STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968596	**07/17/2018**
NAME OF PROVIDER OR SUPPLIER **COLONIAL ASSISTED LIVING AT BOYNTON BEACH FL**	STREET ADDRESS, CITY, STATE, ZIP CODE **1708 NE 4TH STREET** **BOYNTON BEACH, FL 33435**	

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

0000 - Initial Comments

An unannounced Complaint Survey, CCR# 2018010025 and 2018010191, were conducted from to at Colonial Assisted Living At Boynton Beach FL, an assisted living facility was not found to be in compliance during this visit. License #12470.

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

Based on interview and record review, the facility failed to provide a safe and decent living environment which was free from and neglect for 3 out of 3 sampled residents (Resident #1, #2 and #3). Specifically, staff members did not follow the facility's prevention policy and procedures to immediately report any observation, allegation or suspicion of resident or neglect to the Department of Children and Families' central hotline.

The findings are:

In a telephone interview with the facility Consultant on at approximately 11:05 AM she stated, an allegation of against Resident #1 was confirmed on and was being investigated by the local Police Department and Department of Children and Families (DCF.) She stated, 3 employees were suspects in this case and that 2 employees, Employee A and Employee B, were at the facility on . She stated, the facility was conducting their investigation into this event.

During a confidential interview on at 11:50AM, it was reported on at around 7:30PM while walking down the facility's North wing hallway, Employee A came out from and was observed laughing. The confidential individual stated, Employee A said, "do you want to see something funny?" and then employee A opened the door to to show how Resident #1 was tied and bound with both of the resident's arms and legs duct taped to a chair. The confidential individual reported, Employee B placed something inside Resident #1's mouth and told the resident, "Don't scream" and then said, "these pills will make her sleep." The confidential individual, then took photographs of Resident #1 while the resident was restrained in the chair (see photographic evidence) and then later reported this event to the Agency for Health Care Administration (Agency) and the central hotline on or about .

Review of Resident #1's health assessment dated on indicated that the resident was diagnosed with , , and , she had memory problems which required her to be prompted during bathing and self care, and she was independent with the remaining activities of daily living (ADLs.) Further review of this health assessment indicated that the resident was not identified as

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an elopement risk and she required assistance with self- administration of medications. Review of the facility's internal nursing assessment dated on , indicated that the resident was oriented, independent and exhibited no combative behaviors.

In an interview with the Administrator on at 12:40 PM she stated, she was first made aware of this resident event involving Resident #1, when the police arrived to the facility on at around 3:00pm. She stated, Employees A and B were by the police in the facility in front of the residents. She stated, the police notified her that the allegation of was confirmed and the involved employees had been charged with illegally restraining and falsely imprisoning Resident #1, who was identified to have . The Administrator stated, Employee A was employed as a medication technician and Employee B was a caregiver. The Administrator stated, the facility's prevention policy and procedures required every staff member to, and they were trained to "report whatever you see to the supervisor." She stated, the facility supervisors were always available 24-hours a day to respond to any allegation of resident .

In an interview with the Administrator on at 12:55pm, she stated the only other event that she could consider potentially or neglectful towards a resident took place a couple of weeks ago. She stated, that this happened when employee F reported to her that employee E possibly slapped resident #2 on her behind because she heard a loud slap when the resident and employee E were inside . She stated, she interviewed Resident #2 and the resident denied that anything happened. She stated, she also interviewed employee E and the employee denied that anything happened with Resident #2. She stated, she determined that based on her interviews, resident observation and that Employee F just heard a slap sound but did not actually see what caused the sound, this was solved and she did not report this event to the central hotline or anyone else in the facility. She stated, this event did not lead to any staff member disciplinary actions by the facility.

In an interview with the Consultant on at 1:00pm, she stated that she learned of the event involving Resident #2 from the Administrator that same day and that she recommended an immediate suspension of Employee E until the she concluded with a thorough investigation of this event. She stated that this event took place on or about and that she performed a nursing examination of resident #2 on and she found no signs of , or neglect on the resident. She stated that she did not contact the central hotline to report this suspected resident event.

