Agency for Health Care Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965718 | A. BUILDING: _____ B. WING _____ | 08/23/2019 |

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| TERRACINA GRAND | 6825 DAVIS BLVD NAPLES, FL 34104 |

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| A 000 | Initial Comments<br><br>An unannounced complaint survey for complaint #2019013189 was conducted [redacted] through [redacted] at Terracina Grand, an assisted living facility in Naples, Florida.<br><br>Complaint #2019013189 was substantiated at tag #A0025, #A0030, #A0077.<br><br>The following is a description of the deficiencies. | A 000 | | |
| A 025 | 429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision<br><br>429.26<br>(7) The facility must notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition.<br><br>58A-5.0182<br>An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.<br>(1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:<br>(a) Monitoring of the quantity and quality of resident diets in accordance with rule 58A-5.020, F.A.C.<br>(b) Daily observation by designated staff of the activities of the resident while on the premises, | A 025 | | |

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| A 025 | Continued From page 1<br><br>and awareness of the general health, safety, and physical and emotional well-being of the resident.<br>(c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.<br>(d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change.<br>(e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.<br>(f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review, staff and family interview, the facility failed to implement adequate interventions after an allegation of suspicious reports of . . . . . misconduct to ensure the physical and emotional well-being of 1 (Resident #1) of 4 sampled residents. The failure to recognize and intervene appropriately after reports of possible . . . . misconduct, allowed a resident who lacked the capacity to consent to be subjected to . . . . misconduct by a facility staff member.<br><br>The findings included:<br><br>1. Record review revealed, the health assessment for assisted living facilities signed and dated by a medical doctor indicated Resident #1 suffered from 's type and as of . Resident #1 was | A 025 | | |

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| A 025 | Continued From page 2<br><br>admitted to hospice services with a diagnosis of (hardening of the in the ) and . Section 1 of the health assessment also had documentation Resident #1 had moderate due to .<br><br>On , Resident #1's primary care physician provided a written statement that read, "As the Primary Care Physician for [Resident #1] it is my professional opinion this patient lacks full capacity to make informed medical, financial and personal decisions."<br><br>Review of the hospice documentation revealed on , the hospice physician documented "... diagnosis of , ... She has with behavioral disturbances. She also has a had a , scan that can not rule out 's ... She continues to have , forgetfulness, ."<br><br>On the Executive Director (ED) documented at approximately 2:00 p.m., Medication Technician (Med Tech) Staff D reported finding Maintenance Assistant Staff A in Resident #1's room when she went to do a safety check. The ED wrote: "[Staff D] reports that she knocked on the door and there was no answer. She then tried to open the door and it was locked. She entered and [Resident #1] came out of the bedroom... out of the corner of her , she says she saw a shadow in the bedroom cross into the bathroom. She then heard banging of cabinets. The front door to the apt [apartment] shut and then [Staff A] came out of the bedroom into the kitchen. He seemed startled she was there. I asked why she thought this was unusual. She said the door was locked and that did not make | A 025 | | |

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| A 025 | Continued From page 3<br><br>sense, no one answered when she announced herself... and then he came out of the bathroom/bedroom area when the front door closed as he thought she was gone."<br><br>On , the ED documented Certified Nursing Assistant (CNA) Staff B reported Resident #1's private duty aide said, "A while ago, when she came to room she opened the door and saw [Resident #1] leaning against the counter in the kitchen and [Staff A] standing in front of her and [Resident #1] had her shirt up and her were exposed. She told [CNA Staff B] that [Staff A] was touching her ."<br>The ED further documented she spoke to the private duty assistant who said, "... she entered the room and saw [Resident #1] leaning against the counter and the maint assist standing in front of her. She said that [Resident #1's] shirt was up and her were exposed. She said that [Staff A] were at his sides... She said [Resident #1] screamed at her to get out. So she left and went to the bathroom. When she came [Staff A] was gone... when she spoke to the dtr [daughter] later she told her that she had been informed that [Resident #1] had called to the front desk and had a broken zipper and they sent maint [maintenance] up to fix it." The ED documented the private duty aide was not sure of the exact date of the incident but maybe 2 months prior.<br><br>On The ED also documented she checked with the receptionist and asked if there was a maintenance request for Resident #1's room, and she said no.<br>On the ED documented interviewing Housekeeper Staff C who reported "she did see maint [maintenance] there at the rooms several times She was not firm on frequency. She did | A 025 | | |

