STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968863	**04/08/2019**
NAME OF PROVIDER OR SUPPLIER **ACACIA GROVE ASSISTED LIVING FACILITY LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **2485 RIDGECREST AVE** **ORANGE PARK, FL 32065**	

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

0000 - Initial Comments

A complaint investigation (#2019004866) was conducted at Acacia Grove Assisted Living Facility from to . There were deficiencies identified at the time of survey, including Class I citations for both 0025 and 0030.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and staff interview, the facility failed to obtain an 1823 Health Assessment every 3 years for 1 of 5 sampled residents (Resident #4).

The findings include:

Record review for Resident #4 revealed a Health Assessment dated . Resident #4 was admitted on . There was a visit note dated by a physician assistant, but no updated 1823 form was located in the clinical record.

The Administrator on at 2:24 PM confirmed she did not have a more recent Health Assessment for Resident #4. The Administrator stated she thought the Health Assessments needed to be updated every 5 years if there was no change in condition.

Photographic Evidence Obtained

Class III

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

Based on observation, record review, and interviews, the facility failed to provide care and services to meet the needs of 2 of 5 sampled residents, evidenced by the lack of physician coordination for the use of a on Resident #1, and the lack of documentation for and significant issues for Residents #1 and #2. Failure to provide the level of supervision Resident #1 required resulted in a on .

The findings include:

1. Employee B, a caregiver, was interviewed on at 8:45 AM. Employee B stated Resident #1 was constantly trying to get up by herself, even though it was unsafe for her to do so independently, and was sent to the hospital after a on . When asked about Resident #1's behavior, Employee

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B explained that staff was instructed by the Administrator to use a seat belt around the resident's waist to prevent her from getting up from her wheelchair. Employee B stated the behaviors started about a month ago and the facility staff cannot take care of Resident #1's behavioral and physical needs anymore.

On at 8:50 AM, Employee B pointed out Resident #1's wheelchair, which was in the garage at the time of the survey. The seat belt was attached to the chair but there was no clip seen. Towards the end of the strap, there was a knot tied. Employee B explained the resident broke the clip so they had to tie another piece of strap to it so it would fit around the resident.

Record review revealed Resident #1 was admitted to the facility on . She had an 1823 Health Assessment (HA) dated which revealed diagnoses of Hypertensive with , and Right Total , Replacement. Under Activities of Daily Living (ADL) the Independent column had been covered with correction fluid and a line was drawn down column marked "Supervision". There was no entry for the question on page 2 which asked if Resident #1 required 24-hour nursing or , care. Some of her medications included an , medication, , 0.5 mg three times a day, an , , , 10 mg (no frequency listed), and an , , , 25 mg twice a day.

A review of hospice records for Resident #1 showed an initial certification date of for diagnosis of .

There was a new HA dated with a diagnosis of , . Under " or Behavioral status" it listed . The entry for "Special Precautions" listed "Bed alarm/chair alarm" and for "Elopement Risk", the assessor checked Yes. She was also assessed to need assistance with all ADL's. For the question which asked whether Resident #1 required 24-hour nursing or , care, the assessor answered yes, and wrote in, "Nursing Care". Page 4 asked whether Resident #1 needed help taking medications but this question was not answered. A Hospital Discharge Medication List was attached, dated . It revealed the , was to be continued at same dose and frequency, the , was changed to 20 mg daily, and , continued at same dose and frequency. In addition, a sleeping pill , 15 mg was ordered at bedtime. There was no order found in Resident #1's record for a .

The Administrator arrived to the facility on at 9:00 AM and she was interviewed about Resident # 1. She stated that for the past month or so, Resident #1 was no longer appropriate to live here . She and Resident #1's family were actively trying to transition her to a nursing home. The Resident's had progressed with combative behaviors towards others, and needing constant supervision

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for attempts to get out of her chair/wheelchair/bed unsupervised. She was physically unable to safely stand and walk. The Resident's Physician Assistant (PA) had filled out a 3008 form for her transition to a Nursing Home. The Administrator confirmed Resident #1 on Monday but that she was not present, Employee A was. After the , the Administrator told Employee A to send the Resident to the hospital since she was on .

