STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965791	**09/14/2018**
NAME OF PROVIDER OR SUPPLIER **SEAGULL PLACE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1233 ISLAND RD WEST PALM BEACH, FL 33404**	

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

0000 - Initial Comments

An unannounced licensure complaint survey, CCR#s 2018013428 was conducted from to at Seagull Place, License number 10132. The facility had deficiencies identified during survey.

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

Based on observation, interview and record review, the facility failed to provide a safe and decent living environment which was free from neglect for 2 out of 4 sampled residents (Resident #1 and 2). Specifically, the facility staff members failed to implement interventions to prevent escalating events that directly threatened Resident #1 and 2's daily health, safety and wellbeing.

The findings include:

In an interview with the Administrator on at 3:20pm, she stated that a police officer and a Department of Children and Families (DCF) investigator were onsite on to respond to an allegation of on Residents #1 and 2. She stated she was aware that Residents #1 and 2 were involved in a physical altercation on and verbal altercations involving physical threats between residents #1 and 2 on and . She stated that she was not aware if any of the staff members contacted the DCF -neglect prevention hotline and that she did not contact the DCF -neglect prevention hotline for the events involving Residents #1 and 2 after she was informed of the residents' physical altercation that took place on , on . She stated that she did not consider neither Resident #1 or #2 to have been at risk for or neglect, despite knowing that Resident #2 received a and a small cut on her right elbow after the resident was engaged in a physical altercation with resident #1 on . She stated that she did not find out if Residents #1 or 2 felt to be threatened by any person in the facility, including each other, while living in the facility. She stated that the facility did not implement any interventions to mitigate residents #1 and 2's problems which led to their daily fighting on , and .

In an interview with supervisor A on at 3:35pm, she stated that on at around 5:00pm, Resident #1 and 2 argued about a pair of pants that Resident #2 was wearing, and she observed the residents become agitated to the point that they were insulting each other and were both standing in front of each other threatening physical violence on each other. She stated that she intervened to separate the residents and to diffuse the situation. She stated that on at around 4:30pm, Resident#1 and 2 argued about a musical concert that Resident #2 attended, and she observed the residents become agitated to the point that they were insulting each other and were both standing in front of each other threatening physical violence on each other. She stated that she intervened to

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separate the residents and to diffuse the situation. She stated that Resident #1 became angry towards employee B at that time, and her and employee B continued to diffuse resident #1's combative behavior until the resident became calmed. She stated that she knew to immediately separate Residents #1 and 2 when they were in an altercation, but she was not aware on what a long-term solutions the facility must implement to mitigate the violence and threats Residents #1 and 2 placed on each other. She indicated that she did not contact the DCF hotline to prevent any implication of further or neglect towards any resident in the facility.

In an interview with employee B on at 4:00pm, she stated that she learned from employee C that Residents #1 and 2 were involved in a physical altercation on . She stated that on at around 5:00pm, Residents #1 and 2 argued about a pair of pants that Resident #2 was wearing, and she observed the residents become agitated to the point that they were insulting each other and were both standing in front of each other threatening physical violence on each other. She stated that she intervened by redirecting Resident #1 into her talking with her. She stated that on at around 4:30pm, Resident #1 and 2 argued about a musical concert that Resident #2 attended, and she observed the residents become agitated to the point that they were insulting each other and were both standing in front of each other threatening physical violence on each other. She stated that she intervened by walking Resident #1 to her diffuse the situation. She stated that esident #1 was combative towards her and attempted to kick and punch her, but she explained to the resident that she was there to help her and to prevent anyone getting hurt and the resident was calmed after that. She stated that she knew to immediately separate residents #1 and 2 when they were in an altercation, but she was not aware on what a long-term solutions the facility must implement to mitigate the violence and threats residents #1 and 2 placed on each other. She indicated that she did not contact the DCF hotline to prevent any implication of further or neglect towards any resident in the facility.

In an interview with Resident #1 on at 4:25pm, she stated that she was involved in a physical altercation with Resident #2 on and verbal altercations with Resident #2 on and . She stated that she was frustrated how Resident #2 bragged about her clothing and a musical concert she attended. She stated that on , she may have injured Resident #2 while they engaged in a physical altercation and that she was not physically hurt by Resident #2. She stated that she felt continuously threatened by Resident #2 and by no other person in the facility. She stated that she felt that the relationship between her and Resident #2 was severed and she could not trust Resident #2 ever again.

