STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969015	R **06/01/2018**
NAME OF PROVIDER OR SUPPLIER **WALTON PLACE**	STREET ADDRESS, CITY, STATE, ZIP CODE **501 S WALTON AVE** **TARPON SPRINGS, FL 34689**	

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

0000 - Initial Comments

Assisted Living Facility

A revisit was conducted to a complaint investigation (CCR 2018003226) at Walton Place Assisted Living Facility (license 12859), in Tarpon Springs, Florida, from May 31, 2018 to June 1, 2018. At the time of the investigation, the facility had deficient practice related to the revisit.

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

Based on record review and interviews the facility placed one of three residents (Resident #3) at-risk by failing to provide an environment that is safe and decent and free of neglect and ensuring residents have access to health care. .

Findings include:

On 5/31/2018, in a record review of Resident #3's file, Resident #3's file documented an incident report from 2:00 AM on 2/11/2017. The incident report documents, "Resident #3 came out of his room and his face was swollen and bruised, mark on left and right cheeks, as well as a small laceration by the left ..." The incident report ended in mid-sentence. Resident #3's incident report listed the employees involved as Staff N and O. Resident #3's incident report documents the medical doctor was contacted at 9:30 AM on 2/12/2018 and Resident #3's wife was contacted with no time listed. Resident #3's incident report did not contain any signatures of who completed the incident report.

On 5/31/2018, in a record review of the facility work schedule for the week of 2/4/2018 to 2/10/2018, it documents Staff N worked from 3:00 PM to 11:00 PM on 2/10/2018 and Staff O worked from 11:00 PM to 7:00 AM on 2/10/2018.

On 5/31/2018, in a record review of the facility work schedule for the week of 2/ 11/2018 to 2/17/2018, it documents Staff N worked 7:00 AM to 3:00 PM on 2/11/2018 and Staff O was off on 2/11/2018.

On 5/31/2018 at 10:07 AM, an interview was conducted with Resident #3 in his room in Memory Care. Resident #3 had difficulty communicating (understanding and talking). Resident #3's face looked slightly yellow from what appeared to be past bruising. Resident #3 was asked if he fell in February and stated, "I think." Resident #3 could not answer if it was day or night when the fall might have happened.

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On 5/31/2018 at 1:42 PM, in an interview with Staff N, Staff N stated she worked on 2/10/2018 from 7:00 AM to 11:00 PM. Staff N stated when she ended her shift she checked on all of the residents including Resident #3 and everyone was fine. Staff N stated she told the incoming staff, "Everyone was fine, in bed and in their pajamas." Staff N stated the two staff who replaced her in Memory Care, working the 11:00 PM to 7:00 AM shift were Staff H and M.

On 5/31/2018 at 1:42 PM, in a continued interview with Staff N, Staff N stated when she returned to work at 7:00 AM on 2/11/2018, Staff O stated, "why didn't she tell the third shift girls what had happened to Resident #3." Staff N stated when she saw the marks and bruising on Resident #3, she took pictures of him. Staff N stated, "She took pictures of his face and knees, both of his knees had bruising and his face was bruised. His lip was swollen and teeth into the gums on the inside of his mouth." Staff N stated she told the weekend supervisor who contacted the Resident Care Manager around 10:00 AM on 2/11/2018. Staff N stated she completed the incident report the morning of 2/11/2018 and is not aware if anyone contacted the doctor or Resident #3's wife.

On 5/31/2018 at 2:05 PM, in an interview with Staff O, Staff O stated she was working the 11:00 PM to 7:00 AM shift on 2/10/2018. Staff O stated she works on the assisted living (ALF) side of the building. Staff O stated she went into the Memory Care Unit around 2:00 AM looking for Staff H to help her provide a resident with medication. Staff O stated Staff H asked her to come and look at Resident #3. Staff O stated she noticed, "His face was swollen and beat up." Staff O stated she went back to the ALF side of the building. Staff O stated the next day the weekend supervisor called her and asked if she knew what happened to Resident #3.