When the Administrator explained Resident #1 had several in the facility, she was asked for any facility documentation of these events, including any documentation of Resident #1's progression and behaviors, and any other significant changes, including any hospitalizations. The Administrator stated that she did not have any documentation to show of the Resident's decline. She explained that with she usually fills out an incident report, but she did not have time to do it for Resident #1's on . She also stated the Resident might have had 1 or 2 hospitalizations, but could not recall specifics and had no documentation to refer to. She does not require her staff (who are scheduled to work alone) to document any changes in resident condition. Staff were to notify her (as the Administrator and Registered Nurse) and she would assess the resident and document as needed.

On at 9:10 AM, the Administrator was asked if the use of the , , and transfer to the hospital on qualified as a reportable adverse incident. She stated she would do an adverse incident it was something serious or leading to . She did not do a full investigation yet so she did not know if this would qualify for one. She confirmed Resident #1's wheelchair had a seatbelt attached, and that staff was advised to use it when Resident #1 was becoming combative. She said she did not want to restrain Resident #1 but felt she had no choice. The Administrator stated the PA was aware of the restrain use, and told staff that it was needed until Resident #1 could transition into a Nursing Home.

On at 9:42 AM, Employee A was interviewed. She confirmed she was the only staff member present on when Resident #1 . She gave the details of the on as follows: Resident #1 around 8:30 AM. Employee A had just finished taking Resident #1 to the bathroom and placed her in the wheelchair, and put the seat belt on her. Employee A stated Resident #1 was in the living room, while she finished doing the dishes in the kitchen. There was not a clear view of the Resident from the kitchen. She peeked around the corner and could see Resident #1 fidgeting in her chair, trying to get up, but she had the seat belt on at that time, tied around her waist. Resident #1 was only out of her sight for about a minute, and then she heard a thump noise, and an "OH!". Employee A explained she went into the living room and saw Resident #1 on the floor, still strapped in her wheelchair. The Resident was lying on her left side, and Employee A said she could not see anything underneath her, if she was injured. She saw some around the resident's . The was smeared and could not see where it came from. Employee A thought she might have bit her . Employee A untied the strap and the Resident rolled on her .

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Employee A then stated the Resident's hospice nursing assistant had just arrived at that time, and they got her up off the floor. When Employee A was asked how they got her up, and where she was placed (in the wheelchair or to bed), Employee A changed her statement and said they did not get her up. She said she called the Administrator, who told her not to move her, and to call 911 immediately. The Resident was still trying to get up off the floor. Employee A confirmed she did not document this event, and that she was not asked to do so by the Administrator. She stated the Administrator never told her that she could not use the seat belt for this Resident.

On at 9:45 AM, the Resident's PA was interviewed. She stated she has been taking care of Resident #1 since she arrived at the facility. The PA gave details of Resident #1's progression, and increase in agitated and violent behaviors. Resident #1 was getting medications for her behavior and the PA had just increased her , . The goal was to manage her behaviors. She stated Resident #1 was a danger to herself, and had an unsteady gait, and was constantly falling. The PA stated she did not have any conversation with the facility staff or hospice regarding the use of a seat belt. The PA stated she was "kinda" aware that Resident #1 had a seat belt on, and she might have seen it on her but she did not order it. The PA explained that she thought hospice may have ordered it. She acknowledged she was not aware of ALF regulations regarding . The PA was also unaware Resident #1 had a on and was sent to the hospital.

Record review revealed a Health Assessment for Nursing Homes (3008) which was signed by the PA on . The 3008 indicated Resident #1 had a . Section G, titled "Patient Risk Alerts", had the following boxes checked off: Harm to self, Harm to others, , and . "Wheelchair belt" was written in as the type of , and the reason for use was written in as " risk".

During a follow up interview with the Administrator on at 9:47 AM, she was asked about the seat belt being on Resident #1 when she on . The Administrator stated that the seat belt strap was usually loosely tied around the resident. The Resident could slide down in the chair it was so loose. She was asked how necessary the seat belt was if they kept it that loose, and if the resident could slide out of the seat belt, would she consider that a strangulation risk. The Administrator did not answer. The Administrator did not produce any documentation that the physician or PA gave authorization for the use of the seat belt or that it was assessed to be safe and effective.

