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N 000	Initial Comments On 08/17/2023, Surveyor conducted 2 complaint investigations and a standard licensure survey. Information was reviewed through 08/23/2023. Both complaints was substantiated. Six deficiencies were identified. Census: 29	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that each allegation of caregiver misconduct was investigated and	N 158		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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reported to the department. The provider did not ensure the safety of all the residents after three allegations of caregiver misconduct. The provider allowed the staff members to continue to have unsupervised interactions with the residents.

Findings include:

On 06/15/2023, the department received a complaint alleging the provider did not investigate an allegation that a caregiver physically teased a resident.

Surveyor was informed, by Director B, of 3 allegation of caregiver misconduct . Surveyor interviewed Director B and was told of three allegations of caregiver misconduct that that Director B had not recognized as possible caregiver misconduct and were not thoroughly investigated, documented, and subsequently reported to the department.

The first incident was when a caregiver teased and repeatedly grabbed a resident even after the resident asked the caregiver to stop. The second incident was when a caregiver took a video on their personal phone without the resident's permission. The third incident was when a staff member yelled at a resident while pounding on the kitchen counter. The provider did not investigate and document the investigations. The provider did not report these incidents to the department.

The first incident was in February of 2023, involving Caregiver C and Resident 4. Caregiver D observed by Caregiver C tease Resident 4 repeatedly and did not stop when the resident asked him/her to stop.

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The second incident was when Caregiver C videoed this incident without Resident 4's permission and contrary to facility policy.

The third incident was in May of 2023 involving Former Cook F and Resident 1. Former Cook F yelled at Resident 1 while pounding on the kitchen counter.

On 08/17/2023 at 10:00 AM, 1:20 PM and 2:50 PM, Surveyor interviewed Director B about an incident in which Caregiver C was observed teasing Resident 4. Director B stated s/he was aware of an incident in February of 2023 in which Caregiver C was "playing" with a resident. Director B stated s/he had seen a video of the incident and repeatedly described it as "horseplay," "shenanigans," and "taunting," but not abuse. Director B stated taunting was not abusive behavior by a staff. At 2:50 PM, Director B gave Surveyor a copy of a "Verbal Reprimand Log" for Caregiver C, dated 2/8/2023. Director B wrote, "Client Relationships, behavior while on job working with clients. Verbal conversation - re: the definition of abuse. I saw video provided from another staff. It's taunting not abuse." Director B stated s/he did ask other staff about the incident but did not record anything. Director B described the incident as "horseplay that someone would do to their grandma," and not abuse.

Director B stated the incident had come up again on 05/25/2023, as a member of the community had questioned why an investigation was not done. Director B stated the community member was subsequently "barred" from the building as the incident did not pertain to him/her and this person had no family at the facility. Director B stated this person also threatened his/her life. Director B stated s/he did not need the trouble.

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Director B stated that because of this, s/he had interviewed several staff about their observations of Caregiver C. Director B showed Surveyor several "Internal Investigation Forms." The forms had no names on them but had initials on the back. Director B stated s/he could figure out some names but would have to guess on a few. Of the 10 unnamed interviews, one form did state witnessing Caregiver C "Shaking w/c (wheelchair), flicking ears, nose, pushing [their] feet in [Resident 4] way/path w/c." A second form indicated Caregiver C had been observed "messing with" Resident 4 and "looking to instigate." On all the forms, Director B stated there was no abuse. Regional Administrator (RA) A indicated this was the first time s/he had heard of the situation.

At 2:45 PM, Surveyor interviewed Caregiver I. Caregiver I stated that teasing was "definitely abuse." Caregiver I stated s/he had reported abuse to "many directors in the past and nothing was done." Caregiver I did not present any details. Caregiver I stated teasing is abuse and staff "should be just here for the residents and never argue, tease, or pick on them." Caregiver I stated s/he thought Caregiver C was a good caregiver, but s/he was known to agitate the residents to the point they would get mad. Caregiver I indicated s/he had not seen the video but was told Resident 4 was so agitated that s/he started swinging and swearing at Caregiver C.