On 5/31/2018 at 7:47 PM, in an interview with the weekend supervisor, the supervisor stated she is aware of the incident involving Resident #3. The supervisor stated she was working the 7:00 AM to 3:00 PM shift on 2/11/2018. The supervisor stated staff, when getting Resident #3 out of bed stated to her he had the marks on his face. The supervisor stated she took pictures of the injuries and then called the Resident Care Manager. The supervisor stated the Resident Care Manager told her not to worry about it so she did not take any additional actions. The supervisor stated she is not aware of any formal procedures for falls or resident injuries beyond calling the Resident Care Manager. The supervisor stated now thinking about it she should have called for medical attention for Resident #3. The supervisor stated she did not do anything else and she returned to work on the ALF side of the building.

On 5/31/2018 at 11:10 PM, in an interview with Staff H, Staff H stated she does not know anything about the incident with Resident #3. Staff H was shown the pictures of Resident #3 with the injuries and Staff H stated she has never seen them before. Staff H stated the procedure for falls and resident injuries is to call the Resident Care Manager and he makes the decision.

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On 5/31/2018 at 11:20 PM, in an interview with Staff M, Staff M said she does remember the incident involving Resident #3. Staff M stated she was making her rounds and noticed Resident #3 sitting on the edge of his bed. Staff M stated she noticed a mark on Resident #3. Staff M stated she did not think anything of it. Staff M stated she put Resident #3 back to bed. Staff M stated procedures for resident falls, injuries is to call the Resident Care Manager, and he makes the assessment.

On 6/1/2018, in a record review of the photos provided by Staff N, the photos documented the following injuries to Resident #3; pink and purple bruising under the right eye into the right, pink and purple bruising on the left knee, red blood colored eyes and right side of mouth had pink and purple bruising.

On 6/1/2018, in a record review of employee files, the file review documents all employees are provided notification at the time of hiring that they are not allowed to have cell telephones or cameras on the floor while working. The file reviewed documented the facility would take disciplinary action if found and if photos were taken of residents.

On 6/1/2018, in a record review of Resident #3's resident file, the file documents the following information:

" Agency for Health Care Administration 1823 health assessment was completed on 11/28/2017. The health assessment documents that Resident #3 has a diagnosis of Alzheimer's, is an elopement risk and had been prescribed Eliquis. The weight was listed as 139 pounds.
" Weight chart list on 4/1/2018 a weight of 127 pounds.
" The progress chart notes two incidents, one for biting a staff member and the other for ending a medication, both on April 6, 2018.
" The file does not include any documentation of follow up or treatment for the incident on 2/11/2018.
" Physician order dated 12/4/2017 and signed by the nurse practitioner (ARNP) started Resident #3 on 5 mg of Eliquis.

On 6/1/2018 at 11:45 AM, in an interview with the nurse practitioner (ARNP), the ARNP stated he does remember the incident with Resident #3 in February. The ARNP stated he saw Resident #3 on 2/12/2018 and did not have any concerns. The ARNP stated at the time of the incident it would have been concerning for him for Resident #3 to not be transported to the hospital based on Resident #3 taking the medication Eliquis. The ARNP stated he was not aware of Resident #3's weight loss and would address it with the facility. The ARNP stated a 12-pound weight loss is a concern.

On 6/1/2018 at 2:00 PM, in an interview with the Resident Care Manager, it was requested the Resident

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Care Manager provide the medication observation records for Resident #3 for the month of February 2018. The Resident Care Manager stated the printer was down and he could not provide them until it was repaired.

On 6/8/2018, in a record review of the web site Drugs.com, the web site documents the following:
" Eliquis is an anti-coagulate (blood thinner).
" Patients should avoid activities that may increase your risk of bleeding or injury.
" Side effects, which require doctor notification: blood in your eyes, dizziness, bruising or purple area of the skin.
" Cautions, which require medical attention, include minor falls or bumps on the head.