In an interview with the Wellness Director on at 1:35 PM she stated, Resident#1 had been admitted to the facility on and that she had conducted the entrance meeting with the resident and her daughter. She stated, Resident #1 was very and was verbally upset, expressing that she did not understand why she was being left at the facility. She stated, Resident #1 could be

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redirected and was encouraged to participate in activities, which she did reluctantly. She stated, Resident #1 was alert and oriented to self and was not identified as an elopement risk. She stated on at around 7 PM while she was talking with the Consultant in the main nursing station, which has a large glass window overlooking the activity front door/lobby area, she overheard 4 residents banging on the glass front doors and attempting to force the electronic doors open. She stated, she immediately responded to the residents by the front door and that Resident #1 was there and she redirected the resident at that time. She stated, before she left the facility on at around 7 PM, she instructed the direct care staff to monitor Resident #1 to ensure she was stable. She stated, on at around 9PM, she called the facility and spoke to an unnamed staff member, who told her that there were no issues with Resident #1. She stated, at no time after that phone call on , did any staff member notify her of any resident concerns. She stated, she first heard of the event involving Resident #1 when the police arrived to the facility on . She stated, there was no documentation in the 24 hour reporting log that indicated any behavioral concerns with Resident #1. She stated, on , Resident#1 was somewhat agitated and pacing with her purse at her side, and verbally expressed that she wanted to go home, and the resident did not attempt to exit the facility. She stated, staff were able to easily redirect the resident on and that the consultant had notified the physician about the resident's , and pacing, but the facility did not receive any new physician orders for any treatment.

In an interview with the Activity Associate on at approximately 5:00PM, he stated that during the day on , Resident #1 was "quiet and reserved " and she was pacing from area to area within the facility. He stated, Resident #1 was not exit-seeking, yet "seemed not to know what or where to go." He stated, he redirected the resident numerous times to participate in the leisure activities during the day and she would sit for a few minutes, then get up and walk around. He stated, Resident #1 presented to be and about her new surroundings.

In a phone interview with Resident #1's daughter on at 10:40 AM she stated, her mother was admitted to the facility on and her mother was upset about being left at the facility. She stated, on , sometime between 7-8 PM, she received a phone call from an unnamed staff member who told her that her mother (Resident #1) was upset and "crying, yelling and taking swings" at staff. She stated, this staff member told her that due to her mother's combative behavior, it caused the staff member to break a finger nail. She stated, this staff member told her that her mother would be " " if the resident did not calm down. She stated, she pleaded with this staff member to not " " her mother, and to call on her to come onsite if her mother did not calm down. She stated, she did not receive any further calls from the facility on or . She stated, on at about 4 PM, she received a call from the police to inform her about the event involving her mother at the facility on . She stated, she came to the facility early in the morning on and the

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Administrator told her that she did not know much about the investigation involving Resident #1. She stated, her family member did not recall the event that took place on .

Review of the facility's electronic progress record dated on at 5:30PM indicated, Resident #1 was exhibiting behaviors including pacing, attempting to push open the facility front door and that staff were able to redirect the resident with success. Further review of Resident #1's progress notes indicated that the physician had been notified of the resident behaviors, no physician orders were given at that time and there was no additional resident documentation recorded after 5:30PM.
Review of Resident #1's , 2018 Medication Observation Record (MOR) indicated that the resident was prescribed 2 medications during the evening shift, , (for) 10mg at bedtime and , (for high) 10mg at bedtime. Further review of this MOR indicated that no other medication orders were received for the 3-11PM shift.

Review of Resident #2's health assessment dated on indicated that the resident was diagnosed with , , , and , and she required a wheelchair for ambulation. This health assessment indicated that the resident had limited range of motion of her left arm and she was not completely oriented. Further review of this health assessment indicated that she needed assistance with all of her ADLs, with the exception of eating, which she was independent with.
In an interview with Resident #2 on at 6:35 PM she presented to be and disoriented, and could not hold a conversation at this time.

In an interview with Resident #4 on at 2:15pm, he stated that on he saw Resident #3 get fondled on her by Resident #5 while they were in the common living . He stated, he reported this to the Administrator on or about , along with his psychologist, and the Administrator responded to this report by saying that she was aware of this and the facility was handling it. He stated, he felt better reporting this event to his psychologist before going to Administrator, since he felt that the Administrator would be unresponsive to receive this report just from him.

In an interview with the Administrator on at 3:30pm, she stated that there were no other recent reports of potential resident for her to investigate or to report on behalf of the facility. She stated, she was aware that Resident #5 was occasionally disruptive to other residents in the facility, but his actions were never threatening towards other residents.

In an interview with Resident #4's psychologist on at 4:00pm, she stated that she was approached by Resident #4 on or about to report that Resident #5 fondled Resident #3's on or about . She stated, in her professional opinion, Resident #4 had no reason to lie or

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fabricate this event. She stated, she and Resident #4 immediately went to the Administrator on to report this potential resident-on-resident and that the Administrator responded to them by saying that she was aware of this and that the facility was handling the situation. She stated, she had no reason to doubt the facility's prevention actions represented by the Administrator after they reported this event involving residents #3 and 5, and she did not subsequently report this event to the central hotline.

In an interview with the Administrator on at 4:20pm, she reaffirmed that there were no other recent reports of potential resident for her to investigate or to report on behalf of the facility. She stated, she did not specifically receive any reports from any resident and/or the psychologist alleging any potential resident , which included .