Director B stated Caregiver D's video was not a misconduct issue and "okay" because of why the video was taken. During the interview, RA A indicated that the video taken of Resident 4 was not acceptable and was cause for suspension, investigation, and reporting to the department. RA A stated the signed agreements for the residents

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to be photographed was only for the residents' picture in the chart. RA A stated the okay for social media posting was only for the activity staff to show various activities and the residents' participation.

On 08/17/2023 at 2:31 PM, Surveyor interviewed Caregiver D. Caregiver D stated s/he had taken the video of Caregiver C's interaction with Resident 4. Caregiver D stated the video was taken because "It needed to be done. It was abuse, but not really bad, but it needed to be brought to [Director B]'s attention. It's not ok and not allowed here." Caregiver D stated the video was deleted from his/her phone after showing it to Director B. Caregiver D indicated that it was ok to take the video because the residents sign an okay to have pictures taken and an okay to be put on social media. Caregiver D was asked about any direction or training about taking video of a resident. Caregiver D stated it may be in an employee handbook but did not recall where it was outlined.

Director B also told Surveyor and RA A about an incident s/he had witnessed in May when Former Cook F yelled over the kitchen counter at Resident 1 in the dining room. While yelling s/he pounded on the counter "toward" Resident 1. Director B stated Former Cook F was dismissed on 06/20/2023 as s/he could not get along with co-workers and would have loud arguments with foul language with fellow staff in front of the residents. RA A indicated this was the first time s/he had heard about this witnessed interaction. RA A told Director B that this incident sounded like it met the definition of abuse and should have been followed up with the suspension of Former Cook F and an investigation into caregiver misconduct. On 08/23/2023 at 1:30 PM, RA A

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N 158	Continued From page 5 sent Surveyor a copy of an investigation into this incident by RA A. RA A reviewed Former Cook F's employee file and found 2 previous write-ups about loud arguments with fellow staff but nothing about yelling at Resident 1. On 08/23/2023 at 1:30 PM, Surveyor received a copy of a written disciplinary warning for Director B by RA A. The "violation" outlined a failure to complete a report when Director B had witnessed the interaction between Former Cook F and Resident 1. The written warning stated that Director B witnessed an interaction that was "abusive and threatening" and did not investigate and report this to the department. There is no record that the provider reported these allegations through the department's reporting system, Misconduct Incident Reporting (MIR).	N 158		
N 163	83.12(4)(a) Reporting when resident's whereabouts unknown A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time a resident ' s whereabouts are unknown, except those instances when a resident who is competent chooses not to disclose his or her whereabouts or location to the CBRF, the CBRF shall notify the local law enforcement authority immediately upon discovering that a resident is missing. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies or persons recovering from substance abuse.	N 163		

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N 163	Continued From page 6 This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not send a written report to the Department after a resident's whereabouts were unknown. Resident 1 left the facility at least 4 times in 2023 and only one instance was reported. This report was sent in prior to the current director's hire date. Findings include: On 06/15/2023, the department received a complaint that there were little to no activities to detour residents from eloping. On 08/17/2023 throughout the day, Surveyor observed visitors, delivery persons, and staff use the front door to enter and exit. A beeping alarm sounded each time until the door closed. At 3:15 PM, Surveyor observed Resident 1 sitting at a dining room table with another residents. Resident 1 had been sitting there since lunch. Resident 1 was given more coffee a few times. Resident 1 attempted to go out the front door three times. The alarm sounded each time and staff intervened. Resident 1 had attended exercising with pool noodles and a balloon and had his/her nails done in the morning. There was one activity in the afternoon but this was a continuation of nail care at 1:00 PM. There were no other scheduled activities in the afternoon. At 10:00 AM, 1:20 PM and 2:50 PM, Surveyor interviewed Director B. Director B indicated Resident 1 was a safety risk due to elopements and there had been discussion that Resident 1 needs placement in another facility with a locked unit. Director B stated there had been a detailed risk agreement regarding Resident 1's elopements and the fact that the doors were	N 163		