On at 9:49 AM, a family member for Resident #1 was interviewed over the phone. She stated she was aware that Resident #1's behaviors were getting worse and was falling more frequently. She was aware that the facility was using a seat belt to keep Resident #1 in the wheelchair. She encouraged it. She was not aware if it was against assisted living facility regulations. She explained Resident #1

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constantly moved and doesn't sit still. The seat belt was the only thing preventing her from getting up and falling. Even with constant supervision she would become combative if you tried to stop her from getting up. She confirmed Resident #1 was currently in an inpatient hospice center and not expected to go to Assisted Living.

Employee C, a newly hired Caregiver, was interviewed on at 12:35 PM. She stated when she was hired in , Resident #1 was ambulating independently, assisting with laundry, and helped her set the dining table for meals. She stated Resident #1 had a dramatic decline in condition and towards the last 2 weeks or so, she needed constant care. She was continuously trying to get up. Employee C stated when she was assisting other residents with care, she would have to make sure Resident #1 was right next to her to keep an on her. She was aware of the seat belt but she would never strap her up. The Administrator never told her she could not use it. She did not receive any training on or resident rights yet from this facility. She has had it in the past from previous employers.

2. A family member for Resident #2 was interviewed on at 10:10 AM. She stated Resident #2 was on hospice services and needed his at all times. It should be set a 2 liters per minute. She stated he was able to ambulate with a walker, with staff assistance. He did have two previous about 6 months ago. He was falling asleep at the kitchen table after meals and would onto the floor. Now they bring him directly to his recliner after he eats and it has not happened again.

An observation was made on at 11:45 AM of Resident #2, where he had infusing via . It was hooked up to an concentrator in the resident's room. Staff got the resident up out of the recliner and began walking with him to kitchen. The tubing was carried from his bedroom and across the living room and into the kitchen. As he entered kitchen, the tubing began to tighten up even though the tubing was extremely long. Employee B removed the resident's and told him he could eat lunch without it and then sat him down.

Record review for Resident #2 did not reveal any documentation of the two or that the physician was notified. Record review revealed he was admitted to the facility on . He had a Health Assessment dated revealing diagnoses of , , and . For "Special Precautions" it listed and poor safety awareness. He had a physician order dated for at 2 liters per minute continuously for and .

The Administrator on at 10:12 AM confirmed that the resident did have two . She confirmed Resident #2 asleep at the table and onto the floor. She did not document the

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Resident's two or have documentation that the physician was notified.

Photographic Evidence Obtained

Class I

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

Based on observation, record review, and interviews, the facility failed to honor the resident rights of 1 of 5 sampled residents (Residents #1) following the use of a which led to a with injury on .

The findings include:

1. Employee B, a caregiver, was interviewed on at 8:45 AM. Employee B stated Resident #1 was constantly trying to get up by herself, even though it was unsafe for her to do so independently, and was sent to the hospital after a on . When asked about Resident #1's behavior, Employee B explained that staff was instructed by the Administrator to use a seat belt around the resident's waist to prevent her from getting up from her wheelchair. Employee B stated the behaviors started about a month ago and the facility staff cannot take care of Resident #1's behavioral and physical needs anymore.

On at 8:50 AM, Employee B pointed out Resident #1's wheelchair, which was in the garage at the time of the survey. The seat belt was attached to the chair but there was no clip seen. Towards the end of the strap, there was a knot tied. Employee B explained the resident broke the clip so they had to tie another piece of strap to it so it would fit around the resident.

Record review revealed Resident #1 was admitted to the facility on . She had an 1823 Health Assessment (HA) dated which revealed diagnoses of Hypertensive with , and Right Total , Replacement. Under Activities of Daily Living (ADL) the Independent column had been covered with correction fluid and a line was drawn down column marked "Supervision". There was no entry for the question on page 2 which asked if Resident #1 required 24-hour nursing or care. Some of her medications included an , medication, , 0.5 mg three times a day, an , , , 10 mg (no frequency listed), and an , 25 mg twice a day.