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| A 025 | Continued From page 4<br><br>indicate it was in the afternoons after 12:00 and that she would often see his cart in the hall and he would be in the room for as long as 30 mins. She indicated it was [the maintenance assistant]."<br><br>On at 2:30 p.m., the ED documented Staff A was suspended pending investigation related to the allegations that had been made.<br><br>On the ED documented she interviewed Staff A in the presence of the Regional Director. In the document she explained it had been reported that when the private duty aide came in the apt, he was in the kitchen with Resident #1, she had her blouse up over her , and her were exposed. The ED noted, "He stated that is not true that never happened. I am not that kind of person." The ED documented the maintenance assistant said "he thought in the past 2 months he checked on her icemaker once. He said he has had to go in the Resident #1's room for air conditioning issues as she leaves her patio door open, and it affects the air conditioning." According to the documentation, the maintenance assistant said during the interview he was in the hall fixing a light and Resident #1 opened the door and asked him to help her. He said, "there was a paper clip on their through the zipper so you could pull it up and down. She was having trouble with it." The ED also documented "He was very upset and concerned saying he does whatever he can, to help these residents and he would never do anything like that."<br><br>On the ED documented she contacted Resident #1's daughter and explained, "...we had done our investigation, and that we were not able to conclude any occurred. We certainly would have called the police and done further | A 025 | | |

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| A 025 | Continued From page 5<br><br>reporting if warranted. I told her we could interview her mom if that was ok, but not sure she would remember anything and she said no. I let her know we would be bringing...the Maint Asst [maintenance assistant] . . . to work."<br><br>On . . . . . the ED documented the maintenance assistant was "notified no findings return to work next normal scheduled day. He was told not to address any maint [maintenance] issues for this resident and not to enter room."<br><br>On . . . . . at 10:55 a.m., during an interview, the ED said the facility brought the maintenance assistant . . . . to work on . . . . . after the first incident of alleged . . . . misconduct based on the information they had and due to inconsistencies in stories. The ED did not elaborate what the inconsistencies were. She said Staff A was told not to go to Resident #1's room for any reason, just out of caution and also because the resident's daughter requested it. She said they continued to do safety checks on the resident but did not monitor the cameras to ensure the maintenance assistant stayed away from Resident #1's apartment.<br><br>2. Per the facility's investigation, on . . . . . at 10:30 a.m., a Collier County Sheriff's Office detective "came and reported [the resident's daughter] that the maintenance man came to her mother's . . . . . times in the past week. There was a previous allegation report and investigated [sic] and no findings. This person was not to go to the room. Concern for resident safety."<br><br>Review of the maintenance assistant's time record revealed he returned to work on . . . . . and worked a total of 182.75 hours over 14 days from . . . . . through . . . . . when he was again | A 025 | | |

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| A 025 | Continued From page 6<br><br>suspended on . . . . at 11:30 a.m., pending investigation of the new allegation.<br><br>Per the facility's documented investigation, on . . . . at 9:20 a.m., the resident's daughter informed the ED of the camera footage that showed the maintenance assistant "doing , inappropriate acts in room."<br><br>On the ED documented she spoke to the detective from the Collier County Sheriff's department who said he reviewed the camera footage and "it was inappropriate . . . . behavior that he viewed. He would not elaborate on what exactly. He said it was definitely [the maintenance assistant]." The ED further documented the detective informed her "he will talk to the [maintenance assistant] Tuesday and possibly make an . . . ."<br><br>During an interview on . . . . . at 10:55 a.m., the Regional Director said the facility uses monitoring cameras in the hallways. He said, "The cameras loop, they only store so much. Old data is dumped to keep recording. They tried to look at it for the prior 2 weeks. The maintenance director went through the footage and saw the camera on the hallway went blank on and came on . . . He said he personally reviewed the tape. They were able to look at other cameras and were able to see the maintenance assistant coming down the hallway from Resident #1's room toward the equipment room. Then the camera from Resident #1's hallway comes up. On . . . they can see where Staff A goes to the equipment room and the camera goes down. On . . . after the cameras go down around 12:35 p.m., at about 1:47 p.m., the maintenance assistant is seen approaching the resident's room. He knocks and enters the room. About | A 025 | | |

