STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11912046	**10/24/2018**
NAME OF PROVIDER OR SUPPLIER **LIVEWELL AT CORAL PLAZA**	STREET ADDRESS, CITY, STATE, ZIP CODE **5850 MARGATE BLVD.** **MARGATE, FL 33063**	

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

0000 - Initial Comments

An unannounced licensure complaint survey, CCR #2018015861, was conducted on at Livewell at Coral Plaza, an Assisted Living Facility, License #7861. The facility had deficiencies identified at the time of 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 Assisted Living Facility (ALF) failed to ensure a safe and decent living environment free from , for 1 of 1 sampled residents reviewed from the ALF Grievance Log (Resident #1). As evidenced by failing to respond to a grievance in an appropriate manner and failing to follow the facility's , Neglect, & , Policy.

The findings included:

Review of the ALF Resident Rights policy states in part, 'Every resident of a facility shall have the right to 'Live in a safe and decent living environment, free from and neglect.'

Review of the ALF , Neglect and , Policy documents under Definition of Terms: Mental - includes humiliation, harassment and threat of punishment or deprivation.

Review of the ALF , Neglect & , Policy & Procedure states in part, 'This policy is to ensure the safety of our residents in our community. In case an , neglect or , is suspected, it is your responsibility to report this information to your supervisor immediately. The administrator needs to be notified and an investigation needs to be initiated. Upon the investigation, the facility should notify the hotline. If the allegation is pertaining to a specific employee, the employee will be investigated and moved to a different section or upon administrators judgment may be suspended until the investigation by a third party is completed.' Additionally, under Investigating, the Policy documents to 'Investigate what happened, collect statements, complete an occurrence report and notify the Administrator, Director of Nursing, Physician and Family/Representative.'

On at 9:45 AM, the ALF Grievance Log was reviewed to reveal a grievance was documented on at 9:30 AM by the Director of Nurses (DON), stating Resident #1 complained a Home Health Aide (HHA), of the facility, Staff 'A' made , inappropriate comments to her during provision of incontinence care. Per the follow up, actions taken included removing the aide from her assignment with Resident #1; Resident to be interviewed. Further review of the investigative documentation revealed no evidence of documentation the resident's representative was notified; no evidence of documentation

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11912046	**10/24/2018**
NAME OF PROVIDER OR SUPPLIER **LIVEWELL AT CORAL PLAZA**	STREET ADDRESS, CITY, STATE, ZIP CODE **5850 MARGATE BLVD. MARGATE, FL 33063**	

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

the resident's physician was notified; no evidence of documentation residents on Staff 'A's assignments were interviewed to determine if any other residents were subjected to this ; no evidence of documentation other staff members were interviewed; no evidence of disciplinary action or counseling was provided to Staff 'A'; no evidence of any follow up with Resident #1 after the initial conversation documented on when her statement was obtained; and no evidence of reporting the incident to the state Adult Protective Services (APS) hotline.

On at 10:25 AM, an interview was conducted with Resident #1 and an inquiry was made about the incident she reported on . The resident was observed to become fidgety with her voice cracking as she spoke. Resident #1 stated she is for the most part continent during the day while she is up in her wheelchair as she is able to transfer herself to and from the toilet . However, at night time she requires an adult brief as she cannot safely independently transfer herself out of bed to get to the . She stated if she needs assistance during the night she uses the call bell to get help to change her adult brief. She stated when Staff 'A' came in to help change her brief that night, she made derogatory references about Resident #1's female parts with an inappropriate hand and finger demonstration to suggest intercourse. Resident #1 stated Staff 'A' was talking to her in a raw suggestive way and her words and demonstration made her feel upset and nervous, further stating 'I started to shake I was so upset.' Resident #1 stated she was very rattled by the incident and was not sure what she should do. She stated she called a family member the following day and they told her she needs to report the incident to the Administrator. Resident #1 stated she took the family member's advice and went to Medication Technician Staff 'B' who she trusted, and relayed the incident to her and Staff 'B' told her she needs to report this to the DON so that is what she did. Resident #1 stated Staff 'A' is still working here but is no longer on her assignment.