There was a new HA dated with a diagnosis of . Under " or

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Behavioral status" it listed . The entry for "Special Precautions" listed "Bed alarm/chair alarm" and for "Elopement Risk", the assessor checked Yes. She was also assessed to need assistance with all ADL's. For the question which asked whether Resident #1 required 24-hour nursing or , care, the assessor answered yes, and wrote in, "Nursing Care". Page 4 asked whether Resident #1 needed help taking medications but this question was not answered. There was no order found in Resident #1's record for a .

The Administrator arrived to the facility on at 9:00 AM and she was interviewed about Resident # 1. She stated that for the past month or so, Resident #1 was no longer appropriate to live here . She and Resident #1's family were actively trying to transition her to a nursing home. The Resident's had really progressed with combative behaviors towards others and needing constant supervision for attempts to get out of her chair/wheelchair/bed unsupervised, and she was physically unable to safely stand and walk. The resident's Physician Assistant(PA) had filled out a 3008 form for her transition to a Nursing Home. The Administrator confirmed Resident #1 on Monday but that she was not present, Employee A was. At 9:10 AM, the Administrator confirmed Resident #1's wheelchair had a seatbelt attached, and that staff was advised to use it when Resident #1 was becoming combative. She said she did not want to restrain Resident #1 but felt she had no choice. The Administrator stated the PA was aware of the restrain use, and told staff that it needed to be in place until Nursing Home placement was found.

On at 9:42 AM, Employee A was interviewed. She stated she was the only staff member present on when Resident #1 . She gave the details of the on as follows: Resident #1 around 8:30 AM. Employee A had just finished taking Resident #1 to the bathroom and placed her in the wheelchair and put the seat belt on her. Employee A stated Resident #1 was in the living room, while she finished doing the dishes in the kitchen. There was not a clear view of the resident from the kitchen. She peeked around the corner and could see Resident #1 fidgeting in her chair, trying to get up, but she had the seat belt on at that time, tied around her waist. Resident #1 was only out of her sight for about a minute, and then she heard a thump noise, and an "OH!" . Employee A explained she went into the living room and saw Resident #1 on the floor, still strapped in her wheelchair. The resident was lying on her left side, and Employee A said she could not see anything underneath her, if she was injured. She saw some around the resident's . The was smeared and could not see where it came from. Employee A thought she might have bit her . Employee A untied the strap and the resident rolled on her .

Employee A then stated the resident's hospice nursing assistant had just arrived at that time, and they got her up off the floor. When Employee A was asked how they got her up, and where she was placed (in wheelchair or to bed), Employee A changed her statement and stated they did not get her up.

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She called the Administrator, who told her not to move her, and to call 911 immediately. The resident was still trying to get up off the floor. Employee A confirmed she did not document this event, and that she was not asked to do so by the Administrator. She stated the Administrator never told her that she could not use the seat belt for this resident.

On at 9:45 AM, the Resident's PA was interviewed. She stated she has been taking care of Resident #1 since she arrived at the facility. The PA gave details of Resident #1's progression, and increase in agitated and violent behaviors. Resident #1 was getting medications for her behavior and the PA had just increased her , . The goal was to manage her behaviors. She stated Resident #1 was a danger to herself, and had an unsteady gait, and was constantly falling. The PA stated she did not have any conversation with the facility staff or hospice regarding the use of a seat belt. The PA stated she was "kinda" aware that Resident #1 had a seat belt on, and she might have seen it on her but she did not order it. The PA explained that she thought hospice may have ordered it. She acknowledged she was not aware of ALF regulations regarding . The PA was also unaware Resident #1 had a on and was sent to the hospital.

Record review revealed a Health Assessment for Nursing Homes (3008) which was signed by the PA on . The 3008 indicated Resident #1 had a . Section G, titled "Patient Risk Alerts", had the following boxes checked off: Harm to self, Harm to others, , and . "Wheelchair belt" was written in as the type of , and the reason for use was written in as " risk".

During a follow up interview with the Administrator on at 9:47 AM, she was asked about the seat belt being on Resident #1 when she on . The Administrator stated that the seat belt strap was usually loosely tied around the resident. The resident could slide down in the chair it was so loose. She was asked how necessary the seat belt was if they kept it that loose, and if the resident could slide out of the seat belt, would she consider that a strangulation risk. The Administrator did not answer. The Administrator did not produce any documentation that the physician or PA gave authorization for the use of the seat belt or that it was assessed to be safe and effective.