Review of Resident #3's health assessment dated on indicated that the resident was diagnosed with , and she was easily agitated at times. Further review of this health assessment indicated that she needed assistance with bathing, dressing and self-care.

In an interview with Resident #3 on at 6:00pm she presented to be and inattentive, and was unable to hold a conversation.

Review of Resident #5's health assessment dated on indicated that the resident was diagnosed with , , , , , , major , difficulty walking and . Further review of this health assessment indicated that he was independent with all of his ADLs, with exception to self-care, which he needed supervision for.
In an interview with Resident #5 on at 6:45pm, he stated that he didn't remember how long he lived there and that he loved living in the facility. He stated, that he got along with all the residents in the facility and that he had a friendly relationship with Resident #3 and he did not indicate that he was personally involved with any residents in the facility.

Review of the facility's , neglect and , prevention policy and procedures indicated that the facility strived to protect its residents from real or perceived by any person, including staff members and other residents. Review of these policy and procedures indicated that all allegations, observations or suspected cases of that occurred will be investigated by the facility. Further review of this policy and procedures indicated that the administrator will investigate any alleged or suspected case and will make referrals to appropriate the agencies. Review of these policy and procedures indicated that the DCF central hotline telephone contact of 800-96- was clearly displayed in this document. Review of the facility's " crosswalk" document which was attached to the prevention policy and procedures, indicated that immediately after the report of

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actual or suspected . . . . , the staff member is required to begin an investigation, complete an occurrence report and concurrently contact the central . . . . . hotline and report to the supervisor.

In an interview with the Consultant on . . . at 1:20pm, she stated that a DCF investigator came onsite on to investigate the events involving Residents #2 and 3. She stated that the Administrator did not previously inform her of the event involving Resident #3 potentially being abused by Resident #5 and she learned of this on . She stated, the Administrator was placed on suspension since she did not show up for work on . and that the manager was presently the acting administrator. She stated, on at 1:35pm that reports made by the Agency to DCF regarding the suspected abuses on Residents #2 and 3 were false and did not warrant any involvement or inquiry from DCF. She stated, on at 2:30pm that the Administrator resigned from her position at the facility and that the licensee was presently the acting administrator.

In an interview with the DCF investigator on . at 2:05pm, she stated that she was in process of completing the investigation involving Residents #2 and 3, and she did not find any indicators that these residents suffered any . . . . . and/or neglect stemming from this allegation. She stated that it was the facility's responsibility to immediately report to DCF's central hotline, including every staff members and contractors, for any observation, allegation or suspicion of resident . . . . . or neglect.

Class I

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on interview and record review, the facility administrator failed to provide adequate management of its direct care staff and failed to provide appropriate care for 3 out of 3 residents (Residents #1, 2 and 3) by not enforcing or following the facility's prevention policy and procedures.

The findings are:

During a confidential interview on at 11:50AM, it was reported on at around 7:30PM while walking down the facility's North wing hallway, Employee A came out from . . . . . and was observed laughing. The confidential individual stated, Employee A said, "do you want to see something funny?" and then employee A opened the door to . . . . to show how Resident #1 was tied and bound with both of the resident's arms and legs duct taped to a chair. The confidential individual reported, Employee B placed something inside Resident #1's mouth and told the resident, "Don't scream" and then said, "these pills will make her sleep." The confidential individual, then took photographs of Resident #1 while the resident was restrained in the chair (see photographic evidence)

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and then later reported this event to the Agency for Health Care Administration (Agency) and the central hotline on or about .

In an interview with the Administrator on at 12:40 PM she stated that she was first made aware of this resident event involving Resident #1, when the police arrived to the facility on at around 3:00pm. She stated, Employees A and B were by the police in the facility in front of the residents. She stated, the police notified her that the allegation of was confirmed and the involved employees had been charged with illegally restraining and falsely imprisoning Resident #1, who was identified to have . The Administrator stated, Employee A was employed as a medication technician and Employee B was a caregiver. The Administrator stated, the facility's prevention policy and procedures required every staff member to, and they were trained to "report whatever you see to the supervisor." She stated, the facility supervisors were always available 24-hours a day to respond to any allegation of resident .

Review of the facility's investigation for the allegation of of Resident #1 indicated that the facility provided education and in-service to its staff members relating to resident , neglect and , prevention. Review of this investigation indicated that the facility did not implement means to evaluate the effectiveness of this education, in , , if the staff members knew how and when to apply the steps to report events to the central hotline.

