STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969122	**03/07/2019**
NAME OF PROVIDER OR SUPPLIER **THE RESIDENCE AT DANIA BEACH**	STREET ADDRESS, CITY, STATE, ZIP CODE **150 STIRLING RD DANIA BEACH, FL 33004**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

An unannounced licensure Monitoring survey was conducted on - and at The Residence at Dania Beach, License #12950. The facility had deficiencies identified at the time of the survey.

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

Based on observation, interview and record review, it was determined that the facility failed to provide the appropriate level of supervision for residents as physician ordered and as needed based on significant changes (increase aggressive behavior), for 3 out of 3 sampled residents. As evidence of the facility failure to provide additional supervision to Resident #1, Resident # 2 and Resident #4 based on significant health changes (including behavioral changes) and to notify the primary care physician regarding the changes.

The findings included:

Record review of the facility Behavioral Management policy (no date) stated, the facility shall provide appropriate monitoring for residents with to ensure resident safety. Residents within the facility who have been identified as having will be provided appropriate support and supervision to ensure safety. Once resident have diminished to the point the facility can no longer safely care for the resident, appropriate alternative placement will be initiated. Any resident that displays maladaptive behavior or poor coping skills twice within a 14-day period may also constitute a permanent change of condition and requires updating/ changing the Care Plan by the nurse. The policy further stated a behavioral emergency is defined as an occurrence where there is a sudden, generally unexpected change or escalation in the behavior of a resident that is perceived to pose a serious threat to the safety of either the resident or others. The situation demands immediate attention.

A) Record review revealed Resident #1 was admitted to the facility on . The Health Assessment form (AHCA Form 1823) dated stated Resident #1 was admitted to the facility with a diagnoses of . The and behavior status noted as at times and alert and oriented times two. The AHCA 1823 form also stated that the resident requires daily oversight with wellbeing, whereabouts and reminder for important tasks.

Review of Resident #1's , notes after being admitted to the facility on , revealed the resident was evaluated and began receiving treatment for medication management for

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symptoms of , , and , on . The psychiatrist notes further stated it was reported to their office that Resident#1 displays agitation, , restlessness and aggressiveness. The resident is taking three , medications to control his behavioral patterns, further review of these notes revealed that the medications do not control Resident #1's symptoms and that the resident is non-compliant with taking medications. The Resident was than diagnosed with , and , none of which was documented on the AHCA 1823 form.

Review of the facility progress notes dated for revealed that Resident #1 began begging other residents for their cigarettes. When none of the residents gave him, their cigarettes Resident #1 went to the nurse's station to beg for cigarettes. During this time, another resident was in the nurse's station that Resident#1 attempted to hit due to his anger from the other residents and the nurse not giving him any cigarettes. On , it was noted that Resident#1 began showing aggressive behavior with staff regarding his request for cigarettes, stating that he wants it and he wants it now. On , it was noted that the resident entered the facility with a lit cigarette. A staff member approached him and told him to put the cigarette out, Resident #1 told the staff (foul language).

Review of an incident report dated on documented the following regarding Resident#1. A physical altercation that occurred on at 11:50 AM between Resident #1 and Resident #2 got into a big argument in the smoking area in which Resident #1 pushed Resident #2. Resident #2 and hit the left side of his and excoriated the of his . The facility called paramedics on at 11:08 AM but did not report the incident to the local sheriff department. Resident #2 was taken to a local area hospital and returned to the facility later that night.

During multiple confidential interviews conducted on between 1:50 PM an 5:45 PM revealed Resident #1 has been physically, verbally and emotionally towards residents in the facility since date of admission. It was stated that Resident #1 has spit on them, snatched their cigarettes out of their while they were smoking outside on the patio and that he would bully residents into giving him their cigarettes. It was also stated on multiple occasions many of them have filed grievances with the Administrator but no action has been taken. The residents stated they feel as if the Administration in the building does not care about their safety and well-being.

An interview was conducted with the facility Administration team (the Administrator, DON and the Marketing Director (identifies himself the Assistant Administrator)) and the local Sheriff Department regarding Resident #1, behavior on at 3:01 PM. The Administration team was ask to provide documentation indicating the steps and monitoring plan to ensure that the violent behavior does not continue to jeopardize the well-being and safety of the residents. It was further asked of the Administration team how will they address the concerns of the residents and the Administration stated

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they did not currently have a plan in place but they would issue a 45 days' notice to Resident #1 today ( ). The Administration team admitted from to , the facility did not implement any plan or have any procedures in place to prevent Resident #1 from harming other residents until when the State Agency Investigator, and the local Sheriff's Office and the licensing agency was onsite.

