| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11969015** | **04/02/2018** |
| NAME OF PROVIDER OR SUPPLIER<br>**WALTON PLACE** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**501 S WALTON AVE**<br>**TARPON SPRINGS, FL 34689** | |

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

**0000 - Initial Comments**

Assisted Living Facility

Amended

An unannounced complaint investigation, (CCR# 2018003226), was conducted at Walton Place Assisted Living Facility (license 12859), in Tarpon Springs, Florida, from to . At the time of the investigation, the facility had deficient practice.

Tag Z814 was administratively deleted on .

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

Based on observations, record review and interviews, the facility directly threatened the emotional health of one of six residents (Resident #1) by restricting private communication between the resident and friends and family, by denying the resident access to a telephone and not allowing visits with any person of his or her choice. The facility also violated the resident's dignity and right to privacy by filming the resident without consent.

Findings include:

On , in a record review of the facility's Resident Bill of Rights, provided in the resident admission packet, it documented the following statement: all residents have, "unrestricted private communication including receiving and sending unopened correspondence, access to a telephone and visiting with any person of his or her own choice." (Scan #2 -Exhibit K).

On at 10:10 AM, in an interview with Staff N, Staff N stated for residents living in the Memory Care Unit, all of the telephone calls come to the front desk and are then sent into the Memory Care Unit.

On at 10:20 AM, Agency staff observed telephone calls coming into the front desk then being called back to the staff of the Memory Care unit. The Agency observed visitors to the facility are required to sign into the facility prior to being allowed to visit a resident.

On at 11:54 AM, in an interview with Staff P, Staff P stated the administrator told her, "not to allow Resident #1 to have any telephone calls or visitors." Staff P confirmed all of the Memory Care

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resident's calls and visitors come to her, and she is the "clearing point."

On in a record review of Resident #1's resident contract, the contract referenced in section #6 the following; "You understand that as a resident you have the right to associate with your friends and family." (Scan #6)

On in a continued record review of Resident #1's resident contract, it references to Exhibit K as a part of the contract. Exhibit K states you have "unrestricted private communication including receiving and sending unopened correspondence, access to a telephone and visiting with any person of his or her own choice." (Scan #2 -Exhibit K)

On at 1:00 PM, in an interview with Resident #1 (a former resident of the facility), Resident #1 stated she did not think she needed to live in the Memory Care unit. Resident #1 stated that while residing at the facility, no one would talk to her about it. Resident #1 stated when she started to complain, the administrator would not allow her friend, Participant J, to visit with her. Resident #1 stated the facility had a beautiful garden, which was a part of the Memory Care Unit and was secured. Resident #1 stated the staff and administrator would not allow her to go out into the garden because they were afraid she would run away. Resident #1 stated the garden was fenced so no one could leave.

On at 4:00 PM, in an interview with Participant J, Participant J stated Resident #1 was begging her to leave the Memory Care Unit. Participant J stated she approached the administrator and asked about Resident #1 being evaluated to live outside the Memory Care Unit and he told her, "it was none of her business." Participant J stated she took Resident #1 to all of her doctor visits, shopping and church on Sunday. Participant J stated on her last visit, Staff F came to her and stated she needed to leave the facility, she would not be allowed to visit because she was been causing trouble.

On in a record review of Resident #1's file, the file contained a power of attorney (POA's) document, which listed Participant J and Participant I as POA's for Resident #1. (Scan #7).

On at 3:10 PM, in an interview with Participant H, Participant H (employed by an attorney) stated Resident #1 contacted her because Resident #1 wanted to learn how to move from the Memory Care Unit. Participant H stated she reviewed the information and tried on numerous occasions to get back in touch with Resident #1 but was always told she was not available which she stated was odd since she lived in a Memory Care Unit at the facility at the time.

On at 9:00 AM, in an interview with Participant S, Participant S stated she spoke to Resident #1 and Resident #1 requested to move from the Memory Care Unit and stated no one at the facility

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would listen to her. Participant S stated she attempted to talk with the administrator of the facility but he informed Participant S Resident #1 was, "crazy." Participant S stated she arranged to have Resident #1 evaluated. Participant S stated the evaluations showed Resident #1 did not need to be in a locked Memory Care Unit. Participant S stated when she attempted to assist Resident #1 in voluntarily moving from the facility (since Resident #1 did not have a guardian), she and Resident #1 were forced to call local law enforcement for assistance.