On at 9:49 AM, a family member for Resident #1 was interviewed over the phone. She stated she was aware that Resident #1's behaviors were getting worse and was falling more frequently. She was aware that the facility was using a seat belt to keep her Resident #1 in the wheelchair. She encouraged it. She was not aware if it was against assisted living facility regulations. She explained Resident #1 constantly moves and does not sit still. The seat belt was the only thing preventing her from getting up and falling. Even with constant supervision she would become combative if you tried to stop her from getting up. She confirmed Resident #1 was currently in an inpatient hospice center and not expected to go to Assisted Living.

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Employee C, a newly hired Caregiver, was interviewed on at 12:35 PM. She stated when she was hired in , Resident #1 was ambulating independently, assisting with laundry, and helped her set the dining table for meals. She stated Resident #1 had a dramatic decline in condition and towards the last 2 weeks or so, she needed constant care. She was continuously trying to get up. Employee C stated when she was assisting other residents with care, she would have to make sure Resident #1 was right next to her to keep an on her. She was aware of the seat belt but she would never strap her up. The Administrator never told her she could not use it. She did not receive any training on or resident rights yet from this facility. She has had it in the past from previous employers.

Photographic Evidence Obtained

Class I

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(i)

Based on facility policy review, record review, and staff interview, the facility failed to follow their elopement procedure for 2 of 5 sampled Residents, Residents #1 & #5.

The findings include:

On at 2:19 PM the Administrator stated that she keeps an elopement book with resident identification forms with pertinent information, including photo identification for all residents, even those not at risk.

The facility's Elopement Standards and Policy and Procedure revealed the following details: "Elopement risk can pose a real danger to certain residents. All residents assessed at risk for elopement shall be identified so staff can be alerted to their need for supervision. At a minimum, a daily effort to determine that at risk residents have identification on their persons. Special attention given to those residents with and related assessed at high risk. Maintain a photo identification of at risk residents on file. Photo identification will be made available within 10 days of admission."

Record review for Resident #1 revealed a Health Assessment (HA) dated that indicated the resident was at risk for elopement. The resident did have a Resident Identification Form in the elopement book, however there was no photo identification of this resident in there.

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Record review for Resident #5 revealed a HA dated that indicated Resident #5 was an elopement risk. It stated "Very mild, but does not actively seek elopement". The resident did have a Resident Identification Form in the elopement book, however it revealed the resident was not an elopement risk.

The Administrator confirmed that Resident #1 did not have photograph in the elopement book on at 2:19 PM. She explained she had the picture in her phone and just did not print it out yet. She also stated she did not think Resident # 5 was not a elopement risk, and the HA must be wrong.

Photographic Evidence Obtained

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record review and staff interview, the facility failed to maintain an accurate daily medication record for 5 of 5 sampled residents, Resident #1-#5.

The findings include:

1. Review of the medication observation records (MORs) for Residents #2-#5 revealed many medications scheduled for 8:00 AM.

On at 8:53 AM, Employee B, the caregiver on duty, stated she already gave Residents #2- #5 their medications scheduled for 8:00 AM. She confirmed she did not sign the MOR for any of them yet, and she usually signs them around lunch time . She was taught that she should sign the medication record immediately after giving them but she usually waits until lunch when she has more time to complete them.

2. Record review for Resident #1 revealed a physician order for 0.5 mg at night, written on . On , a second physician order for , 1 mg tab, every 8 hours as needed for agitation was written, with orders to discontinue the 0.5 mg tab.

Review of Resident #1's MOR for revealed the 0.5 mg at night was still there, with no notation that it was discontinued. Additionally, the new order for 1 mg of was not written correctly. It was written as , 0.5 mg , two tabs per 3 times a daily as needed. There was a staff initial under the "hour" section, but no date or time that it might have been given.

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Review of the card of [redacted], [redacted] 1 mg showed a label with instructions to take 1 by [redacted] every 8 hours as needed for agitation. The [redacted], was filled on [redacted] totalling 90 pills. There were 2 missing tablets from the card during the observation on [redacted]. There was no description if and why medications may have been given to the resident.

