STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966366	C 05/08/2019
NAME OF PROVIDER OR SUPPLIER **CROWN COURT**	STREET ADDRESS, CITY, STATE, ZIP CODE **109 NORTH SEMINOLE AVENUE** **INVERNESS, FL 34450**	

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

0000 - Initial Comments

A complaint investigation (Complaint #2019004412) was conducted at Crown Court Assisted Living Facility on , through , and , . Deficiencies were identified at the time of the survey.

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on record review and interview, the facility failed to ensure 1 of 5 sampled residents (Resident #1) met the criteria for admission into an assisted living facility.

Findings:

Record review of the facility's admission/discharge log revealed Resident #1 was admitted to the facility on .

Record review of Resident #1's Health Assessment for Assisted Living Facilities (AHCA Form 1823) dated revealed on page 1, under Section 1, Health Assessment - or Behavioral Status: Impulse control (related to frontal), other specified , (probably related to frontal), uncontrolled or increased , impulsive, agitated, unable to follow directions, and assault/threatening behaviors and , . On page 2, Section C., Pose a danger to self or others? (Consider any significant history of physically or aggressive behavior.), the response indicated "Y".

On at 9:55 AM, during an interview, the Administrator stated: "There was nothing I could have done to keep Resident #1's behaviors from happening." He further stated Resident #1 had begun to exhibit aggressive behaviors, and as these behaviors became more frequent, he advised staff if the resident had another outburst of anger to contact the police, which ended up resulting in Resident #1's .

Record review of the affidavit concerning the incident involving Resident#1 confirmed that law enforcement responded to an assault, which occurred in the dining room at the facility on at 5:23 PM. Further review of the affidavit revealed that Resident #1 pushed Resident #12 onto the floor of the dining room.

Class III

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0008 - Admissions - Health Assessment - 429.26( ) FS; 58A-5.0181(2) FAC

Based on record review and interview, the facility failed to ensure 1 of 2 reviewed residents (Resident #7) had accurate and complete health assessment (AHCA Form 1823).

Findings:

A record review of Resident #7's health assessment (AHCA Form 1823) dated was conducted. Page 2, Section 1- A (Assistance) revealed no information about the type of assistance Resident #7 requires with activities of daily living; Page 4 did not have any medications listed or a note referencing "See attachment" and indicated Resident #7 needed administration of medication; Page 5 was completely blank.

Record review of Resident #7's Medication Observation Record (MOR) revealed Resident #7 received assistance with self-administration of medication from unlicensed staff.

On at 5:45 PM, during an interview, the Administrator confirmed the omissions identified on Resident #7's health assessment (AHCA Form 1823), and the inaccuracy found on page 4 related to the type of medication assistance needed by Resident #7.

Class III

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

Based on record review and interview, the facility failed to maintain a written record, updated as needed, of any significant changes in a resident's condition for 1 of 2 reviewed residents (Resident #1).

Findings:

On at 9:55 AM, an interview was conducted with the Administrator. He stated after a short while at the facility, Resident #1 began exhibiting belligerent and aggressive outbursts. He stated he had a meeting with the resident concerning his aggressive behaviors. He also referenced Resident #1 had several aggressive outbursts with other residents; and that these residents informed him that if Resident #1 continued to stay at the facility, they would leave. The Administrator further stated he contacted Shands in an effort to find Resident #1 alternative housing because he did not feel the resident was appropriate for the facility after learning more about him and his needs. The Administrator stated Resident #1 was sent out to Shands Hospital on because of his behaviors.

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Record review of Resident #1's chart revealed no information concerning the resident's admission to Shands Hospital on . Further review of the record also found no documented evidence concerning Resident #1's aggressive and belligerent behaviors.

Record review of the facility's grievance log revealed no documentation of a grievance having been completed pertaining to any incidents between Resident #1 and other facility residents.

On at approximately 3:10 PM, an interview was conducted with the Assistant Administrator concerning the grievances. She confirmed the facility had never had a grievance in the seven years she had been there.

On at 5:40 PM, during an interview, the Administrator confirmed he had no documentation of Resident #1's significant change in behavior, discussions with Resident #1 concerning his behaviors, his conversation with Shands Hospital, or the incidences involving Resident #1 and other residents. The Administrator stated the other residents voiced their concerns during the resident council meetings related to Resident #1's behaviors.

A record review of the facility's Resident Council Meeting minutes for , and revealed no documentation or reference of discussions related to Resident #1's behaviors.