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| A 025 | Continued From page 7<br><br>. . . minutes later you can see him exiting. We immediately shared that with the detective." The Regional Director said, "based on the information it would appear that on shortly after noon hour, the staff exited the elevator, approached the utility room and a few minutes later camera 1 and 2 come down, they go blank. Approximately 3 minutes later they come up. When they came . . . up the cameras were switched. The cameras are located in the center each pointing away from each other. The physical connections were switched so that when they came up, they were pointing at a different hallway."<br><br>During an interview on at 1:00 p.m., CNA Staff B said she does safety checks on Resident #1. She said around the private duty aide reported to her she had seen the Maintenance Assistant several times in the resident's room. She said once she came in and found the him lifting the resident's shirt but never reported it to anyone. CNA Staff B said she immediately reported the conversation to the Director of Nursing. She said the private duty aide even gestured showing how she saw the maintenance assistant lifting the resident's shirt.<br><br>On at 1:40 p.m., during a telephone interview Resident #1's daughter said she was out of the country in , when the facility called and informed her of the incident on . . . and involving the maintenance assistant. She said upon her return (unknown date), she installed a camera in her mother's apartment and informed the facility. The Resident's daughter said she had noticed a sharp decline in her mother's cognition and increase in stress level that was surprising. She said she thought there were enough oddities that made her concerned. The daughter said for instance, she had recently | A 025 | | |

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found a pair of her mother's ripped depends under her bed and one in her drawers. The daughter said when she spoke to the private duty aide about her observation, she mentioned she frequently found the resident without underwear under her pants in the afternoon when she came on duty.
Resident #1's daughter said the facility posted a notice outside the apartment indicating a video surveillance was in use. The Resident's daughter said the video footage on . . . . and . . . . showed "the maintenance man coming to mom's room. The first time he came in, he closed the door and hugged her. He put his up her shirt and down her pants. He took her into the bedroom for 11 minutes then came out. He kissed her . . . . and tried to kiss her lower. My mother was pulling away and tapped him on the . . . . indicating she wanted him to leave." She said definitely her mother wasn't a willing participant of that. She said she didn't remember the exact sequence of what she saw but on both days she observed inappropriate interaction. The daughter also said she was advised by the police not to show the video footage to anyone as it was part of discovery.

On at 3:05 p.m., during an interview Med Tech Staff D said the facility conducts safety checks on all residents and depending on her assignment, she would check on Resident #1. She said one day she went to the resident's room and the door was locked. The resident took a long time to answer the door and that was unusual for her. She opened the door since she has the key. She said she observed the resident rushing toward the door. She was in the kitchen pouring some water for Resident #1 when she saw a shadow in the bedroom. She asked Resident #1 if someone was in there, but she did

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| A 025 | Continued From page 9 | A 025 | | |

not answer. She said the Maintenance Assistant came out of the bedroom and said, " I fixed the sink for you, come see." Staff D said she left the apartment and immediately reported the incident to the Director of Nursing. Med Tech Staff D said she thought it was "weird" that the maintenance assistant was in there with Resident #1 with the door locked. She said Resident #1 was and kept saying she was with her son. She said things that didn't make sense. Med Tech Staff D said she works on the 2nd and 4th floor. Staff D said she sees the Maintenance Assistant more often on the 4th floor than the 2nd floor. He would ask if there were any light bulbs that needed to be replaced.

On at 6:00 p.m., during a telephone interview, the private duty aide said she started employment with Resident #1 around mid- , . Approximately 3 weeks after beginning her employment when she arrived for her shift, she pushed open the apartment door, it wasn't locked. She observed Resident #1 leaning on the kitchen counter. Her shirt was up and her were exposed. She saw the Maintenance Assistant standing in front of the resident. She said Resident #1 yelled at her to "get out" which she did. She went to the restroom and came a few minutes later. The Maintenance Assistant had already left the room. The resident's daughter arrived shortly thereafter. She said Resident #1 explained to her daughter she called the front desk and requested for someone to come and help her with the zipper of her pants that was broken. She explained to her daughter the receptionist sent the Maintenance Assistant to help her. The private duty aide said in , when Staff D told her she found the maintenance assistant in Resident #1's bedroom and the apartment was locked, she recalled what she had