Additionally, Resident #1 stated the night after she reported the incident, another aide, who she identified as Staff 'C', a HHA, came in to her the 11 to 7 shift and started cursing her out about making accusations against Staff 'A' and that made her feel scared and nervous and hopes that she will not be retaliated against for reporting the incident. An inquiry was made if she reported this incident to anyone and Resident #1 stated she thinks she reported it to the DON. Resident #1 stated she was very rattled by these incidents and just thinking and talking about it now makes her feel shaky.

On at 10:55 AM, a telephone interview was conducted with Resident #1's family representative who stated he found out about the incident the following day when Resident #1 called to tell him what happened. He stated no one from the facility called him, he called the facility to find out what was going on. He stated he spoke to the Administrator and got the impression that she was defending the aide and the patient's well being was not the priority. The family member stated he was afraid there might be retaliation against Resident #1 for coming forward. As evidenced already by an aide cursing out

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11912046	10/24/2018
NAME OF PROVIDER OR SUPPLIER **LIVEWELL AT CORAL PLAZA**	STREET ADDRESS, CITY, STATE, ZIP CODE **5850 MARGATE BLVD.** **MARGATE, FL 33063**	

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

Resident #1 the following night after she reported the incident.

On at 11:55 AM, an interview was conducted with the Administrator who stated APS was in the facility yesterday and she was told it was a non-facility staff member who put in the complaint. The Administrator confirmed she did not report the incident to APS when they were apprised of the incident, stating she and the DON interviewed Staff 'A' and who denied the allegations, further stating sometimes residents do not always tell the truth. The Administrator further confirmed they only spoke to Resident #1 the one time, stating they removed Staff 'A' off that assignment so they would have no further interactions. An inquiry was made if she was aware of an aide identified as Staff 'C' going into Resident #1's . . . the night shift the following night and was cursing the resident out, making the resident feel more nervous. The Administrator stated she was not aware of this incident until now, therefore have not done an investigation of the allegation.

On . . . . at 2:45 PM an interview was conducted with Medication Technician Staff 'B' who confirmed Resident #1 came to her on the morning of and told her about what happened the night before. Staff 'B' stated she has never encountered anything like this before and could not believe what Resident #1 was saying and told Resident #1 that this was not in her purview and Resident #1 has to report this to the DON. Staff 'B' stated Resident #1 stated the remarks Staff 'A' made to her made her nervous and the resident was visibly upset. An inquiry was made to Staff 'B' under what circumstances would the family be notified of an incident as there was no documentation in the Observation Record about the family or physician being notified of the incident to which Staff 'B' stated the DON and Administrator would be the ones to determine if the family should be notified.

On . . . . at 3:15 PM, a telephone interview was conducted with the DON who confirmed she did not speak with the resident's family member, it was the Administrator who spoke to him. The DON stated they made a report about the incident and removed Staff 'A' from the assignment further stating Staff 'A' wrote a written statement and denied the allegations. She stated APS was in the facility yesterday and she would have called APS to report the incident if there were any claims of physical interactions and the aide denied using vulgar words with Resident #1. She stated she spoke with Resident#1, the one time and when apprised of the cursing incident the following night, she stated she was not aware of that incident.

Record review of Resident #1's record and observations revealed she was alert and oriented. The resident was able to respond to all questions appropriately without any signs of . . . . .

On . . . . at 3:38 PM, an interview was conducted with the Administrator who stated she did not document any conversation with the family member. Further, she stated she counseled Staff 'A' however

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11912046	10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVEWELL AT CORAL PLAZA	**5850 MARGATE BLVD. MARGATE, FL 33063**

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

did not document anything, stating she told Staff 'A' not to say anything that could be misconstrued and to just stick to giving care. The Administrator confirmed again she did not report anything to APS; she spoke with the resident's representative, however he called her; she did not document any further conversations with Resident #1. She did not document any interviews with residents on that assignment; she did not document any interviews with other staff; she did not notify the resident's physician; she did not conduct any follow up with Resident #1; she did not follow the ALF policy protocol.

Class II

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

Based on interview and record review, the facility's Administrator failed to provide adequate management of its direct care staff and failed to provide appropriate care (emotionally and physically), for 115 out of 115 residents (Residents #1-#115) by not enforcing or following the facility's prevention policy and procedures and honoring all residents right to a safe environment.