An interview was conducted with the Mental Health Nurse Practitioner (ARNP) from confidential company on at 4:24 PM, the ARNP stated he has been evaluating Resident #1 for about 6 months and that he was diagnosed with . It was further stated that the facility has never informed him about Resident #1 being physically aggressive only verbally aggressive. He stated he was at the facility on and the DON informed him of the behavior so he adjusted his medication. It was further stated that based on his evaluations, he never felt that the resident was inappropriate and that the facility never told him about any physical incidents that had occurred with the resident. Today he would say that he is inappropriate but it is a little too late and we should wait for medication adjustment. It was stated the facility called him today to inform him that the licensing agency was in the building and for him to identify the resident to be inappropriate. He further stated the facility wanted him to Resident #, so that they can remove him immediately. The ARNP evaluated the resident in the presents of the surveyors and stated that he is calm and does not meet criteria for . The ARNP explained to the DON (of the facility) that they are supposed to call him the day of the incident not two or three days after the incident, the would not be effective. The ARNP wrote orders dated for stating "Provide close monitoring for resident even one on one if necessary for four weeks, call provider if any changes in behavior such as being aggressive. Does not meet criteria for ".

An interview was conducted with the DON on at 4:45 PM. It was stated that they discovered Resident #1's aggressive behavior in , shortly after his arrival in . She further stated the ARNP was called in a couple days after his admission to handle his medication management. The DON stated, it is her responsibility to call the ARNP and request when a resident need to be evaluated for . The DON admitted to not telling the ARNP about the verbal aggression and physical incidents towards residents and staff as documented in the facility observation log. The DON also stated that she had not placed the call to the ARNP on after the assault occurred by Resident #1 because the psychiatrist was coming to the facility for a routine visit on . The DON acknowledged that she was fully aware of the physical altercation that had occurred between Resident #1 and Resident #2. The DON admitted to having knowledge of the criteria, yet still fail to call the ARNP on to put in an order to evaluate and Resident #1.

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B) Review of an incident report dated on documented the following regarding Resident#1 and Resident #2. A physical altercation occurred on at 11:50 AM between Resident #1 and Resident #2 in the smoking area in which Resident #1 pushed Resident #2. Resident #2 and hit the left side of his and excoriated the of his . The facility called paramedics on at 11:08 AM, Resident #2 was taken to a local area hospital and returned to the facility later that night.

Review of the file for Resident #2 revealed an AHCA 1823 form dated for , stated that the resident has a medical history and diagnosis of , and . The resident requires supervision with all Activities of Daily Living (ADL's) except for ambulation in which the resident is independent. Further review of the file revealed that the resident was admitted to Hospice Care on . The notes upon admission to Hospice revealed that Resident #2 was observed to have a left , an upper extremity , multiple areas of scraps, and appeared to be . The condition of Resident #2 upon returning from the hospital was never documented by the facility staff. Additional review of the documentation provided by Hospice exemplified that a significant change had occurred with Resident #2 after the incident on and that the facility failed to document the residents change in condition, failed to notify the residents emergency contact regarding the change of condition of the resident, and failed to notify law enforcement regarding the incident. An adverse incident report for the resident was never completed.

Upon return of Resident # 2 on , observations of the facility daily census sheet and progress notes for the resident revealed that Resident #1 was still present inside the facility after abusing Resident #2 with no medical interventions and no plans documented to provide supervision to Resident #2 to stop the violent behavior or follow-up after hospital discharge due to the injuries.

During an interview on at 2:33 PM with Resident #5 that witnessed the on , it was stated that Resident #1 physically Resident #2 and that he has been throwing up and other stuff every since. It was further stated that throughout the week Resident #2 would scream out in , and that I would call in the Nurses and that instead of calling to take him to the hospital they will give him a pill and just walk out the room. His condition got worse once he was pushed down by Resident #1, and the staff acted as though they did not care.

C) Review of the file for Resident #4's file (including the AHCA form 1823) revealed a medical history of dated . Further record review revealed the resident exhibited constant verbal aggressive behavior since admission approximately around to present. Record review failed to reveal any notification to the resident's physician or any steps implemented (including increased

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supervision) by the facility to address Resident #4's aggressive behavior.