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| A 025 | Continued From page 10<br><br>observed a couple of months earlier and reported it as a suspicious activity to the resident's daughter. She also said prior to the [redacted], incident, the daughter had requested to replace the apartment lock. She said, one day the Maintenance Assistant approached her and was very angry, complaining about the request to change the lock. He told her that he would no longer be able to come in the apartment. She said she reported that incident to the Director of Nursing who said not to worry about it. They sent a different person to change the lock approximately 10 minutes later.<br><br>On [redacted] a local news station reported the following "Maintenance man [redacted] for molesting elderly woman in senior living facility. On several occasions, the maintenance man was found in the victim's room with the door locked by the CNA ... The daughter installed CCTV [closed circuit television] cameras in her mother's home to monitor her, and saw [the maintenance assistant] the man in the red shirt attempting to kiss her mother, place his [redacted] down her pants and up her shirt, and try to remove her mother's diaper to perform oral [redacted] on her without her consent, according to the report ... After showing [the maintenance assistant] the video of him molesting the victim, deputies [redacted] him. He is now facing charges of felony molestation on an elderly [redacted] adult and criminal mischief, according to the report."<br><br>Class I | A 025 | | |
| A 030 | 58A-5.0182(6) FAC; 429.28( ) FS 429.27<br>Resident Care - Rights & Facility Procedures<br><br>58A-5.0182 | A 030 | | |

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| A 030 | Continued From page 11<br><br>(6) RESIDENT RIGHTS AND FACILITY PROCEDURES.<br>(a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 58A-5.0181, F.A.C.<br>(b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.<br>(c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; [illegible] Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- [illegible] or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.<br>(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 58A-5.0181, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:<br>1. Resident responsibilities;<br>2. and tobacco use;<br>3. Medication storage; | A 030 | | |

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| A 030 | Continued From page 12<br><br>4. Resident elopement;<br>5. Reporting resident , neglect, and ;<br>6. Administrative and housekeeping schedules and requirements;<br>7. control, sanitation, and universal precautions; and,<br>8. The requirements for coordinating the delivery of services to residents by third party providers.<br>(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.<br>(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.<br>(g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical .<br><br>429.28 Resident bill of rights.-<br>(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges | A 030 | | |

Agency for Health Care Administration

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| A 030 | Continued From page 13<br>guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:<br>(a) Live in a safe and decent living environment, free from and neglect.<br>(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.<br>(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.<br>(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.<br>(e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community.<br>(f) Manage his or her financial affairs unless the resident or, if applicable, the resident ' s representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.<br>(g) Share a room with his or her spouse if both are residents of the facility.<br>(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at | A 030 | | |

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| A 030 | Continued From page 14<br>regular and frequent intervals except when prevented by inclement weather.<br>(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.<br>(j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.<br>(k) At least 45 days ' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.<br>(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall | A 030 | | |

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| A 030 | Continued From page 15<br><br>establish a grievance procedure to facilitate the residents ' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.<br>(2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident ' s access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida.<br><br>429.27(1)(a), FS<br>Property and personal affairs of residents.-<br>(1)(a) A resident shall be given the option of using his or her own belongings, as space permits; | A 030 | | |

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| A 030 | Continued From page 16<br>choosing his or her roommate; and, whenever possible, unless the resident is adjudicated [illegible] or [illegible] under state law, managing his or her own affairs.<br>(b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review, staff and family interview, the facility failed to implement adequate interventions to ensure a safe, decent environment, free from misconduct for 1 (Resident #1) of 4 sampled residents.<br>The failure to recognize and intervene appropriately after reports of possible misconduct allowed Resident #1 who lacked the capacity to consent to be subjected to misconduct by a facility staff member.<br><br>The findings included:<br><br>1. Record review revealed, the health assessment for assisted living facilities signed and dated by a medical doctor indicated Resident #1 suffered from 's type and as of Resident #1 was admitted to hospice services with a diagnosis of (hardening of the | A 030 | | |

