 stated that she is not aware of what happened to Resident #1 but she was always walking off from the facility and staff had to go find her. She stated that the facility cannot keep any staff here and the other ladies are over worked.

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During interview on at 4:15 PM, Resident #7 stated that he feels safe in the facility because he can do a lot for himself. He stated that the facility is very short of staff and the girls work double shifts sometimes back to back. He stated that sometimes there are argument and fights but no staff around to stop it and someone is going to get hurt one day.

During interview on at 4:45 PM, Resident #10 stated that she is the of Resident #1. She stated that in the past weeks Resident #1 had been wandering away from the facility during the evening hours and staff had to go search for her and bring her back to the facility. She had no knowledge of the incident which occurred on with Resident #1. [sic] Resident #1 had lost her glasses and was unable to see clearly.

On at 3:30 PM, an interview was conducted with the facility Manager who stated that the facility had no record of hourly well-being checks of the residents. She stated that the facility is short staffed and employees are poorly trained.

On an incident of resident on resident aggression occurred in the memory care unit. The incident involved Resident #2, and Residents #11, #12 and #13. The memory unit was left unsupervised by staff, against protocol, and at approximately 1:06 PM a physical confrontation took place between Resident #2 ( ), who had a diagnosed of late stage , and Resident # 11 ( ), diagnosed with . The incident between Resident #2 and #11 started as verbal confrontation over a cup cake, which turned physical.

On at 4:30 PM, an observation of the video clip of the incident which occurred on between Resident #2 and #11 showed Resident #11 hitting Resident #2 with his fist causing him to to the floor. Resident #11 was observed to hit Resident #2 approximately 55 times making contact with his face and trunk area. This act of aggression lasted for about two minutes then ended when the facility manager, the cook, and the maintenance man walked into the area at 1:08 PM separating the residents. The video showed Residents #12 and #13 attempting to stop the fight but they were unsuccessful in doing so.

On at 4:40 PM, an interview was conducted with the facility Manager who stated that Resident #11 has a and has limited capacity but is able to answer questions. She stated that he has been at the facility since 2015 and has never displayed any aggression but he has wandered from the facility in the past. The facility manager stated that Resident # 11 has been served with his 45 day notice and the facility will be assisting him with finding another facility to move to.

On at 5:15 PM, the facility Manager stated she did not notify the primary care physician or

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Resident #2's son.

On at 11:10 AM, a record review for Resident #1, 1823 health assessment was conducted. Resident #1's 1823, dated , identified a diagnosis of , history of facial surgery with wiring due to injury. Section under general oversight indicated the extent to which Resident #1 needed general oversight daily: observing wellbeing, observing whereabouts, and reminders for important tasks. Medications included Triazodone, and .

On at 11:30 AM, an interview was conducted with the facility Manager who stated there is no written documentation indicating change in condition, notification to health care provider, or notification of emergency contact person regarding Resident #1's and changes in condition.

Records Review of Resident #1's observation log contained no documentation of resident having a change in condition including problems with breathing, gasping for air or . There was no documentation of notification of any concerns to the Health Care Provider.

On , record review was conducted on Resident #1's Emergency instructions, documenting she was transported to Shands Emergency at 3:07 PM with diagnosis of and . Follow-up instructions indicated for Resident #1 to schedule an appointment as soon as possible for a visit in 1 day with Family Medicine in Newberry. Resident's observation log has no documentation of the incident, Emergency or follow-up visit to primary physician.

Interview conducted with the facility Manager at 12:15 PM, revealed the manager stated no documentation of any change in condition exists concerning Resident #1's condition requiring medical attention on and . There was no documentation showing the facility contacted the primary care physician or the resident's emergency contact person regarding both hospital visits.

Interview conducted with the facility manager on at 12:30 PM, revealed the manager stated that Family Medicine in Newberry was Resident #1's primary care physicians. The Manager confirmed the facility did not notify Family Medicine of Resident #1's transfer to hospital or the Emergency .