The findings include:

On at 9:45 AM, the ALF Grievance Log was reviewed to reveal a grievance was documented on at 9:30 AM by the Director of Nurses (DON), stating Resident #1 complained a Home Health Aide (HAH of the facility) Staff 'A' made , inappropriate comments to her during provision of incontinence care. Per the follow up, actions taken included removing the aide from her assignment with Resident #1; Resident to be interviewed. Further review of the investigative documentation revealed no evidence of documentation the resident's representative was notified; no evidence of documentation the resident's physician was notified; no evidence of documentation residents on HAH Staff 'A's assignment were interviewed to determine if any other residents were subjected to this ; no evidence of documentation other staff members were interviewed; no evidence of disciplinary action or counseling was provided to HAH Staff 'A'; no evidence of any follow up with Resident #1 after the initial conversation documented on when her statement was obtained; and no evidence of reporting the incident to the state Adult Protective Services (AP'S) hotline.

On at 10:25 AM, an interview was conducted with Resident #1 and an inquiry made about the incident she reported on . The resident was observed to become fidgety with her voice cracking as she spoke. Resident #1 stated she is for the most part continent during the day while she is up in her wheelchair as she is able to transfer herself to and from the toilet . However, at night time she requires

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11912046	**10/24/2018**
NAME OF PROVIDER OR SUPPLIER **LIVEWELL AT CORAL PLAZA**	STREET ADDRESS, CITY, STATE, ZIP CODE **5850 MARGATE BLVD. MARGATE, FL 33063**	

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

an adult brief as she cannot safely independently transfer herself out of bed to get to the . She stated if she needs assistance during the night she uses the call bell to get help to change her adult brief. She stated when HAH Staff 'A' came in to help change her brief that night, she made derogatory references about Resident #1's female parts with an inappropriate hand and finger demonstration to suggest intercourse. Resident #1 stated HAH Staff 'A' was talking to her in a raw suggestive way and her words and demonstration made her feel upset and nervous, further stating 'I started to shake I was so upset.' Resident #1 stated she was very rattled by the incident and was not sure what she should do. She stated she called a family member the following day and they told her she needs to report the incident to the Administrator. Resident #1 stated she took the family member's advice and went to Medication Technician Staff 'B' who she trusted, and relayed the incident to her and Staff 'B' told her she needs to report this to the DON so that is what she did. Resident #1 stated HAH Staff 'A' is still working here but is no longer on her assignment.

Additionally, Resident #1 stated the night after she reported the incident, another aide, who she identified as HAH Staff 'C' came in to her the 11 to 7 shift and started cussing her out about making accusations against HAH Staff 'A' and that made her feel scared and nervous and hopes that she will not be retaliated against for reporting the incident. An inquiry was made if she reported this incident to anyone and Resident #1 stated she thinks she reported it to the DON. Resident #1 stated she was very rattled by these incidents and just thinking and talking about it now makes her feel shaky.

On at 10:55 AM, a telephone interview was conducted with Resident #1's family representative who stated he found out about the incident the following day when Resident #1 called to tell him what happened. He stated no one from the facility called him, he called the facility to find out what was going on. He stated he spoke to the Administrator and got the impression that she was defending the aide and the patient's well being was not the priority. The family member stated he was afraid there might be retaliation against Resident #1 for coming forward. As evidenced already by an aide cussing out Resident #1 the following night after she reported the incident.

On at 11:55 AM, an interview was conducted with the Administrator who stated AP'S was in the facility yesterday and she was told it was a non-facility staff who put in the complaint. The Administrator confirmed she did not report the incident to AP'S when they were apprised of the incident, stating she and the DON interviewed HAH Staff 'A' and HAH Staff 'A' denied the allegations, further stating sometimes residents do not always tell the truth. The Administrator further confirmed they only spoke to Resident #1 the one time, stating they removed HAH Staff 'A' off that assignment so they would have no further interactions. An inquiry was made if she was aware of an aide identified as HAH Staff 'C' going into Resident #1's the night shift the following night and was cussing the resident out, making the resident feel more nervous. The Administrator stated she was not aware of this incident until now,

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11912046	10/24/2018
NAME OF PROVIDER OR SUPPLIER **LIVEWELL AT CORAL PLAZA**	STREET ADDRESS, CITY, STATE, ZIP CODE **5850 MARGATE BLVD.** **MARGATE, FL 33063**	

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

therefore have not done an investigation of that allegation.