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| A 030 | Continued From page 17<br>... in the ...) and ... Section 1 of the health assessment also had documentation Resident #1 had moderate ... due to ...<br><br>On Resident #1's primary care physician provided a written statement that read "As the Primary Care Physician for [Resident #1] it is my professional opinion this patient lacks full capacity to make informed medical, financial and personal decisions."<br><br>Review of the hospice documentation revealed on the hospice physician documented "... diagnosis of ..., ... She has with behavioral disturbances. She also has a had a ... scan that can not rule out 's ... She continues to have ..., forgetfulness, ."<br><br>On the ED documented at approximately 2:00 p.m., Medication Technician (Med Tech) Staff D reported finding Maintenance Assistant Staff A in Resident #1's room when she went to do a safety check. The Executive Director (ED) wrote " [Staff D] reports that she knocked on the door and there was no answer. She then tried to open the door and it was locked. She entered and [Resident #1] came out of the bedroom... out of the corner of her ... she says she saw a shadow in the bedroom cross into the bathroom. She then heard banging of cabinets. The front door to the apt shut and then [Staff A] came out of the bedroom into the kitchen. He seemed startled she was there. I asked why she thought this was unusual. She said the door was locked and that did not make sense, no one answered when she announced herself... and then he came out of the bathroom/bedroom area when the front door | A 030 | | |

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| A 030 | Continued From page 18<br>closed a he thought she was gone."<br><br>On [redacted] the ED documented Certified Nursing Assistant (CNA) Staff B reported Resident #1's private duty aide said, "A while ago, when she came to room she opened the door and saw [Resident #1] leaning against the counter in the kitchen and [Staff A] standing in front of her and [Resident #1] had her shirt up and her [redacted] were exposed. She told [CNA Staff B] that [Staff A] was touching her [redacted]."<br><br>The ED further documented she spoke to the private duty assistant who said, "... she entered the room and saw [Resident #1] leaning against the counter and the maint assist standing in front of her. She said that [Resident #1's] shirt was up and her [redacted] were exposed. She said that [Staff A] [redacted] were at his sides... She said [Resident #1] screamed at her to get out. So she left and went to the bathroom. When she came [redacted] [Staff A] was gone... when she spoke to the dtr [daughter] later she told her that she had been informed that [Resident #1] had called to the front desk and had a broken zipper and they sent maint up to fix it". The ED documented the private duty aide was not sure of the exact date of the incident but maybe 2 months prior.<br><br>On [redacted] the ED also documented she checked with the receptionist and asked if there was a maintenance request for Resident #1's room, and she said no.<br>On [redacted] the ED documented interviewing House Keeper Staff C who reported "she did see maint there at the rooms several times. She was not firm on frequency. She did indicate it was in the afternoons after 12:00 and that she would often see his cart in the hall and he would be in the room for as long as 30 mins. She indicated it | A 030 | | |

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| A 030 | Continued From page 19<br>was [the maintenance assistant]."<br><br>On . . . . at 2:30 p.m., the ED documented Staff A was suspended pending investigation related to the allegation that had been made.<br><br>On . . . . the ED documented she interviewed Staff A in the presence of the Regional Director. In the document she explained it had been reported that when the private duty aide came in the apt, he was in the kitchen with Resident #1, she had her blouse up over her . . . , and her . . . . . were exposed. The ED noted, "He stated that is not true that never happened. I am not that kind of person."<br><br>The maintenance assistant said he thought in the past 2 months he checked on her icemaker once. He said he has had to go in the Resident #1's room for air conditioning issues as she leaves her patio door open, and it affects the air conditioning. According to the documentation, the maintenance assistant said during the interview he was in the hall fixing a light and Resident #1 opened the door and asked him to help her. He said, "there was a paper clip on their through the zipper so you could pull it up and down. She was having trouble with it."<br><br>The ED also documented " He was very upset and concerned saying he does whatever he can, to help these residents and he would never do anything like that."<br><br>On . . . . the ED documented she contacted Resident #1's daughter and explained, "...we had done our investigation, and that we were not able to conclude any occurred. We certainly would have called the police and done further reporting if warranted. I told her we could | A 030 | | |