Record review of Resident #1 Incident/Accident report dated at 8:30 PM revealed resident condition was normal, with no other noted specifications documented. Description of damage indicated "saw resident with on her right forehead and bumped, applied first aid, ice compress. Patient

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refused to go to the hospital;" and indicated that physician was notified and actions taken to prevent reassurance is to closely monitor resident specially when going out to smoke. No follow-up actions documented. No family contacted per incident report. (Photo obtained)

Record review of Resident #1's Incident/Accident report dated , report was undated with no documentation of the location of the incident and no conditions were documented by facility. The description revealed that the caregiver found her with a cut on her chin, sent to hospital in Williston for treatment. Report indicated Resident #1 said she , incident was unwitnessed. (Photo of report obtained)

On , a record review of the Incident Report for the facility revealed there was no adverse incident report filed for Resident #1 when the resident was sent to the hospital via Emergency Management Services on and .

On , a record review of the Incident Report for the facility revealed there was no adverse incident report filed for Resident #2 when the resident was sent to the hospital via Emergency Management Services on .

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on record review and interview, the facility failed to have adequate staff to provide resident supervision, monitor residents and render emergency care to a compromised resident for 28 of 28 residents.

Findings:

A review of scheduled staff schedule for the weeks of - show total hours worked of 273 with a minimum staffing requirement per regulations of 294 hours per week; facility staffing is below minimum requirements for 28 residents.

A review of scheduled staff schedule for the weeks of - show total hours worked of 288 with a minimum staffing requirement per regulations of 294 hours per week; facility staffing is below minimum requirements for 28 residents.

A review of scheduled staff schedule for the weeks of - show total hours worked of 273 with a minimum staffing requirement per regulations of 294 hours per week; facility staffing is below

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minimum requirements for 28 residents.

A review of scheduled staff schedule for the weeks of - show total hours worked of 273 with a minimum staffing requirement per regulations of 294 hours per week; facility staffing is below minimum requirements for 28 residents.

A review of scheduled staff schedule for the weeks of - show total hours worked of 286 with a minimum staffing requirement per regulations of 294 hours per week; facility staffing is below minimum requirements for 28 residents.

A review of scheduled staff schedule for the weeks of - show total hours worked of 267 with a minimum staffing requirement per regulations of 294 hours per week; facility staffing is below minimum requirements for 28 residents.

A review of scheduled staff schedule for the weeks of - show total hours worked of 286 with a minimum staffing requirement per regulations of 294 hours per week; facility staffing is below minimum requirements for 28 residents.

A review of scheduled staff schedule for the weeks of - show total hours worked of 274 with a minimum staffing requirement per regulations of 294 hours per week; facility staffing is below minimum requirements for 28 residents.

A review of scheduled staff schedule for the weeks of - show total hours worked of 271 with a minimum staffing requirement per regulations of 294 hours per week; facility staffing is below minimum requirements for 28 residents.

A review of the schedule showed staffing (Sun-Sat) for the week of to consisted of the manager and all three shifts. Total hours of 251 with a minimum requirement per regulation is 294 hours per week; facility staffing is below minimum requirements for 28 residents.

A review of the schedule showed staffing (Sun-Sat) for the week of to consisted of the manager and all three shifts. Total hours of 262 with a minimum requirement per regulation is 294 hours per week; facility staffing is below minimum requirements for 28 residents.

During interview on at 1:00 PM, Resident #5 stated there is not enough staff at the facility to assist as needed and that makes her mad at times. She stated that during the evening and night hours there is only one staff working at the facility. She stated that Staff B was pulled to be the cook and that

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made it worse, now they are really short.

During interview on at 1:15 PM, Resident #8 stated that the ladies are over worked and the Administrator needs to hire more staff before they quit like the other girl. Resident stated that new staff came to work for one day and quit after she found out she had to work a double.

During interview on at 2:30 PM, Resident #4 stated that he had been at the facility for about 2 years. He stated that the facility is very short on staff and at night there is only one staff working at the facility. He stated that he was the "Supervisor" and watches the residents of the memory unit every Friday from 1-PM because there is no staff available to watch them. He stated that he also knows the PIN code to get in and out of the secured unit, which is a restricted area. Resident #4 stated that he was on the unit the day that there was a battery incident, that resulted in a resident having a hip back in early .

