STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910733	09/04/2018
NAME OF PROVIDER OR SUPPLIER **VIP CARE PAVILION LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **6810 SW 7TH STREET** **MARGATE, FL 33068**	

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

0000 - Initial Comments

An unannounced licensure complaint survey, CCR #201800743, was commenced on and concluded on at VIP Care Pavilion LLC, License #4783. The facility had deficiencies at the time of the investigation.

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

Based on interviews, records review and observation, the facility failed to ensure that 5 of 22 sampled residents (Residents #1, #2, #3, #4, #5, #6) received adequate supervision to prevent intermittent altercations between them and injuries.

The findings included:

Observation made during a complaint investigation conducted on and at the facility, revealed many residents congregating in the common area during activities. As this writer and the Administrator toured the premises at about 10:00 AM, it was noted that the facility is subdivided into four independent sections accessible only with security codes. The Administrator pointed out that residents with behavior concerns are housed in section I.

In section I, there were twenty residents observed on at about 10:45 AM, either seating, ambulating, pacing back and forth, or in bed sleeping and staff reported that there were two residents in their . No one in section 1 at that time had the key to open the door when this writer requested to enter the . The Administrator asked different staff members if they had the key but no one had it. After about five minutes, the Maintenance Director arrived and he opened the door which revealed a male resident in the and another female resident (Resident #6) who was in another . Resident #6's bed had full side rails raised up. Upon further inquiry on the health status of Resident #6, the Administrator and other staff members reported that she was and stayed in the of the time. The Administrator stated that Resident #6 was not receiving hospice care services.

Review of Resident #1's record showed she was admitted to the facility with diagnoses of , , and among others. On her admission date of she was noted to have on both of her arms yet, in stable condition. Her health Assessment revealed that Resident #1 suffered from and gets agitated and is resistive to care. The record showed that the facility needed to monitor her whereabouts and wellbeing daily. Review of a progress note and incident report dated at 1:30 PM revealed that Resident #1 was involved in an altercation with another resident

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on that day. Resident #1 was hit in the face and the other patient got a on his right hand, confirmed by the Administrator. Review of a Physician's order dated revealed that the patient (Resident #1) could be to prevent altercation with other residents during meal and activities. The facility provided no additional records describing the antecedent of the incident.
During an interview with Employee A on at 12:30 PM, she reported that Resident #1 had an altercation with Resident #2 on because Resident #1 was following Resident #2 around and instigating him. Resident #1 slapped Resident #2 on the back and told him "I don't like you". Then, Resident #2 turn around and slapped Resident #1. Employee A indicated that this information was reported to her by the Administrator; she did not witness the events. She also added, when asked, that she was not sure how many times Resident #2 had slapped Resident #1. She reported that Resident #1's daughter was contacted and she came to the facility right away, and she saw the on her mother's face. However, the daughter denied the facility's offer to take Resident #1 to the hospital. Employee A said that Resident #1 customarily followed other residents around and hit them and said that "I don't like you". Resident #1 would routinely portray that behavior, about twice or more daily. Employee A motioned that Resident #2 usually gets aggressive when he is bothered. She affirmed when questioned that the employees know that Resident #2 would get aggressive when he is bothered.

During lunch observation on at 12:45 PM, two residents were noted seated at the table with Resident #2 (Resident #5 and another nameless Resident). A brief interview with Employee B at around 12:47 PM on indicated that the aforementioned residents had no behaviors besides, the way they sat at the table was to prevent problems from arising among them, she added. And, she clarified that Resident #2 only get upset if he is bothered.

During an interview conducted with Employee B on at 1:15 PM, She reported that she has been working at this facility for nearly 8 years. She said that the residents in section I have fluctuating behaviors. One moment they are calm and unexpectedly they can become upset or aggressive. She said that there are usually 4 Aides working in that section which gives a ratio of 4 employees to 20 residents. She reported that when Resident #1 first came to the facility, she would occasionally go around and pick on other residents. She would pick stuff off the table and with no apparent reasons throw them at residents. She said that they had reported these behaviors to the supervisors. She said that they would come over and remove Resident #1 from that section and returned her back to section I, once she was calm.

Employee B also reported that she was not present when Resident #1 had the altercations with the other resident (Resident #2). She added that Resident #2 is "okay". He does not give any problems unless he is triggered. Once he gets upset, he will curse or go away. Employee B emphasized that when Residents in section want to fight, staff would remove the aggressor and report it to the supervisor who

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would then remove the more aggressive resident from section I. She added that she is very familiar with the residents and what may cause them to be aggressive.

