STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911942	01/03/2018
NAME OF PROVIDER OR SUPPLIER **ROYAL PALM RETIREMENT CENTRE**	STREET ADDRESS, CITY, STATE, ZIP CODE **2500 AARON STREET** **PORT CHARLOTTE, FL 33952**	

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

0000 - Initial Comments

An unannounced complaint survey for CCR# 2018000017 was conducted though at Royal Palm Retirement Centre, an assisted living facility (license #3915) in Port Charlotte, Florida.

The complaint contained 3 allegations, which were substantiated with deficiencies.

A0025 and A0030 were cited at the Class I level.

The following is description of the deficiencies.

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

Based on staff interview and record review, the facility failed to ensure supervision of 1 (Resident #1) resident to prevent and control behaviors towards other residents. The facility repeatedly failed to take steps to adequately supervise residents which allowed Resident #1 to have contact with 2 other residents.

The findings included:

Resident #1 was admitted to the facility on . At the time of admission, The resident was assigned the A bed of a two-bed apartment. He had a male . Resident #1 was noted as alert, pleasant, able to make his needs known, and was capable of ambulating independently with a walker. Review of the Resident Health Assessment (Form 1823) showed Resident #1 had a history of , , , (, damage, or) and was noted to be . The resident resided on a memory care unit. A subsequent Adult Protective Services report noted Resident #1 lacked the capacity to consent.

A review of the charting notes for Resident #1 revealed a late entry dated at 11:30 a.m. for events of . The note documented Resident #1 was , inappropriate with a female resident (Resident #5). The Resident Health Assessment noted Resident #5 had , , and . Resident #1 and Resident #5 were found putting their hands down each others clothing and touching their private parts. They were talking "dirty" to each other and trying to get each other to go to their . The note further indicated the staff monitored the residents until bedtime. No other interventions were noted at that time. There was no documentation about the incident in Resident #5's chart notes.

A late entry dated at 11:41 a.m. for events up to noted it was reported that Resident #1

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was sitting in the dining trying to touch Resident #5 and trying to get her to fondle him. The staff had to intervene several times, according to the documentation, to keep Resident #1 out of Resident #5's .
The Resident Health Assessment noted Resident #4 had . Late chart entry of noted that on Resident #1 was found in his , his (Resident #4) had his brief off and Resident #1 was having Resident #4 touch his "private parts". Staff had both residents dressed and then left. Then 30 minutes later staff returned to the found Resident #1 totally naked and Resident #4 had his brief around his neck. Both men were touching each others . Resident #1 was moved to another the night. The note documented the Memory Care Unit Supervisor (writer of note) spoke with the Executive Director, the Wellness Director, and the Regional Nurse. The Executive Director spoke with the Resident #1's family. There was no documentation of physician notification for a possible medication evaluation for the behavior. There was no documentation of any further behavior issues noted with this resident.

Charting Notes indicated on at 11:55 a.m., the Memory Care Director was told by the night shift that Resident #4 was upset, combative, and afraid to enter his night. "He would yell 'get off me you bastard!'" The staff reassured the resident and kept the door open. During that night Resident #1 would peek around the door and then pretend like he was asleep. The note indicated that the nurse suspected inappropriate behavior. She spoke with the Executive Director and Regional Team concerning inappropriate behavior. The note further indicated they were moving Resident #1 to a private .

On starting at 1:45 p.m., Resident Care Aide Staff A, Activity Director Staff B, and Resident Care Aide Staff C were interviewed separately about what they had been told. All insisted that Resident #1 was polite, quiet, and calm on the day shift. He was , with medications. All were aware of the behaviors. They said their interventions were to do every 15-minute monitoring of the resident and to keep him away from other residents. They also had him sit at the head of the table so no residents were nearby. They said the interventions had not changed since the incidents. Staff C further said she found Resident #1 being , inappropriate with Resident #2 (a female) and Resident #3 (a male) on the evening shift. There was no documentation of this in the record, and no change in interventions resulted.
Resident Health Assessments noted Resident #2 had , Resident #4 had , and both were noted as .

On at 2:40 p.m., the Memory Care supervisor said Resident #1 was moved back into the Resident #4 (on) because the facility was painting the had been staying in. It was felt there were no further behaviors, so they could move the two residents back together. On

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they moved Resident #1 to a private (after the incident).