On at 2:45 PM, interview was conducted with Staff B. She stated that she was not working on and does not know how the injury occurred. She stated that she is both a caregiver and the cook working double shift because the facility is short on staff right now. Record review of the staffing schedule indicated that Staff B was on duty.

During interview on at 3:15 PM, Resident #9 stated that she is not aware of what happen to Resident #1 but she was always walking off from the facility and staff had to go find her. She stats that the facility cannot keep any staff here and the other ladies are over worked.

On at 3:30 PM, an interview was conducted with the facility Manager who stated that the facility had no record of hourly well-being checks of the residents. She stated that the facility is short staffed and employees are poorly trained because they are not doing their job competently.

During interview on at 3:45 PM, Resident #6 stated that he was not aware of anybody wandering away from the facility but he was aware of the two residents fighting over a cup cake in the memory unit and there was no staff there to stop the fight. Resident #6 stated that the Administrator needs to hire more staff because a lot of the time there is only one staff working.

During interview on at 4:15 PM, Resident #7 stated that he feels safe in the facility because he can do a lot for himself. He stated that the facility is very short of staff and the girls work double shifts sometimes back to back. He stated that sometimes there are argument and fights but no staff around to stop it and someone is going to get hurt one day.

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During interview on at 4:45 PM, Resident #10 stated that the facility does not have enough staff during afternoon and night hours and anything can happen to them without someone to help them.

On at 10:00 AM, Review of the staffing schedule for the date of the incident with Resident #1 revealed:

1st shift: 7 am-PM	2nd shift	3rd shift
Staff A (7a-3p)	Staff C (3p-11p)	Staff G(11p-7a)
Staff F(7a-2p)		
Staff E (7a-3p)		

Staff B currently In the role of the caregiver/cook 7am-1pm and 4pm-7pm.

On at 10:12 AM, Review of the staffing schedule for the date of the incident with Resident #2 revealed:

1st shift: 7 am-PM	2nd shift	3rd shift
Staff A (7-3p)	Staff B(3-11pm)	Staff C (11p-7am)
Staff F (7a-2p)	Staff C (4p-6p)	
Staff E (9a-3p)		

On , an observation of the video clip of the incident that occurred on between Resident #2 and #11 showed Resident #11 hitting Resident #2 with his fist causing him to to the floor. Resident #11 was observed to hit Resident #2 approximately 55 times making contact with his face and trunk area. This act of aggression lasted for about two minutes then ended when the facility manager, the cook, and the maintenance man walked into the area at 1:08 PM separating the residents. The video showed Resident #12 and #13 attempting to stop the fight but they were unsuccessful in doing so.

Class I

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and interview, the facility failed to follow the reporting requirements following an adverse incident for 2 of 2 sampled residents (Resident #1 and Resident #2).

Findings:

On Resident #1 suffered a outside the building. On , Resident #1 was found

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unconsicous and was transported to the hospital via ambulance. Subsequent to the , Resident #1 succombed to the injuries and .

On at 10:30 AM, review of facility Adverse Incident Reporting Procedure (Undated). 400.423 Definition-Adverse Incident: An event over which the facility personnel could exercise control rather than as a result of the resident's condition or process and results in:

*
* and spinal damage
* Permanent
* or of bone or joint
* Any medical condition requiring attention to which the resident has not given consent and or legal guardian has given consent including failure to honor Advanced Directives.

All incidents will be kept in a separate folder in the Administrator's office. Incident reports will not be copied, the exception to this would be the facsimile report sent to AHCA for a code 15 occurrence within the 24 hour time period. Incident reports will not be copied and not placed in the resident's chart. An explanation of the incident is to be written on the progress report, but the statement that an incident report was filed will not appear on the chart.

On at 1:30 PM, an interview was conducted with the facility Manager who stated that on at 8:30 PM she pulled up to the facility and discovered Resident #1 walking around outside because she wanted to smoke a cigarette. Manager stated it was dark and getting late so she escorted Resident #1 back into the facility. She stated, when she reached a lit area, she observed a bump on the right side of Resident #1's forehead with a small amount of dry . She stated that Resident #1 said she in the parking lot and did not wish to go to the hospital. The Manager stated resident #1 was and responsive. The Manager stated that Staff B and Staff C helped clean Resident #1's wounds and then placed her within the memory unit to be monitored better and to prevent her from wandering out of the facility. The Manager stated she did not contact Emergency Medical Service ( ) or the Department of Children and Families (DCF) because Resident #1 was and responsive.