Class III

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

Based on record review and interview, the facility failed to ensure resident rights were honored for the management of medications for 2 of 10 reviewed residents (Residents #1 and #7).

Findings:

Record review of the physician's orders for Resident #1 revealed 97.2 mg tablet, by at bedtime (a medication used to control); Omega 3 1000 mg, take 2 tablets by daily (a supplement used for the management of).

Record review of Resident #1's Medication Observation Record (MOR) for revealed Resident #1 did not receive Omega 3 1000 mg tablets on to / 2018. There was no documentation provided for the resident not having received the physician-ordered medication. Review

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of the MOR for revealed Resident #1 did not receive 97.2 mg tablets at bedtime on and . Documentation in the record read: " on order, zero given".

On at 11:58 AM, a telephone interview was conducted with Resident #1's primary care physician (PCP). The PCP stated: "Myself and his was concerned he might not be receiving his medications as ordered."

Record review of the physician's order for Resident #7 revealed 20 mg tablet by at bedtime for 30 days (a medication used to lower the level of in the).

Record review of Resident #7's MOR for revealed Resident #7 did not receive on to for a total of 14 missed doses. The documentation on the MOR for the period of to read: " on order - none given".

On at approximately 2:10 PM, during an interview, the Assistant Administrator stated: "The facility's policy is to request refills when there are about 10 days' worth of the medication left, and not to wait until the resident is out."

On at 11:20 AM, an interview was conducted with the Medication Technician (Staff H) regarding reordering medications. She stated the pharmacy was to be notified no less than 5 days before a resident runs out of medication.

Class III

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

Based on record review and interview, the facility failed to ensure medications were provided as ordered by the physician for 1 of 10 reviewed residents (Resident #1).

Record review of Resident #1's hospital discharge medication orders dated revealed: "Modified order to administer 100 mg 2 capsules in morning and 3 capsules at bedtime by ."

Record review of Resident #1's health assessment (AHCA Form 1823) signed and dated by the physician on revealed 100 mg 2 capsules in the morning and 3 capsules at bedtime by .

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Record review of Resident #1's Medication Observation Record (MOR) for [redacted] to [redacted] revealed 100 mg 2 capsules in the morning, 2 capsules at noon, and 3 capsules in the evening by [redacted]. The MOR was initialed by staff, revealing the medication was provided in the morning, at noon, and at bedtime.

On at 11:58 AM, a telephone interview was conducted with Resident #1's primary care physician (PCP). The PCP stated: "Myself and his [redacted] was concerned he might not be receiving his medications as ordered."

On at 1:55 PM, during an interview, the Assistant Administrator confirmed the physician's order on the AHCA Form 1823 was not followed and [redacted] 100 mg 2 capsules were being given at noon and there was no physician's order in the record for the medication to be given at noon.

Class III

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

Based on record review and interview, the facility failed to report an adverse incident to the Agency for Health Care Administration (AHCA) of resident to resident [redacted] involving law enforcement.

Findings:

Record review of the affidavit for Resident #1 confirmed law enforcement responded to an assault, which occurred in the dining room at the facility on [redacted] at 5:23 PM. Further review of the affidavit revealed: "Resident #1 pushed Resident #12 onto the floor of the dining room. After gathering multiple witness statements, which collaborated the victim and primary witness statement confirming Resident #1's aggressive and belligerent behaviors, Resident #1 was placed under for assault on person over [redacted]."

Record review of the facility's admission/discharge log revealed Resident #1 was admitted to the facility on [redacted].

Record review of Resident #1's Health Assessment for Assisted Living Facilities (AHCA Form 1823) dated [redacted] revealed on page 1, under Section 1, Health Assessment - [redacted] or Behavioral Status: Impulse control (related to frontal [redacted]), other specified [redacted] (probably related to frontal [redacted]), uncontrolled or increased [redacted], impulsive, agitated,

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unable to follow directions, and assault/threatening behaviors and , . On page 2, Section C., Pose a danger to self or others? (Consider any significant history of physically or aggressive behavior.), the response indicated "Y".

On at 9:55 AM, during an interview, the Administrator stated: "There was nothing I could have done to keep Resident #1's behaviors from happening." He further stated Resident #1 had begun to exhibit aggressive behaviors, and as these behaviors became more frequent, he advised staff if the resident had another outburst of anger to contact the police, which ended up resulting in Resident #1's .

Class III