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| A 030 | Continued From page 20<br><br>interview her mom if that was ok, but not sure she would remember anything and she said no. I let her know we would be bringing...the Maint Asst to work."<br><br>On the ED documented the maintenance assistant was "notified no findings return to work next normal scheduled day. He was told not to address any maint issues for this resident and not to enter room."<br><br>On at 10:55 a.m., during an interview, the ED said the facility brought the maintenance assistant to work on , after the first incident of alleged misconduct, based on the information they had and due to inconsistencies in stories. The ED did not elaborate of what the inconsistencies were. She said Staff A was told not to go to Resident #1's room for any reason, just out of caution and also because the resident's daughter requested it. She said they continued to do safety checks on the resident but did not monitor the cameras to ensure the maintenance assistant stayed away from Resident #1's apartment.<br><br>2. Per the facility's investigation, on at 10:30 a.m., a Collier County Sheriff's Office detective "came and reported [the resident's daughter] that the maintenance man came to her mother's times in the past week. There was a previous allegation report and investigated [sic] and no findings. This person was not to go to the room. Concern for resident safety."<br><br>Review of the maintenance assistant's time record revealed he returned to work on and worked a total of 182.75 hours over 14 days from through when he was again suspended on at 11:30 a.m., pending | A 030 | | |

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| A 030 | Continued From page 21<br>investigation of the new allegation.<br><br>Per the facility's documented investigation, on at 9:20 a.m., the resident's daughter informed the ED of the camera footage that showed the maintenance assistant "doing , inappropriate acts in room."<br><br>On the ED documented she spoke to the detective from the Collier County Sheriff's department who said he reviewed the camera footage and "it was inappropriate behavior that he viewed. He would not elaborate on what exactly. He said it was definitely [the maintenance assistant]." The ED further documented the detective informed her "he will talk to the [maintenance assistant] Tuesday and possibly make an ."<br><br>During an interview on at 10:55 a.m., the Regional Director said the facility uses monitoring cameras in the hallways. He said, "The cameras loop, they only store so much. Old data is dumped to keep recording. They tried to look at it for the prior 2 weeks. The maintenance director went through the footage and saw the camera on the hallway went blank on and came on . He said he personally reviewed the tape. They were able to look at other cameras and were able to see the maintenance assistant coming down the hallway from Resident #1's room toward the equipment room. Then the camera from Resident #1's hallway comes up. On they can see where Staff A goes to the equipment room and the camera goes down. On after the cameras go down around 12:35 p.m., at about 1:47 p.m., the maintenance assistant is seen approaching the resident's room. He knocks and enters the room. About minutes later you can see him exiting. We | A 030 | | |

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| A 030 | Continued From page 22<br><br>immediately shared that with the detective." The Regional Director said "based on the information it would appear that on ... shortly after noon hour, the Staff A exited the elevator, approached the utility room and a few minutes later camera 1 and 2 come down, they go blank. Approximately 3 minutes later they come .... up. When they came up the cameras were switched. The cameras are located in the center each pointing away from each other. The physical connections were switched so that when they came up, they were pointing at a different hallway."<br><br>During an interview on at 1:00 p.m., CNA Staff B said she does safety checks on Resident #1. She said around the private duty aide reported to her she had seen the maintenance assistant several times in the resident's room. She said once she came in and found the him lifting the resident's shirt but never reported it to anyone. CNA Staff B said she immediately reported the conversation to the Director of Nursing. She said the private duty aide even gestured showing how she saw the maintenance assistant lifting the resident's shirt.<br><br>On at 1:40 p.m., during a telephone interview Resident #1's daughter said she was out of the country in ..., when the facility called and informed her of the incident of and ..... involving the maintenance assistant. She said upon her return (unknown date), she installed a camera in her mother's apartment and informed the facility. The resident's daughter said she had noticed a sharp decline in her mother's cognition and increase in stress level that was surprising. She said she thought there were enough oddities that made her concerned. The daughter said for instance, she had recently found a pair of her mother's ripped depends | A 030 | | |

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| A 030 | Continued From page 23<br><br>under her bed and one in her drawers. The daughter said when she spoke to the private duty aide about her observation, she mentioned she frequently found the resident without underwear under her pants in the afternoon when she came on duty.<br>Resident #1's daughter said the facility posted a notice outside the apartment indicating a video surveillance was in use. The resident's daughter said the video footage on and showed "the maintenance man coming to mom's room. The first time he came in, he closed the door and hugged her. He put his up her shirt and down her pants. He took her into the bedroom for 11 minutes then came out. He kissed her and tried to kiss her lower. My mother was pulling away and tapped him on the indicating she wanted him to leave." She said definitely her mother wasn't a willing participant of that. She said she didn't remember the exact sequence of what she saw but on both days she observed inappropriate interaction. The daughter also said she was advised by the police not to show the video footage to anyone as it was part of discovery.<br><br>On at 3:05 p.m., during an interview Med Tech Staff D said the facility conducts safety checks on all residents and depending on her assignment, she would check on Resident #1. She said one day she went to the resident's room and the door was locked. The resident took a long time to answer the door and that was unusual for her. She opened the door since she has the key. She said she observed the resident rushing toward the door. She was in the kitchen pouring some water for Resident #1 when she saw a shadow in the bedroom. She asked Resident #1 if someone was in there, but she did not answer. She said the Maintenance Assistant | A 030 | | |