Review of the ALF Resident Rights policy states in part, 'Every resident of a facility shall have the right to 'Life in a safe and decent living environment, free from and neglect.'

Review of the ALF , Neglect and , Policy documents under Definition of Terms: Mental - includes humiliation, harassment and threat of punishment or deprivation.

Review of the facility's ALF , Neglect & , Policy & Procedure states in part, 'This policy is to ensure the safety of our residents in our community. In case an , neglect or , is suspected, it is your responsibility to report this information to your supervisor immediately. The administrator needs to be notified and an investigation needs to be initiated. Upon the investigation, the facility should notify the hotline. If the allegation is pertaining to a specific employee, the employee will be investigated and moved to a different section or upon administrators judgment may be suspended until the investigation by a third party is completed.' Additionally, under Investigating, the Policy documents to 'Investigate what happened, collect statements, complete an occurrence report and notify the Administrator, Director of Nursing, Physician and Family/Representative.'

On at 2:45 PM an interview was conducted with Medication Technician Staff 'B' who confirmed Resident #1 came to her on the morning of and told her about what happened the night before. Staff 'B' stated she has never encountered anything like this before and could not believe what Resident #1 was saying and told Resident #1 that this was not in her purview and Resident #1 has to report this to the DON. Staff 'B' stated Resident #1 stated the remarks HAH Staff 'A' made to her made her nervous and the resident was visibly upset. An inquiry was made to Staff 'B' under what circumstances would the family be notified of an incident as there was no documentation in the Observation Record about the family or physician being notified of the incident to which Staff 'B' stated the DON and Administrator would be the ones to determine if the family should be notified.

On at 3:15 PM, a telephone interview was conducted with the DON who confirmed she did not speak with the resident's family member, it was the Administrator who spoke to him. The DON stated they made a report about the incident and removed HAH Staff 'A' from the assignment further stating HAH Staff 'A' wrote a written statement and denied the allegations. She stated AP'S was in the facility yesterday and she would have called AP'S to report the incident if there were any claims of physical interactions and the aide denied using vulgar words with Resident #1. She stated she spoke with Resident#1, the one time and when apprised of the cursing incident the following night, she stated she was not aware of that incident.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11912046	**10/24/2018**
NAME OF PROVIDER OR SUPPLIER **LIVEWELL AT CORAL PLAZA**	STREET ADDRESS, CITY, STATE, ZIP CODE **5850 MARGATE BLVD.** **MARGATE, FL 33063**	

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

On at 3:38 PM, an interview was conducted with the Administrator who stated she did not document any conversation with the family member. Further, she stated she counseled HAH Staff 'A' however did not document anything, stating she told HAH Staff 'A' not to say anything that could be misconstrued and to just stick to giving care. The Administrator confirmed again she did not report anything to AP'S; she spoke with the resident's representative, however he called her; she did not document any further conversations with Resident #1. She did not document any interviews with residents on that assignment; she did not document any interviews with other staff; she did not notify the resident's physician; she did not conduct any follow up with Resident #1; she did not follow the ALF policy protocol.

The facility's failure to investigate aforementioned events, implement steps and procedures to ensure the safety of all residents (including Resident #1) in the facility directly placed all residents at risk for harm. The facility allowed the perpetuator to continue to have access to the victim and other residents in the facility. The facility also caused emotional distress on the victim by having her constantly repeat the circumstances (verbally) due to staff 's lack of knowledge of how to handle , neglect and upon notification. Secondly, the facility's failure to properly address the matter also caused the resident to undergo retaliation from facility staff members. The facility had no evidence to conclude the the situation didn't occur. Therefore, the Administrator and the facility had an to protect the victim and residents. Record review revealed the facility had an internal Resident Rights Policy, , Neglect and policy to follow, that dictates steps to follow any time allegations regarding these matters are reported. However, the facility failed to implement the policy.

Class II