On . . . . . in a record review of a local law enforcement report written by Participant M, a detective, the law enforcement report documented the following information regarding the movement of Resident #1 on . . . . . at 5:00 PM:
" (Participant M) reviewed the medical paper work provided by the state agency and found Resident #1 had mental capacity, "therefore if she does not want to continue her stay at the facility, she will be leaving with the assistance of law enforcement, if that is her wish."
" At the time of arrival, (Participant M) requested to see Resident #1, "staff surrounding us at that time, seemed to not want to direct us to or allow entry to the locked unit in which Resident #1 was located." Participant M had to request the locked unit to be opened.
" In an interview with (Participant M), "(Resident #1) asked if she could please leave and move to an ALF of her choosing."

" While exiting (Resident #1's) . . ,( Participant M) wrote, "I carried some of her clothing and a bag to the end of the hallway, where I was met with approximately a dozen staff members, nearly blocking the exit, all with their cell phone cameras presumable actively recording me in a blatant fashion. I advised staff to enter the code into the key , so I could exit the memory care unit. I was told, loudly, by several staff members, "We forget the code" as nearly all staff members walked to the end of the hallway. I sternly advised all staff members if I was not granted access to immediately leave I would everyone who obstructed me at once."
Review of the report further revealed "(Resident #1) was escorted out of the building at that time. Many of the same (nearly dozen) staff members of the locked memory unit continued to presumably video record this on cell phones, making (Resident #1) uncomfortable and visibly upset."

On at 12:02 PM, in an interview with Participant L, Participant L stated she was hired to provide an evaluation of Resident #1. Participant L stated while talking with Resident #1, Staff F came into the knocking and stated Participant L needed to leave the facility because Resident #1 is not allowed to have visitors.

Class II

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

Based on record review and interviews the facility failed to ensure one of five staff (Staff E) had submitted a written statement from a health care provider, within 30 days of employment indicating the staff member does not have any signs or symptoms of communicable .

Findings include:

On , in a record review of Staff E's employee file, the file documented Staff E's date of hire was . The file for Staff E did not document a written statement within 30 days of employment that Staff E is free from any signs or symptoms of communicable .

On at 3:00 PM, in an interview with Staff F, Staff F stated the administrator was unavailable to meet with the Agency. Staff F stated that the employee files reviewed by the Agency were the complete copy for the sampled staff members.

Class III

**0081 - Training - Staff In-Service - 58A-5.0191(2) FAC**

Based on record reviews and interviews, the facility failed to ensure two of five staff (Staff B and E) had completed the required 1 hour of in-service training related to assistance with activities of daily living, incident reporting, resident rights and safe food handling. The facility failed to ensure one of five staff (Staff E) completed the required 1 hour of in-service training related to emergency procedures and recognizing, and reporting , neglect and , .

Findings include:

On , in a record review of Staff B's employment file, the file documented Staff B's date of hire as . The file for Staff B was missing documentation of Staff B having completed the required training related to assistance with activities of daily living, incident reporting, resident rights and safe food handling.

On , in a record review of Staff E's employment file, the file documented Staff E's date of hire as . The file for Staff E was missing documentation of Staff E having completed the required training related to assistance with activities of daily living, emergency procedures, incident reporting, resident rights, safe food handling and recognizing , neglect and , .

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On at 3:00 PM, in an interview with Staff F, Staff F stated the administrator was unavailable to meet with the Agency. Staff F stated that the employee files reviewed by the Agency were the complete copy for both staff members.

Class III

**0082 - Training - / - 58A-5.0191(3) FAC**

Based on record reviews and interviews the facility failed to ensure two of five staff (Staff B and E) had documentation of compltеing the required training regarding ( / ) within 30 days of employment.

Findings include:

On , in a record review of Staff B's employment file, Staff B's employment file documented Staff B's date of hire as . The file for Staff B did not contain documentation of Staff B having completed the required training for / .

On , in a record review of Staff E's employment file, Staff E's employment file documented Staff E's date of hire at . The file for Staff E did not contain documentation of Staff E having completed the required training for / .

On at 3:00 PM, in an interview with Staff F, Staff F stated the administrator was unavailable to meet with the Agency. Staff F stated that the employee files reviewed by the Agency were the complete copy for both staff members.

Class III

**0086 - Training - ADRD - 58A-5.0191(9) FAC**

Based on record review and interviews the facility failed to ensure one of five staff (Staff E) had completed the required 's and Related (ADRD) training with 90-days of employment.

Findings include:

On , in a record review of Staff E's employment file, Staff E's employment file documented

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Staff E's date of hire at . The file for Staff E did not contain documentation of Staff E having completed the required training for ADRD.

On at 3:00 PM, in an interview with Staff F, Staff F stated the administrator was unavailable to meet with the Agency. Staff F stated that the employee files reviewed by the Agency was complete for the sampled staff.

Class III