Review of Resident #4's progress notes documented the following aggressive behavior towards staff and residents, no documentation of intervention noted. On , it was noted Resident #4 was verbally to staff calling them stupid (foul language) and demanding to leave the facility. On , it was noted that the police officer arrived at the facility shortly before lunch and was called by the receptionist due to Resident #4 being and threatening her. On , it was also noted the staff on the 11PM - 7AM shift also called the police on the resident due to Resident #4 threatening to punch her in the . The decision was made by the police officer to not the resident at the time of the incident. It was further noted that staff was advised to be on their guard for Resident #4 and if possible avoid having the resident walk up behind them or on the corner of them and to also avoid all confrontation. On , it was noted the resident was walking and forth in the hallway talking to himself and eating from other peoples plates in the dining room. On at 9:30 AM, it was noted that the resident was refusing his medications then slamming his on the med cart and yelling at the med tech, Resident #4 then barged into the nurses station yelling at the staff member. Resident was redirected by a staff member and escorted into the TV room. On at 5:36 PM, it was noted that Resident #4 signed out of the facility and did not return to the facility until at 1:40 PM. On at 10:30 AM, Resident #4 returned to the facility. It was further noted for staff to be on guard and if possible to avoid Resident #4 to prevent confrontation was also noted at this time and that Resident #4 was being disrespectful to staff. The resident was observed eating breakfast and left the facility once again. On , it was noted at 7:00 AM, Resident #4 was speaking very aggressive to others, stating he was going to "knock them out". The reporting staff member met with the Administrator at 1PM about the behavior of Resident #4 and the Administrator stated we can't force him to take his medications and their thoughts of issuing Resident #4 a 45 day notice. On , a resident was complaining to the staff member that Resident #4 stalks her and causes her to feel intimidated and afraid.

Further record review revealed a pattern of continuous refusal of all Resident #4's medications to include medications to treat his . An interview was conducted with the DON on at 3:42 PM requesting proof of informing the physician that Resident #4 was refusing his medication and that could not be provided. An interview conducted with the ARNP on at 3:35 PM who stated he was scheduled to conduct a psych evaluation on and the was cancelled. It was further stated the facility never called his corporate office to reschedule the .

Multiple confidential interviews on between 1:50 PM an 5:45 PM revealed Resident #4 has been verbally and emotionally towards residents in the facility since admission. The

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interviewees stated that Resident #4 has continuously followed them, intimidate them and curse at them for no reason. It was also stated on multiple occasions many of them have filed grievances with the Administrator, staff members and the DON but no action has been taken to control Resident #4's behavior. The residents stated they feel as if the Administration in the building does not care about their safety and well-being.

During an exit interview with the Administrator on at 5 PM, aforementioned was discussed. The facility was also asked to provided documentation/evidence to illustrate how the facility implemented and provided supervision to the residents based on the signficant behavior changes and notification to the their primary care physicians for interventions. The facility provided no documentation.

Class II

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on record review and interview, it was determined that the facility failed to ensure residents reside in a safe living environment free from verbal and , for 55 out of 55 residents (Resident #1-#55). It was also determined that the facility failed to address residents' grievances (verbal and written) in a timely manner regarding aggressive behavior (physical and verbal) demonstrated by Resident #1 and #4.

The findings included:

Record review of incident reports and progress notes reveal Resident #1 and #4 are verbally and physically aggressive towards residents residing in the facility and staff members on multiple occasions since they were admitted to the facility to current date. Further review failed to reveal any written documentation illustrating inventions and steps implemented to address the concerns and ensure safety. Further review revealed the facility failed to notify the primary care physicians of both residents regarding the concerns.

During multiple confidential interviews conducted on between 1:50 PM an 5:45 PM, revealed Resident #1 has been physically, verbally and emotionally towards residents in the facility since date of admission. It was stated that Resident #1 has spit on them, snatched their cigarettes out of their while they were smoking outside on the patio and that he would bully residents into giving him their cigarettes. It was also stated on multiple occasions many of them have filed grievances with the Administrator but no action has been taken. The residents stated they feel as if the Administration in the building does not care about their safety and well-being.

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Multiple confidential interviews on [redacted] between 1:50 PM an 5:45 PM, revealed Resident #4 has been verbally and emotionally towards residents in the facility since admission. The interviewees stated that Resident #4 has continuously followed them, intimidate them and curse at them for no reason. It was also stated on multiple occasions many of them have filed grievances with the Administrator, staff members and the DON but no action has been taken to control Resident #4's behavior. The residents stated they feel as if the Administration in the building does not care about their safety and well-being.

Review of the facility's grievances failed to illustrate any of the aforementioned concerns and/or resolutions regarding Resident #1 and #4. Review of the facility's policy confirmed that the facility has an [redacted] to ensure the safety and well-being of all residents residing in the facility from physical and mental . However, record review failed to illustrate any steps the facility implemented to ensure the safety of all residents residing in the facility after being notified of these concerns.

During an interview with the Administrator on [redacted] at 5 PM, aforementioned was discussed. The facility was asked to provide documentation/evidence to illustrate how the facility implemented and provided a safe living environment and addressed the residents' grievances. The facility provided no documentation.

Refer to A 0025 for additional findings related to A 0030.

Class II