Employee B stated that she was not too familiar with Resident #3. She pointed out that Resident #3 was "in and out of the hospital". She said that she was not aware that Resident #3 had ever hit anyone. Resident #3 had a private Aide that stayed with her during the day; on her shift, Employee B indicated Resident #3 showed no signs of aggression. She concluded that they (Employees) can manage the residents that they have in section I.

During an interview with Employee C, on at 3:34 PM, she reported that she has been working at this facility for 2 and half years. She works from 2 PM to 10 PM. During the observation conducted in section I at 3:20 PM, Employee C was the only one watching 12 residents. She said that she was called from section 3 to replace the aide that was in section 1 because that Aide had an emergency. She reported that she has worked in the past in that section and that she is familiar with the residents who reside there. When asked if she was familiar with the characteristics of the residents in section I or whether there was anything unique or , about them, she said that they are friendly, very good patients. She said that they are "like kids". "There was not much more that she caould say about them". "They all have their own , . I don't treat them like babies, I treat them like my grandparents" she added. They are all loveable. She said that she usually does not work in that section. When questioned about the two residents that were sleeping in their with the doors locked, she said that she knew that Resident #6 and the other one were in their sleeping. She said at last, that she was not aware of any of the residents' aggressive behaviors.

Resident #2 was admitted to the facility with , , , and other . His health assessment revealed that he gets , agitated and resistive to care. He needed to be supervised daily to ensure his wellbeing and his whereabouts. Review of the Nurses' progress (NP) notes indicated that on , at 4:37 PM, he was involved in an altercation with another resident which caused him to receive two small scratches to the right side of his forehead. The Nurses' Progress notes showed that on Resident #2 was found in the some to his eye. The report indicated that the resident alleged that someone hit him (but, no one was near him at that time) as per the Nurses' progress notes. On the NP indicated that Resident #2 had some discoloration in his eye, facility staff applied ice to it. The Nurse Practitioner's note dated revealed that the patient may be to prevent altercation with other residents during meal and activities.

During an interview with the Administrator on at 1:46 PM, she reported that she has been working at this facility for 19 years. She said that Section I have residents with behaviors such as spiting, stripping of clothing, aggression and any behaviors that other people may not want to tolerate. She said

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that she is very familiar with Residents #1 and #2. Firstly, Resident #2 she said was a quiet man, he can be sweet but if you bother him he can get aggressive where he would shout at you and walk away. The first time Resident #2 hit someone was when he hit Resident #1. She said that Resident #2 can get agitated if staff insist on getting him to shower; he would shout or pull himself away from staff but he would not hit. She indicated that it was never reported that he had hit anyone prior to the incident with Resident #1. She never saw or heard anyone reporting that Resident #2 had hit someone or attempted to hit anyone. However, after the incident with Resident #1, they noted an increase in his aggressive behavior, he tried to hit other residents with no success. She said that they always have three Aides from 6 to 2 PM and one person working from 8:00 AM to 4:00 PM in section I.

The Administrator said that Resident #1 was first in a section 2. But, she wandered from . When reprimanded by other residents about her behavior, she would scream at them. Then, Resident #1's daughter had the family Physician adjust Resident #1's medications. But the adjustment of her medications from routine to as needed (PRN) triggered an increase in Resident #1's aggression. She would slap people when she was not pleased with a situation. They spoke to Resident #1's daughter thereafter and she agreed to have her mother moved to section I. The Administrator said that the resident was a wanderer. When her daughter came to visit, she would bring her mother to section II and leave her there and that caused problem because Resident #1 would again go to other resident's and other residents would at times hit or push her out of the . She reported that in section I, because of the resident's behaviors, all the are locked.

Resident #1 would walk in the hallways or in the patio with no problem. At the date when Resident #1 was hit on the face, the Administrator said Employee A and Employee B as well as two other staff members were working.

She said that the altercation was between Resident #1 and Resident #2. The latter had a on the arm, and the former had a face, they put ice on it. When they contacted the daughter and she came to the facility, she did not want to have her mother to taken to the hospital. After asking the Administrator who was present during the incident, she reported that a former Maintenance worker was the one who reported the incident. She said that the aides were checking and changing residents and that no one was present during the altercations (when she reviewed the video). However, a request to review the recorded events that took place when Resident #1 was hit was not possible. The Executive Director informed this writer that the recorded video was damaged.