In an interview with Resident #2 on at 5:00pm, she stated that she was involved in a physical altercation with resident #1 on and verbal altercations with Resident #1 on and . She stated that Resident #1 did not like her because Resident #1 was jealous of her. She stated that on

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, Resident #1 hit her on her right elbow causing a and a small cut. She stated that she did not feel comfortable with Resident #1 around and that she felt continuously threatened by Resident #1. She stated that she felt that the relationship between her and Resident #1 was forever severed. In an observation at this time, Resident #2 had a right elbow with slight discoloration and a open cut approximately 1/2 inch in length.

Review of Resident #1's health assessment dated on indicated that she was diagnosed with , and mental . Further review of the resident's record indicated that the resident's physician was not contacted by the facility immediately after the altercations she encountered with resident #2 on , and .

Review of Resident #2's health assessment dated on indicated that she was diagnosed with , and spectrum . Review of this assessment indicated that the resident had and behavioral limitations involving impulsiveness, poor coping skills and was at times. Further review of this assessment indicated that the resident needed , services and that the resident's physician was not contacted immediately by the facility after the altercations she encountered with resident #1 on , and .

In an interview with Resident #2's mother on at 6:25pm, she stated that she understood that the relationship between Residents #1 and 2 was increasingly polarizing and that she was not notified by the facility on that Resident #2 was injured due to a physical altercation with resident #1. She stated that the facility did not arrange for Resident #2 to be immediately assessed by the physician so to determine a long-term solution to the increased tension between Residents #1 and 2.

In an interview with the DCF investigator on at 11:40am, he stated that the investigation involving Residents #1 and 2 was in process and that he understood that the facility did not immediately implement any long-term interventions to prevent Residents #1 and 2 from continuing to engage in threatening behaviors towards each other.

In an interview with the administrator on at 1:25pm, she stated that Resident #1 saw her physician extender on and that the facility did not receive any update on the resident's behavioral status because the facility did not communicate the resident's potential destabilization due to the resident's increased tensions with Resident #2. She stated that Resident #1 had not yet seen her psychiatrist and that Resident #2 was planned to see her psychiatrist later that day. She stated that the facility had not formed any interventions to provide a long-term solution to remove any threats between Residents #1 and 2 to ensure their continued health, safety and wellbeing.

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In an interview with employee C on at 4:30pm, she stated that on after 4:00pm, Residents #1 and 2 were involved in a physical altercation and that she did not know if any of the residents were injured. She stated that on at around 5:00pm, Residents #1 and 2 were agitated and verbally arguing with each other. She stated that another employee deescalated the residents and she doesn't remember anything else.

In an interview with Resident #1's physician extender on at 10:20am, he stated that Resident #1 was physically stable and that he could not go into further detail of the resident's condition due to privacy issues. He stated that his office could not assist the Agency to gain consent from the resident to obtain further detail on her medical care.

In an interview with Resident #1's sister on at 3:45pm, she stated that Resident #1 called her on and presented to be very distraught and then supervisor A got on the telephone to describe the tensions between Residents #1 and 2. She stated that she was aware that Resident #1 needed her medications adjusted from time to time and that she was not contacted by the facility until she spoke with supervisor A on and the administrator on , but she was not explained the series of events that potentially destabilized Resident #1. She stated that she was aware that the relationship between Residents #1 and 2 was tense, but did not know the degree of the threat to the residents involved. She stated that the facility did not arrange for Resident #1 to be immediately assessed by the physician so to determine a long-term solution to the increased tension between Residents #1 and 2.

In an interview with Resident #2's psychiatrist on at 2:30pm, he stated that Resident #2 got frustrated with Resident #1 that eventually led to the physical altercation that caused her and cut on her right elbow. He stated that without knowing the behavioral condition of Resident #1, he was not sure how safe Resident #2 was in the facility. He stated that Resident #2 was physically stable and the minimal and cut on her right elbow did not need further nursing or medical attention. He stated that Resident #2's behavioral status was also stable and he felt that the resident could resist attempted provocations from another resident. He stated that he had not consulted with the facility to determine the resident's viability to remain living in the facility.

Resident #1 and Resident #2 were in constant altercations (verbal and physical) from to with each other throughout the facility, including the dining other residents were . The facility failure to implement effective safety precautions into place, the knowledge of the continued altercations between the two residents and the administrators admission of the lack of administrative oversight and that the staff were not properly trained to handle such situations placed the residents involved in the altercation and the other residents that witnessed the altercation at a direct threat of harm.

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Class II

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

Based on observation, interview and record review, the facility administrator failed to provide adequate management of its direct care staff and failed to ensure appropriate care for 2 out of 4 residents (Residents #1 and 2) by not having immediately notified the residents' representatives and physicians to address their suspected change in conditions.