On at 2:40 p.m.,The Executive Director indicated that Resident #1 had been in several , had been moved several times. None of the staff could verbalize when the resident had moved and what he had occupied during his time (6 1/2 weeks) at the facility.

The records showed, on the , Advanced Registered Nurse Practitioner visited Resident #1, did an assessment, and ordered a (a medication with a known side effect of decreased drive).
On , Resident #1's wife was given a 45-day notice because the facility was no longer able to meet his needs due to his behaviors. There was no mention of any behaviors between and . On there was a late entry which noted on Resident #1 was sent to the hospital. He remained in the hospital at the time of the survey.

Class I

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

Based on record review and staff interview, the facility failed to ensure 1 (Resident #4) remained free from . The facility repeatedly failed to take steps to adequately supervise residents which allowed Resident #1 to have unwanted contact with Resident #4. Neither resident had capacity to consent.

The findings included:

Resident #1 was admitted to the facility on . At the time of admission, the resident was noted to be in the A bed of a two-bed apartment. He had a male , Resident #4. Resident #1 was noted to be alert, pleasant, able to make his needs known, and was capable of ambulating independently with a walker. Resident #1 resided on a memory care unit. Review of the Resident Health Assessment (Form 1823) showed Resident #1 had a history of , , , (, damage, or) and was noted to be . The resident resided on a memory care unit.

The Resident Health Assessment noted Resident #4 had . A late chart entry dated at 11:41 a.m. for noted Resident #1 was found in his his (Resident #4). Resident #4 had his brief off and Resident #1 was having Resident #4 touch his "private parts". Both residents were dressed and left alone. When staff returned to the minutes later, they found Resident #1 totally naked and Resident #4 had his brief around his neck. Both men were touching each others . Resident #1 was moved to another the night. The note documented the

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Memory Care Unit Supervisor (writer of note) spoke with the Executive Director, the Wellness Director, and the Regional Nurse. The Executive Director spoke with the Resident #1's family. There was no documentation of physician notification for a possible medication evaluation for the behavior. There was no documentation of any further behavior issues with this resident.

Facility records indicated on at 11:55 a.m., the Memory Care Director was told by the night shift, that Resident #4 was upset, combative, and afraid to enter his night. "He would yell 'get off me you bastard!'" The staff reassured the resident and kept the door open. Resident #1 would peek around the door and then pretend like he was asleep. The notes indicated that the nurse suspected inappropriate behavior. She spoke with the Executive Director and Regional Team concerning inappropriate behavior. The note further indicated they were moving Resident #1 to a private .

A subsequent Adult Protective Services report noted both Resident #1 and #4 lacked the capacity to consent.

On starting at 1:45 p.m., Resident Care Aide Staff A, Activity Director Staff B, and Resident Care Aide Staff C were interviewed separately about what they had been told. All staff insisted that Resident #1 was polite, quiet, and calm on the day shift. He was , with medications. All 3 staff were aware of the behaviors. They said the interventions were to do every 15 minutes monitoring of the resident and to keep him away from other residents. They also had him sit at the head of the table so no residents were nearby. They said the interventions had not changed since the incidents. Staff C said she found the Resident #1 being , inappropriate with Resident #2 (a female) and Resident #3 (a male) on the evening shift. There was no documentation of this in the record, and no change in interventions resulted.

On at 2:40 p.m., the Memory Care Supervisor said Resident #1 was moved back into the Resident #4 as the facility was painting the had been staying in. It was felt there was no further behaviors so they could move the two residents back together.

On at 4:25 p.m., Resident Care Aide Staff F said an incident occurred when Resident #1 and Resident #4 were moved back together. She said they woke up Resident #4 to clean him during the night. Resident #4 became combative and yelled at them to let him go and stay away from him. She said once the resident realized it was the staff cleaning him, he calmed down right away. She said Resident #4 had been refusing to go into the evening.

Chart Notes showed on they were moving Resident #1 to a private .

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On at 2:40 p.m., the Executive Director indicated that Resident #1 had been in several and had been moved several times. None of the staff could verbalize when the resident had moved and what he had occupied during his time at the facility.

Class I