On at 1:45 PM, an interview was conducted with the facility Manager who stated that Resident #1 was monitored on an hourly basis by Staff C from 9:00 PM until 11:00 PM, then Staff G from 11:00 PM until resident was discovered unresponsive. The Manager stated that at about 1:38 AM she was notified by staff and she called 911 for assistance.

On , record review was conducted on Resident #1's Emergency instructions documenting she was transported to Shands Emergency at 3:07 PM with diagnosis

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910275	C 11/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN RETIREMENT HM	**507 S.E. 1ST AVENUE WILLISTON, FL 32696**

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

of and . Follow-up instructions indicated for Resident #1 to schedule an appointment as soon as possible for a visit in 1 day with Family Medicine in Newberry. Resident's observation log has no documentation of the incident, Emergency or follow-up visit to primary physician.

Interview conducted with the facility Manager at 12:15 PM, revealed the manager stated no documentation of any change in condition exists concerning Resident #1's condition requiring medical attention on and . There was no documentation showing the facility contacted the primary care physician or the resident's emergency contact person regarding both hospital visits.

Record review of Resident #1's Incident/Accident report dated , showed report was undated with no documentation of the location of the incident and no conditions were documented by facility. The description revealed that the caregiver found her with a cut on her chin, sent to hospital in Williston for treatment. Report indicated Resident #1 said she , incident was unwitnessed. (Photo of report obtained)

On , a record review of the Incident Report for the facility revealed there was no adverse incident report filed for Resident #1 when the resident was sent to the hospital via Emergency Management Services on and .

On , a record review of the Incident Report for the facility revealed there was no adverse incident report filed for Resident #2 when the resident was sent to the hospital via Emergency Management Services on .

An interview was conducted with the facility Manager on at 5:20 PM. She stated an Adverse Incident, 1 day or 15 days, was not completed or filed with the Agency for Health Care Administration.

On at 4:30 PM, review/observation of the video clip of the incident which occurred on between resident #2 and #11 showed Resident #11 hitting Resident #2 with his fist causing him to to the floor. Resident #11 was observed to hit Resident #2 approximately 55 times making contact with his face and trunk area. This act of aggression lasted for about two minutes then ended when the facility manager, the cook, and the maintenance man walked into the area at 1:08 PM separating the residents. The video showed Resident #12 and #13 attempting to stop the fight but they were unsuccessful in doing so. The facility did not report the incident as required.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910275	C 11/06/2017
NAME OF PROVIDER OR SUPPLIER **GOOD SAMARITAN RETIREMENT HM**	STREET ADDRESS, CITY, STATE, ZIP CODE **507 S.E. 1ST AVENUE** **WILLISTON, FL 32696**	

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

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on record review and interview, the facility failed to maintain a current employee roster within the Background Screening Clearinghouse for 3 of 10 direct care staff (Staff C, D, E).

Findings:

A review of the Agency Employee Roster on the Background Screening Clearinghouse website on revealed that Good Samaritan Retirement ALF staff roster had no information entered into the website for Staff C, D, and E.

On , during an interview with the manager at 12:48 pm, she stated that she had not had a chance to get around to that. She stated she felt the most pressing issue to tackle when she was hired was the resident's medication and emergency supplies.

Unclassified

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c) FS

Based on record review and interview, the facility failed to obtain the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., which must be in the employee's personnel file and maintained by the provider for 6 of 10 care staff reviewed. (Staff A, B, C, D, E and G).

Findings:

An Employee Record review of Good Samaritan Retirement ALF revealed that 6 care staff files were missing the attestation form for Staff A, B, C, D, E and G.

On , during and interview with the manager, at 12:09 pm, she stated she was uncertain what the paper looked like. She was not able to produce the requested documentation.

Unclassified