The findings are:

In an interview with the administrator on at 3:20pm, she stated that a police officer and a Department of Children and Families (DCF) investigator were onsite on to respond to an allegation of on Residents #1 and 2. She stated she was aware that Residents #1 and 2 were involved in a physical altercation on and verbal altercations involving physical threats between Residents #1 and 2 on and . She stated that she was not aware if any of the staff members contacted the DCF -neglect prevention hotline and that she did not contact the DCF -neglect prevention hotline for the events involving residents #1 and 2 after she was informed of the residents' physical altercation that took place on , on . She stated that she did not consider neither Resident #1 or #2 to have been at risk for or neglect, despite knowing that Resident #2 received a and a small cut on her right elbow after the resident was engaged in a physical altercation with resident #1 on . She stated that she did not find out if Residents #1 or 2 felt to be threatened by any person in the facility, including each other, while living in the facility. She stated that the facility did not implement any interventions to mitigate Residents #1 and 2's problems which led to their daily fighting on , and .

Review of Resident #1's health assessment dated on indicated that she was diagnosed with , and mental . Further review of the resident's record indicated that the resident's physician was not contacted by the facility immediately after the altercations she encountered with Resident #2 on , and .

Review of Resident #2's health assessment dated on indicated that she was diagnosed with and spectrum . Review of this assessment indicated that the resident had and behavioral limitations involving impulsiveness, poor coping skills and was at times. Further review of this assessment indicated that the resident needed services and that the resident's physician was not contacted immediately by the facility after the altercations she encountered with resident #1 on , and .

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In an interview with Resident #1 on at 4:25pm, she stated that she was involved in a physical altercation with Resident #2 on and verbal altercations with Resident #2 on and . She stated that she was frustrated how Resident #2 bragged about her clothing and a musical concert she attended. She stated that on , she may have injured Resident #2 while they engaged in a physical altercation and that she was not physically hurt by resident #2. She stated that she felt continuously threatened by Resident #2 and by no other person in the facility. She stated that she felt that the relationship between her and Resident #2 was severed and she could not trust Resident #2 ever again.

In an interview with resident #2 on at 5:00pm, she stated that she was involved in a physical altercation with Resident #1 on and verbal altercations with resident #1 on and . She stated that Resident #1 did not like her because resident #1 was jealous of her. She stated that on , resident #1 hit her on her right elbow causing a and a small cut. She stated that she did not feel comfortable with resident #1 around and that she felt continuously threatened by Resident #1. She stated that she felt that the relationship between her and resident #1 was forever severed. In an observation at this time, Resident #2 had a right elbow with slight discoloration and a open cut approximately 1/2 inch in length.

Review of the facility's management instructions for accident/incident reporting dated on indicated that it was the facility's responsibility to establish procedures for reporting and evaluating unusual events, involving resident behavioral problems and altercations involving injury. Review of these instructions indicated that the facility was required to immediately report any resident event alleging or suspecting neglect.

In an interview with the administrator on at 1:25pm, she stated that resident #1 saw her physician extender on and that the facility did not receive any update on the resident's behavioral status because the facility did not communicate the resident's potential destabilization due to the resident's increased tensions with Resident #2. She stated that Resident #1 had not yet seen her psychiatrist and that resident #2 was planned to see her psychiatrist later that day. She stated that the facility had not formed any interventions to provide a long-term solution to remove any threats between Residents #1 and #2 to ensure their continued health, safety and wellbeing.

In an interview with Resident #1's sister on at 3:45pm, she stated that Resident #1 called her on and presented to be very distraught and then supervisor A got on the telephone to describe the tensions between Residents #1 and 2. She stated that she was aware that resident #1 needed her medications adjusted from time to time and that she was not contacted by the facility until she spoke

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with supervisor A on and the administrator on , but she was not explained the series of events that potentially destabilized Resident #1. She stated that she was aware that the relationship between Residents #1 and 2 was tense, but did not know the degree of the threat to the residents involved. She stated that the facility did not arrange for Resident #1 to be immediately assessed by the physician so to determine a long-term solution to the increased tension between residents #1 and 2.

In an interview with the administrator on at 5:10pm, she stated that she was ultimately responsible to ensure that the facility's management instructions were followed as per established procedure. She stated that she spent about 15 hours per month in the facility for the last few months and that this did not allow for her to adequately manage the facility staff so they can respond to unusual events like the events that involved Residents #1 and 2. She stated that she did not adequately evaluate the events leading up to the numerous altercations involving Residents #1 and 2 that potentially compromised their health, safety and wellbeing.

See A 0030 for additinal findings

Class II