In an interview with the Administrator on at 12:55pm, she stated that the only other event that she could consider potentially or neglectful towards a resident took place a couple of weeks ago. She stated, this happened when Employee F reported to her that Employee E possibly slapped Resident #2 on her behind because she heard a loud slap when the resident and Employee E were inside . She stated, she interviewed Resident #2 and the resident denied that anything happened. She stated, she also interviewed Employee E and the employee denied that anything happened with Resident #2. She stated, she determined that based on her interviews, resident observation and that Employee F just heard a slap sound but did not actually see what caused the sound, this was solved and she did not report this event to the central hotline or anyone else in the facility. She stated, this event did not lead to any staff member disciplinary actions by the facility.

In an interview with the consultant on at 1:00pm, she stated that she learned of the event involving Resident #2 from the administrator that same day and that she recommended an immediate suspension of Employee E until the she concluded with a thorough investigation of this event. She stated, this event took place on or about and that she performed a nursing examination of Resident #2 on and she found no signs of , or neglect on the resident. She stated, she did not contact the central hotline to report this suspected resident event.

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Review of the facility's , neglect and , prevention policy and procedures indicated that the facility strived to protect its residents from real or perceived by any person, including staff members and other residents. Review of these policy and procedures indicated that all allegations, observations or suspected cases of that occurred will be investigated by the facility. Further review of this policy and procedures indicated that the administrator will investigate any alleged or suspected case and will make referrals to appropriate the agencies. Review of these policy and procedures indicated that the DCF central hotline telephone contact of 800-96- was clearly displayed in this document. Review of the facility's " crosswalk" document which was attached to the prevention policy and procedures, indicated that immediately after the report of actual or suspected , the staff member is required to begin an investigation, complete an occurrence report and concurrently contact the central hotline and report to the supervisor.

Review of the facility's investigation for the allegation of of Resident #2 indicated that Employee F reported to the administrator on that she heard a loud clapping noise which sounded like someone slapped the resident's bare , inside Resident #2's Employee E was assisting Resident #2 change her clothes. Review of this investigation revealed that the administrator described the allegation of towards Resident #2 as a "miscommunication." Further review of this investigation indicated that the administrator did not immediately report this event to the central hotline and the administrator did not implement the prescribed steps to identify , as per the facility's prevention policy and procedures.
In an interview with the acting administrator and the consultant on at 4:25pm, they stated that the alleged case involving Resident #2 did not warrant reporting it to the central hotline because they knew the conclusion of the investigation would lead to no findings of .

In an interview with Resident #4 on at 2:15pm, he stated that on he saw Resident #3 get fondled on her by Resident #5 while they were in the common living . He stated, he reported this to the Administrator on or about , along with his psychologist, and the Administrator responded to this report by saying that she was aware of this and the facility was handling it. He stated, he felt better reporting this event to his psychologist before going to Administrator, since he felt that the Administrator would be unresponsive to receive this report just from him.

In an interview with the administrator on at 3:30pm, she stated that there were no other recent reports of potential resident for her to investigate or to report on behalf of the facility. She stated, she was aware that Resident #5 was occasionally disruptive to other residents in the facility, but his actions were never threatening towards other residents.

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In an interview with Resident #4's psychologist on at 4:00pm, she stated that she was approached by Resident #4 on or about to report that Resident #5 fondled Resident #3's on or about . She stated, in her professional opinion, Resident #4 had no reason to lie or fabricate this event. She stated, she and Resident #4 immediately went to the Administrator on to report this potential resident-on-resident and that the Administrator responded to them by saying that she was aware of this and that the facility was handling the situation. She stated, she had no reason to doubt the facility's prevention actions represented by the Administrator after they reported this event involving residents #3 and 5, and she did not subsequently report this event to the central hotline.

In an interview with the administrator on at 4:20pm, she reaffirmed that there were no other recent reports of potential resident for her to investigate or to report on behalf of the facility. She stated, she did not specifically receive any reports from any resident and/or the psychologist alleging any resident , which included .

Review of the facility's investigation for the allegation of of Resident #3 indicated that Resident #4 and his psychologist reported to the administrator on or about that resident #3 was touched on her by Resident #5, while she was lying on the couch, and that Employee A and an unnamed resident saw this happen. Review of this investigation revealed that the administrator interviewed two staff members who did not witness this event, did not interview Employee A because she was not available due to her on and Resident #4's psychologist's statement was not documented. Further review of this investigation indicated that the administrator introduced an alternate event describing one "resident pushing another resident" and that Employee A corrected this event "on the spot" so to dismiss the original allegation of involving Resident #3 and concluded that no inappropriate act happened. Review of this investigation found that the administrator did not immediately report this event to the central hotline and the administrator did not implement the specific steps to identify , , as per the facility's prevention policy and procedures.

In an interview with the acting administrator and the consultant on at 4:45pm, they stated that they were not aware that the psychologist also reported the alleged case involving resident #3 to the administrator on or about . They stated at this time that if the administrator received this report from the psychologist, she was absolutely required to have immediately reported this event to the central hotline.

Class I