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| A 030 | Continued From page 24<br><br>came out of the bedroom and said, "I fixed the sink for you, come see." Staff D said she left the apartment and immediately reported the incident to the Director of Nursing. Med Tech Staff D said she thought it was "weird" that the maintenance assistant was in there with Resident #1 with the door locked. She said Resident #1 was . . . . . and kept saying she was with her son. She said things that didn't make sense. Med Tech Staff D said she works on the 2nd and 4th floor. Staff D said she sees the maintenance assistant more often on the 4th floor than the 2nd floor. He would ask if there were any light bulbs that needed to be replaced.<br><br>On at 6:00 p.m., during a telephone interview, the private duty aide said she started employment with Resident #1 around mid- , . . . Approximately 3 weeks after beginning her employment when she arrived for her shift, she pushed open the apartment door, it wasn't locked. She observed Resident #1 leaning on the kitchen counter. Her shirt was up and her . . . . . were exposed. She saw the maintenance assistant standing in front of the resident. She said Resident #1 yelled at her to "get out" which she did. She went to the restroom and came . . a few minutes later. The Maintenance Assistant had already left the room. The resident's daughter arrived shortly thereafter. She said Resident #1 explained to her daughter she called the front desk and requested for someone to come and help her with the zipper of her pants that was broken. She explained to her daughter the receptionist sent the Maintenance Assistant to help her. The private duty aide said in , when Staff D told her she found the maintenance assistant in Resident #1's bedroom and the apartment was locked, she recalled what she had observed a couple of months earlier and reported | A 030 | | |

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| A 030 | Continued From page 25<br><br>it as a suspicious activity to the resident's daughter. She also said prior to the , incident, the daughter had requested to replace the apartment lock. She said, one day the Maintenance Assistant approached her and was very angry, complaining about the request to change the lock. He told her that he would no longer be able to come in the apartment. She said she reported that incident to the Director of Nursing who said not to worry about it. They sent a different person to change the lock approximately 10 minutes later.<br><br>On a local news station reported the following "Maintenance man for molesting elderly woman in senior living facility. On several occasions, the maintenance man was found in the victim's room with the door locked by the CNA ... The daughter installed CCTV [closed circuit television] cameras in her mother's home to monitor her, and saw [the maintenance assistant] the man in the red shirt attempting to kiss her mother, place his down her pants and up her shirt, and try to remove her mother's diaper to perform oral on her without her consent, according to the report ... After showing [the maintenance assistant] the video of him molesting the victim, deputies him. He is now facing charges of felony molestation on an elderly adult and criminal mischief, according to the report."<br><br>Class I | A 030 | | |
| A 077 | 429.176 FS; 429.52( ),58A-5.019(1) FAC Staffing Standards - Administrators<br><br>429.176<br>Notice of change of administrator.-If, during the | A 077 | | |

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| A 077 | Continued From page 26<br><br>period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements.<br><br>429.52( ), FS<br>(4) A new facility administrator must complete the required training and education, including the competency test, within 90 days after date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19.<br>(5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years.<br><br>58A-5.019<br>Staffing Standards.<br>(1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by Part II, Chapter 408, F.S., Part I, Chapter 429, F.S., Rule Chapter 59A-35, F.A.C., and this rule chapter.<br>(a) An administrator must:<br>1. Be at least ;<br>2. If employed on or after , have, at a minimum, a high school diploma or G.E.D.;<br>3. Be in compliance with Level 2 background | A 077 | | |