On 6/1/2018, in a record review of the facility policy on incident reporting documents the following:
" All incidents shall be reported to the supervisor immediately.
" The supervisor makes the determination on steps to be taken.
" If it is deemed a major incident, call the administrator.
" Major incidents include: hospitalization of a resident, ER visit of a resident, Death of a resident, injury to staff by a resident, Baker Act, police called to the facility, incidents of abuse, neglect or exploitation.
" All other incidents are considered minor and the staff complete an in-house incident report.

On 6/1/2018 at 12:58 PM, in an interview with the administrator and Resident Care manager, the administrator stated the facility does not have an operating procedure regarding resident falls. The administrator stated the staff are required to evaluate the situation, ask the resident about pain and if the resident cannot move, call 911, otherwise call the Resident Care Manager. The administrator stated staff had contacted the Resident Care Manager and he instructed the staff to complete the incident report. The administrator stated they did not do an internal investigation. The administrator stated he left a message for Resident #3's wife who was on a cruise. The administrator stated the message was left on 2/11/2018.

On 5/31/2018 at 11:06 AM, in an interview with Resident #3's wife, Resident #3's wife stated she was on a cruise until 2/11/2018 but she never got a call from the facility. Resident #3's wife stated she learned of the incident when a state agency called her on 2/16/2018.

On 6/7/2018 at 8:411 PM, in an interview with Resident #3's wife, Resident #3's wife stated she did not get any messages from the administrator concerning Resident #3. Resident #3's wife stated she was contacted about Resident #3 on 2/16/2018 and went to see him on 2/16/2018. Resident #3's wife stated the wounds were almost healed at that point. Resident #3's wife stated she is concerned about Resident #3's weight but she addresses it with the Resident Care Manager and the Resident Care Manager

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stated the doctor would look into it.

Class III

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

Based on record review and interviews the facility failed to ensure two of ten staff (Staff I and J) had completed the required emergency preparedness training. The facility failed to ensure one of ten staff (Staff J) had completed the required training for resident rights.

Findings include:
On 5/31/2018 at 9:20 AM, in an interview with the Resident Care Manager, the Resident Care Manager was requested to provide the current copy of requested employee files for review.
On 6/1/2018, in a record review of Staff I's employee file, the file for Staff I documented Staff I started employment on 2/1/2018. Staff I's file did not contain documentation of Staff I having completed the required emergency preparedness training.
On 6/1/2018, in a record review of Staff J's employee file, the file for Staff J documented Staff J started employment on 10/6/2016. Staff J's file did not contain documentation of Staff J having completed the required emergency preparedness and resident rights training.
On 6/1/2018 at 5:20 PM, in an interview with the administrator, the administrator was presented with the missing documentation of Staff I (emergency preparedness) and Staff J (emergency preparedness and resident rights). The administrator was unable to provide any additional documentation.

Class III

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

Based on record review and interviews the facility placed residents at-risk by failing to ensure two of ten staff (Resident Care Manager and Staff K) had completed the required training related to Alzheimer's disease and Related Disorders (ADRD) for facilities that advertise providing special care for persons with ADRD.

Findings include:

On 5/31/2018 at 9:20 AM, in an interview with the Resident Care Manager, the Resident Care Manager was requested to provide the current copy of requested employee files for review.
On 6/1/2018, in a record review of the Resident Care Managers employee file, the file documented the Resident Care Manager started employment at the facility on 6/21/2017. The Resident Care Managers

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file did not contain any documentation of the Resident Care Manager having completed either Alzheimer's I training (4 hours within 3 months of employment) or Alzheimer's II training (four additional hours within 9 months of employment).
On 6/1/2018, in a record review of Staff K's employee file, the file document Staff K started employment at the facility on 5/26/2017. Staff K's file does not document Staff K having completed the required Alzheimer's II training (4 hours within 3 months of employment).
On 6/1/2018 at 5:20 PM, in an interview with the administrator, the administrator was presented with the missing training for the Resident Care Manager and Staff K related to ADRD. The administrator was unable to provide any additional documentation.

Class III