Resident #3, was admitted to the facility with , type 2 , and and resided in Section I. The Nursing progress notes dated indicated that the resident was uncontrollable. Her private duty aide could not control her and

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left her in the middle of the night on the day of her admission to the facility. On , the NP showed that the patient had exhibited aggressive behaviors towards staff. It was noted that she often cursed out the staff and hit people. On , at 11:30 AM, she fought with the aide and she threw a patient's food to the ground, the notes also revealed that Resident #3 was soiled with feces. As the aide tried to remove her from section I, Resident #3 sustained multiple to her arms. Employee A was educated to call for assistance when faced with these situations. On at 11:30 PM, Resident #3 was involved in an altercation with another resident. She was consequently hit in the face. The residents were separated for the remainder of the night. The Administrator was informed as well as the resident's niece.

Resident #4 was admitted to the facility with a diagnosis of . He gets and agitated and resist care from time to time. On at 5:15 PM, Resident #5 hit another resident (identified as Resident #2) on the head with his fist. They got involved in an altercation and were separated. There was no incident report filed. Only a progress note with no clear indication of what event led to the aggression.

Resident #5 was admitted to the facility with , , , , and other in . On the 2nd of , 2018 at 11:30 PM as Resident #3 walked by Him, Resident #5 hit her. The employee who witnessed the incident said that she did not consider the incident major. She reported that she believed Resident #5 hit Resident #2 in the arm. However, after she took the Resident's record, she clarified that the resident was struck in face. Basic first aid (ice pack) was applied. The two residents were separated for the remainder of the night. Resident #5 gets and agitated and resist care from time to time. On at 5:15 PM, Resident #5 hit another resident later identified as Resident #2 on the head with his fist. They got involved in an altercation and were separated.

On at 5 am, Resident #7 entered another resident's had an altercation with the other Resident. Resident #7 sustained lacerations and a hematoma. The incident report did not specify the location of the laceration nor the antecedent to this behavior. No one was present while resident #7 left his locked opened up the other resident's .

On , at 3:22 PM, during an interview with Employee D, she reported that she has been working at this facility for the past two years. She reported that she is "a floater", she works in all the four units. She said occasionally, they have a full house and three staff work at that section. She said that she is not sure whether the residents in Section I have any special characteristics that caused them to be in that unit. She said to her knowledge none of them have any behaviors. She said that her shift starts at 2 PM and every hour she checks on the residents to see if they need to be changed. She stated that she never witnessed any of the Residents fighting with each other in the units, since she has been

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working at the facility. No one has ever sustained any injuries to her knowledge. No one reported to her that any of the residents has ever been injured.

Employees E reported at 3:44 PM, on . . . . . that her employment with the this facility started in 2017. She said that she has been working here for two years and she is a floater. She said that she has never been told about the residents' behaviors. She said that she gives food, and assist the residents. She said that on occasion, she stays in section 1 by herself from 2-4, but not all the time. She said that at times, some of the residents may get upset and throw things away but they are not really violent. She said that she is not aware that any of the residents have ever had any altercations with other residents. Employee F present during that interview shared Employee E's point of views and agreed with everything Employee E said.

During an interview on at 4:36 PM, with Employee H alleged involved or present during altercations that took place between Resident #3 and Resident #4. He reported that he worked mostly in section 4 and 3. And worked occasionally for another employee in section 1. However, he never witnessed any resident hitting any other residents. Employee D work's schedule is usually in the evening in section I. He said that there are usually three employees there. However, on occasion there are only two employees working in that section. But, he never saw residents fighting with other residents nor heard of it. Employee D said that when they have new patients admitted to the facility, they are often told to be aware of the resident's behavior they work with.

Employee G, a supervisor who was also alleged witnessing the altercation that took place between, Resident #1, Resident #3 and another residents reported during an interview conducted on at 5:12 PM, that she has been working at this facility for 18 years. She performs supervisory duty for the entire building. However, she said that she did not witness any of the incidents.

On five residents were observed outside on the barricaded porch, among whom were Residents #2 and # 4, two residents who in the past had an altercation. There was no staff outside with the residents to supervise.

During an interview with the Administrator on at 2:28 PM, the Administrator and the Executive Director said that in order to prevent these situations from happening, they remove residents involved in altercations from the unit until they calm down, and informed their staff to be mindful and aware of the residents who have aggressive behaviors. In addition, they work with the residents' physicians to adjust their medications. However, the residents are returned to the unit with no further interventions in place and ensuring that employees are always present to closely monitor residents who displayed more aggression.

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Class III