The Administrator was interviewed on [redacted] at 12:29 PM. She confirmed the new order written [redacted] for [redacted], [redacted] 1 mg was not added to the [redacted] Medication Record and was incorrectly written on the [redacted], [redacted] Medication Record. The facility had a Control Medication Log for the 1 mg of [redacted], [redacted], but it was blank. The Administrator stated that she did not know when the two missing tablets were given to the resident. Even though there were initials under the hour on the MOR, it was not clear that how it was given. Because the order was not transcribed correctly onto the MOR, it was unclear if staff should give 1 or 2 tablets. The Administrator stated she was the one who transcribed that order and confirmed she did not write it correctly.

The Administrator stated that they did not have the [redacted], [redacted] 0.5 mg card any more. The Control Medication Log record revealed the last 0.5 mg of [redacted], was signed out on [redacted] at 8:00 PM. Even though there were no 0.5 mg tablets of [redacted], [redacted] signed out from [redacted] to [redacted] on the Control Medication Log , the staff documented on the MOR that they were giving it at 8:00 PM from the [redacted]-[redacted]. The Administrator could not prove where the [redacted], [redacted] came from to give on those days or if it was even given.

Photographic Evidence Obtained

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on record review and staff interview, the facility failed to properly assist with medication administration for 1 of 5 sampled residents (Resident #1) by not having an indication for use for "as needed" [redacted], [redacted] on the medication record.

The findings include:

Record review for Resident #1 revealed a physician order for [redacted], [redacted] 1 mg tab one every 8 hours as needed for agitation written on [redacted].

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	AL11968863	**04/08/2019**
NAME OF PROVIDER OR SUPPLIER **ACACIA GROVE ASSISTED LIVING FACILITY LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **2485 RIDGECREST AVE** **ORANGE PARK, FL 32065**	

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

Review of the Medication Observation Record (MOR) for , revealed the , was not written correctly. It was written , 0.5 mg , two tabs per 3 times a daily as needed. There was no indication for use on the Medication Record. The current schedule was such that unlicensed staff assisted with medication self-administration.

The Administrator was interviewed on at 12:29 PM. She confirmed the medication record did not have an indication for use.

Photographic Evidence Obtained

Class III

0081 - Training - Staff In-Service - 58A-5.0191( ) FAC

Based on employee record review and staff interview, the facility failed to provide training on recognizing , neglect, and , , and resident rights, within 30 days of hire for 1 of 3 sampled employees, Employee C.

The findings include:

Record review revealed Employee C was hired on and provided direct care to residents. Her record did not have evidence of training in recognizing , neglect, and , , or resident rights.

The Administrator on at 11:18 AM confirmed she had 30 days to ensure new employees receive these training. She was the one who does the training. She did not do it yet for Employee C. She confirmed Employee C began providing direct patient care on and it was past 30 days.

Class III

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

Based on record review and staff interview, the facility failed to report an adverse incident for 1 of 5 sampled residents (Resident #1) following an incident requiring transfer to a higher level of care for which the facility could have exercised control.

The findings include:

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Employee B, a caregiver, was interviewed on at 8:45 AM. Employee B stated Resident #1 was constantly trying to get up by herself, even though it was unsafe for her to do so independently, and was sent to the hospital after a on . When asked about Resident #1's behavior, Employee B explained that staff was instructed by the Administrator to use a seat belt around the resident 's waist to prevent her from getting up from her wheelchair. Employee B stated the behaviors started about a month ago and the facility staff cannot take care of Resident #1's behavioral and physical needs anymore.

The Administrator arrived to the facility on at 9:00 AM and she was interviewed about Resident # 1. She stated that for the past month or so, Resident #1 was no longer appropriate to live here . She and Resident #1's family were actively trying to transition her to a nursing home. The Resident's had really progressed with combative behaviors towards others and needing constant supervision for attempts to get out of her chair/wheelchair/bed unsupervised, and she was physically unable to safely stand and walk. The resident's Physician Assistant(PA) had filled out a 3008 form for her transition to a Nursing Home. The Administrator confirmed Resident #1 on Monday but that she was not present, Employee A was. At 9:10 AM, the Administrator confirmed Resident #1's wheelchair had a seatbelt attached, and that staff was advised to use it when Resident #1 was becoming combative. She said she did not want to restrain Resident #1 but felt she had no choice. The Administrator stated the PA was aware of the restrain use, and told staff that it needed to be in place until Nursing Home placement was found.

