STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942934	11/19/2018
NAME OF PROVIDER OR SUPPLIER **GRAND COURT ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **295 SW 4TH AVENUE** **POMPANO BEACH, FL 33060**	

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

0000 - Initial Comments

An unannounced licensure complaint survey, CCR# 2018013811 was conducted on at Grand Court ALF, License #5464. The facility had deficiencies identified at the time of the survey.

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

Based on observation, record review and interview, the facility failed to provide a safe living environment free from (physical and verbal) as evidenced by failing to respond and act on grievances of alleged that involved law enforcement for all sampled residents residing at the facility.

The findings included:

Review of the facility's reporting policy reads as follows: 'Any person who knows or has reasonable cause to suspect adult , neglect or , should immediately report such knowledge or suspicion to the hotline. The following persons, including ALF staff, are mandated by law to report , neglect or , .'

During an interview with the Administrator and the Maintenance Director at 10:00 am on regarding aggressive residents at the facility, it was stated by the Administrator that we have a guy that's called (Resident #1) that can get very loud. Lets say he wants coffee he would be like 'get me my coffee now!' but he would not break or throw any tables or chairs. It was further stated that the resident is .

During an interview with Resident #3 on at 12:00 PM, it was stated that we have one resident (Resident #1) that's down the hall he is violent. He always threatens to hit people and pushes tables and chairs. There are residents that's afraid of him. Imagine being a , lady and you have someone in front of you with a fist drew threatening to punch you in the . We have written so many complaints to try and get this resident out of here but yet he is still here. The police have been called on this resident at least 10 different times, and they said they can't the resident because he hasn't hit anyone yet.

During an interview with Resident #2 on at 1:00 PM, it was stated that Resident #1 is very aggressive and is problematic. It was stated that he is always yelling and that one day he pushed over some tables and chairs during lunch. Almost everyone have told the management here and that they don't do anything about it. It was also stated that I have not seen him hit anyone yet but if he gets too angry may hit someone.

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Review of the Grievance log on revealed a grievance put in on that stated Resident #1 is coming and taking over the table at second seating during lunch screaming at four residents starting a riot if anyone questions or corrects him. It was stated that the residents are not able to eat at their table and that Resident #1 threatens people. It was stated that the police was called last time this past week and the Administrator had to calm him down with the police here as up.

Review of the Resident Council meeting minutes on revealed that in , of 2018 a resident was reported yelling in the dining room everyday. In , of 2018 residents expressed complaints about , , , and assault and battery.

During an interview with the Administrator and Corporate personnel on 11/19/2018 at 1:25 pm, it was asked to both staff are the counsel meeting minutes being reviewed? It was stated by the Administrator "yes we go through them." When asked to see documentation of resolution of the complaints brought to the staffs attention it was stated that she would have to go to the activities person because she keeps a list of written notes that are more detailed. During this time, the staff was given the opportunity to locate and provide the documentation, no documentation was ever provided.

During an interview with the Director of Nursing (DON) on at 1:00 pm, it was stated that the resident has never hit anyone and he gets really loud but does not recall him pushing any tables or chairs. It was stated that the resident has not physically hit anyone that she knows of.

Review of Resident #1's progress notes with the Administrator and the Corporate personnel on revealed that on , the resident was by the police department and transferred to the hospital due to aggressive behavior physical and verbal towards nursing staff.

Review of the Health Assessment (AHCA 1823 form) for Resident #1 revealed that the resident has a medical history and diagnosis of memory loss and that he requires routine supervision. He is independent with all of his Activities of Daily Living (ADL's). Review of the hospital report dated for revealed that the resident has a medical history and diagnosis of brief , , , and with behavioral disturbance. It was documented that the resident was at the hospital in of 2018. It was stated that the resident was due to threatening nursing staff, then struck/punched a nursing home resident. When the physician confronted the resident it was stated by the resident that he had a verbal argument with the resident but denies physically striking someone, and that the resident does have some . It is stated that the resident becomes violent quickly without warning. The resident admits to racing thoughts and irritability in which the resident rates as a 7 out of 10 on a severity scale with symptoms worse at night time.

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During an interview with the DON, the Administrator, and the Corporate personnel on at 1:53 PM, it was stated by the Administrator that the resident was not by the police and that now she remembers taking the resident to the hospital in her personal car, and that the resident was once he got to the Hospital. There was no documentation of how the resident got to the Hospital by the police department or in the car of the Administrator. Upon request of the police reports, it was stated by the Administrator that no police reports were filed for any of the occurrences because the police stated that they could not take the resident from the facility if he did not physically hit someone. Record review revealed no adverse incident reports were completed on the occurrence of the resident striking someone, or on any of the other occurrences involving law enforcement. There was also no resolution to the verbal and physical aggression complaints expressed by residents. The facility failed to document and report complaints of (resident to resident and resident to staff) and ensure the safety of all the residents residing at the facility.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(&) FS; 58A-5.0241 FAC

Based on interview and record review, the facility failed to provide, within 1 business day, an Adverse Incident Report to the Agency for Health Care Administration (AHCA) related to multiple events that involved law enforcement that placed all sampled residents at risk of harm and injury, for 1 out of 3 sampled record reviews (Resident #1).

The findings Included:

During random interviews with residents conducted on between 10 AM and 3 PM, it was revealed that Resident #1 is extremely agressive and violent. It was also revealed that the local law enforcement had been called out to the facility regarding Resident#1's behavior on numerous occassions.

Review of the Grievance log on revealed a grievance put in on that stated Resident #1 is coming and taking over the table at second seating during lunch screaming at four residents starting a riot if anyone questions or corrects him. It was stated that the residents are not able to eat at their table and that Resident #1 threatens people. It was stated that the police was called last time this past week and the Administrator had to calm him down with the police here as up.

Review of the Resident Counsel meeting minutes on revealed that in , of 2018 a resident

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Review of the Health Assessment (AHCA 1823 form) for Resident #1 revealed that the resident has a medical history and diagnosis of memory loss and that he requires routine supervision. He is independent with all of his Activities of Daily Living (ADL's). Review of the hospital report dated for revealed that the resident has a medical history and diagnosis of brief , , and with behavioral disturbance. It was documented that the resident was at the hospital in of 2018. It was stated that the resident was due to threatening nursing staff, then struck/punched a nursing home resident. When the physician confronted the resident it was stated by the resident that he had a verbal argument with the resident but denies physically striking someone, and that the resident does have some , . It is stated that the resident becomes violent quickly without warning. The resident admits to racing thoughts and irritability in which the resident rates as a 7 out of 10 on a severity scale with symptoms worse at night time.

Review of Agency records failed to indicate any adverse reports had been filed regarding incidents for Resident #1. The facility staff also confirmed no adverse reports had been filed for Resident #1.

During an interview with the DON, the Administrator, and the Corporate personnel on at 1:53 pm it was stated by the Administrator that the resident was not by the police and that now she remembers taking the resident to the hospital in her personal car, and that the resident was once he got to the Hospital. There was no documentation of how the resident got to the Hospital by the police department or in the car of the Administrator. Upon request of the police reports, it was stated by the Administrator that no police reports were filled for any of the occurrences because the police stated that they could not take the resident from the facility if he did not physically hit someone. No Adverse incident reports were completed on the occurrence of the resident striking someone, or all

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