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| A 077 | Continued From page 27<br>screening requirements pursuant to Sections 408.809 and 429.174, F.S.; and<br>4. Complete the core training and core competency test requirements pursuant to Rule 58A-5.0191, F.A.C., no later than 90 days after becoming employed as a facility administrator. Individuals who have successfully completed these requirements before , are not required to take either the 40 hour core training or test unless specified elsewhere in this rule. Administrators who attended core training prior to , , , are not required to take the competency test unless specified elsewhere in this rule.<br>5. Satisfy the continuing education requirements pursuant to Rule 58A-5.0191, F.A.C.<br>Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department.<br>(b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraphs (1)(a)4. of this rule to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must:<br>1. Complete the core training and core competency test requirements pursuant to Rule 58A-5.0191, F.A.C.; and<br>2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility.<br>(c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing | A 077 | | |

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| A 077 | Continued From page 28<br>and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities.<br>(d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements of an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility.<br>(e) Pursuant to Section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No =Ref-04002.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and staff interview, the Administrator failed to ensure the safety of the | A 077 | | |

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| A 077 | Continued From page 29<br><br>residents from . . . . misconduct by an employee for 1 (Resident #1) of 4 residents sampled. Failure to monitor Staff A allowed Resident #1 to be . . misused.<br><br>The findings included:<br><br>Review of Resident #1's file revealed a diagnosis of . . . . . type . . . . . On . . . . . Resident #1's primary care physician determined she lacked full capacity to make informed medical, financial and personal decisions.<br><br>Facility investigation revealed: On Medication Technician (med tech) Staff D reported to the Administrator when she went in to check on Resident #1, the apartment door was locked and she found Maintenance Assistant Staff A in the resident's bedroom.<br><br>Facility's investigation further reports on . . . . Certified Nurse Assistant (CNA) Staff B reported to the Director of Nursing (DON) and the Administrator that Resident #1's private duty aide reported witnessing an incident that happened "maybe 2 months ago". The private duty aide told Staff B "she entered the room and saw Resident #1 leaning against the counter and Staff A was standing in front of her." Private duty aide said that Resident #1's shirt was up and her were exposed. She was asked if she had a bra on and she said "no". She said that Staff A's . . . were at his sides.<br><br>On . . . . . at 10:15 a.m., the Administrator agreed that in . , 2 separate employees (Staff D and Staff B) had reported to her allegations of misconduct involving Staff A and Resident #1. The Administrator said she suspended Staff A on at 2:30 p.m., | A 077 | | |

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| A 077 | Continued From page 30 | A 077 | | |

pending investigation. The Administrator said she did an investigation at the time and they looked at what they had and what they had were inconsistencies and stories. It was something that had happened several months prior, and based on what they had and the inconsistencies they weren't able to verify anything. Staff A was brought to work with instructions not to go to her room or do any work in her room. There was no monitoring system established to ensure further contact did not occur. The Administrator said sometimes following this investigation Resident #1's daughter had installed surveillance cameras in her mother's apartment.

The Administrator said on a Collier County Sheriff Detective arrived around 10:30 a.m., and spoke to a few residents. He informed the Administrator there had been a report made by Resident #1's daughter that Maintenance Assistant Staff A had gone to Resident #1's room twice in the past week. The detective took Staff A's phone number and left.

Per the facility's documented investigation, on a Collier County Sheriff's Office detective "came and reported Resident #1's daughter reported that Staff A came to her mother's times in the past week. There was a previous allegation report, and investigated and no findings. This person was not to go to the room. Concern for resident safety."

On at 11:30 a.m., the facility suspended Staff A.

On . . . . the Administrator documented she spoke to the detective who informed her he had just reviewed the camera footage and said that it was inappropriate behavior that he

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| A 077 | Continued From page 31<br><br>viewed. He would not elaborate on what exactly. He said, "It was definitely Staff A". The detective said he would "talk to Staff A and possibly make an ."<br><br>Per the documentation provided to the survey team, on at 9:20 a.m., Resident #1's daughter informed the Administrator the camera footage showed Staff A "doing , inappropriate acts in room."<br><br>The facility's investigation file contained a copy of a certified mail sent on to Staff A informing him his employment was terminated effective .<br><br>Per the news report on WBBH/WZVN, Staff A was " on Monday by Collier County deputies."<br><br>On at 10:15 a.m., the Administrator said they had known nothing about further contact following the investigation. She said Staff A had been instructed not to go to Resident #1's room, but although there were security cameras in the hallways, no one had been monitoring to see if Staff A had complied with the directive.<br><br>Class I | A 077 | | |