On at 9:10 AM, the Administrator was asked if the use, , and transfer to the hospital was a reportable adverse incident. She stated she would if it was something serious, or leading to . She did not know at this time. She did not do a full investigation yet so she did not know if this would qualify for one.

On at 9:42 AM, Employee A was interviewed. She stated she was the only staff member present on when Resident #1 . She gave the details of the on as follows: Resident #1 around 8:30 AM. Employee A had just finished taking Resident #1 to the bathroom and placed her in the wheelchair and put the seat belt on her. Employee A stated Resident #1 was in the living room, while she finished doing the dishes in the kitchen. There was not a clear view of the resident from the kitchen. She peeked around the corner and could see Resident #1 fidgeting in her chair, trying to get up, but she had the seat belt on at that time, tied around her waist. Resident #1 was only out of her sight for about a minute, and then she heard a thump noise, and an "OH!" . Employee A explained she went into the living room and saw Resident #1 on the floor, still strapped in her wheelchair. The resident was lying on her left side, and Employee A said she could not see anything underneath her, if she was injured. She saw some ˬ around the resident's . The was

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smeared and could not see where it came from. Employee A thought she might have bit her . Employee A untied the strap and the resident rolled on her .

Employee A then stated the resident's hospice nursing assistant had just arrived at that time, and they got her up off the floor. When Employee A was asked how they got her up, and where she was placed (in wheelchair or to bed), Employee A changed her statement and stated they did not get her up. She called the Administrator, who told her not to move her, and to call 911 immediately. The resident was still trying to get up off the floor. Employee A confirmed she did not document this event, and that she was not asked to do so by the Administrator. She stated the Administrator never told her that she could not use the seat belt for this resident.

On at 9:45 AM, the Resident's PA was interviewed. She stated she has been taking care of Resident #1 since she arrived at the facility. The PA gave details of Resident #1's progression, and increase in agitated and violent behaviors. Resident #1 was getting medications for her behavior and the PA had just increased her , . The goal was to manage her behaviors. She stated Resident #1 was a danger to herself, and had an unsteady gait, and was constantly falling. The PA stated she did not have any conversation with the facility staff or hospice regarding the use of a seat belt. The PA stated she was "kinda" aware that Resident #1 had a seat belt on, and she might have seen it on her but she did not order it. The PA explained that she thought hospice may have ordered it. She acknowledged she was not aware of ALF regulations regarding . The PA was also unaware Resident #1 had a on and was sent to the hospital.

Record review for Resident #1 revealed a physician order for , 0.5 mg at night written on . On s physician order for , , 1 mg tab, one every 8 hours as needed for agitation was written, with orders to discontinue , 0.5 mg tab.

PReview of the Medication Record for , , revealed the , 0.5 mg at night was still on there (and none had been documented as given). There was no indication it had been discontinued. Additionally, the new order for 1 mg of , was not written correctly on the Medication Record. It was written " , , 0.5 mg , two tabs per 3 times a daily as needed". There was no indication for use on the Medication Record. There was a staff initial under the " hour " section, but no date or time that it might have been given. Review of the medication card label was , 1 mg tablet, take 1 by every 8 hours as needed for agitation. The , was filled on , with 90 pills, but upon review on , there were 2 pills missing from the card. There was no description if and why medications may have been given to manage the resident's behaviors.

The Administrator was interviewed on at 12:29 PM. She confirmed the new order written on

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for , 1 mg, and that it was not added to the Medication Record and was incorrectly written on the , Medication Record. The facility did not have a Control Medication Log for the 1 mg of , filled in. The Administrator stated that she did not know when the two missing pills were given to the resident. Even though there were initials under the hour on the Medication Record, it did not mean that it was given at all or both at once. Because the order was not transcribed exactly onto the Medication Record, it was unclear if 1 or 2 tablets should be given (since two doses were written, 1 mg on the actual order, and 0.5 mg on the Medication Record). The Administrator stated she was the one who transcribed that order and confirmed she did not write it correctly.

On a review of the Adverse Incident Reporting System showed no adverse incidents created by this facility for Resident #1's on .

Class III