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N 163	Continued From page 7 unlocked. Resident 1's Individual Service Plan (ISP), under the subject of "Wandering," stated, "Resident: Escaped from building a bit ago and s/he made it a miles [sic] distance in 10 minutes. She will leave the building. She packs on the daily to do so. SHE IS NOT TO BE LEFT ALONE AND UNDIRECTED AT ALL." Director B was unsure when the incident happened. Regional Administrator (RA) A stated incidents that need to be reported to the Department should be sent to Vice President (VP) of Resident Services J by the director and this incident was never reported to VP J. The incident was also not reported to the Department. On 08/17/2023 at 5:00 PM, Surveyor reviewed the self-reports sent to the Department. There was one for Resident 1 in 2023. The report indicated that on 01/15/2023, Resident 1 exited a side door that was alarmed. Staff searched for the resident in the facility and called 911. Resident 1 was found 1 block from the facility and this was his/her first elopement. On 08/23/2023 at 1:30 PM. Surveyor received 3 additional incidents in which Resident 1 left the building without staff knowing where s/he was. On 03/31/2023, Resident 1 was found in his/her car in the parking lot. On 02/02/2023, Resident 1 was discovered walking back though the front door. On 05/27/2023, Resident 1 was found "down the road." None of the reports indicated that Resident 1 was found a mile from the facility. These instances were not reported to the state agency.	N 163		
N 394	83.35(5)(b) Annual evaluation of evacuation limits Evaluation update. The CBRF shall evaluate each resident ' s mental or physical capability to	N 394		

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N 394	Continued From page 8 respond to a fire alarm at least annually or when there is a change in the resident ' s mental or physical capability to respond to a fire alarm. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure each resident was assessed at least annually for their ability to respond to a fire alarm. This was discovered for 2 of 2 sampled residents that had been admitted over a year ago. Resident 2 and Resident 3 had no evacuation assessment since their admission. Director B was not aware of the need to re-evaluate the residents. This had the potential to affect all of the residents. Findings include: On 08/17/2023, Surveyor reviewed the records of Resident 2 and Resident 3. Surveyor found one evacuation assessment for Resident 2, dated 06/20/2022, and one for Resident 3, dated 03/03/2022. At 1:20 PM, Surveyor interviewed Director B. Director B stated s/he was unaware of the need to address each resident's ability to evacuate on an annual basis. Director B indicated that any resident that needed a re-evaluation since s/he was hired in January of 2023, did not have one done by him/herself. Director B stated the re-evaluations were his/her responsibility.	N 394		
N 407	83.37(1)(h) Scheduled psychotropic medications. Scheduled psychotropic medications. When a psychotropic medication is prescribed for a resident, the CBRF shall do all of the following: 1. Ensure the resident is reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired	N 407		

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responses and possible side effects of the medication. The results of the assessments shall be documented in the resident ' s record as required under s. HFS 83.42(1)(q). 2. Ensure all resident care staff understands the potential benefits and side effects of the medication.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that each resident taking a behavior or mood-altering drug was assessed/reviewed by a pharmacist, practitioner, or a registered nurse on at least a quarterly basis for the resident's response and possible side effects. This was discovered for 3 of 3 sampled residents routinely taking a psychotropic medication.

Findings include:

On 08/17/2023 at 10:00 AM, Surveyor requested of Director B, a list of residents that routinely get a psychotropic medication. At 1:20 PM, Surveyor requested the quarterly reviews for 3 sampled residents: Resident 1, Resident 2, and Resident 3. Director B stated that the reviews had not been routinely done and could not locate the quarterly reviews for these 3 residents.

On 08/23/2023, Surveyor reviewed information about the psychotropic medications taken by the three sampled residents at drugs.com.

Resident 1 was given donepezil 5 milligrams (mg) at bedtime. Donepezil is used to improve mental function in people with Alzheimer's disease. There was no assessment to its effectiveness. There was no review of the side effects as it can

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N 407	Continued From page 10 have the opposite effect on some people and make them more confused. Common side effects are nausea, diarrhea and insomnia. Resident 2 was given citalopram 10 mg every day. Citalopram is used to treat depression. There was no assessment of its effectiveness. There was no review of the side effects as it can have the opposite effect and cause new or worsening depression in some people. Common side effects are drowsiness, agitation, confusion, and nausea. Resident 2 was also given memantine 10 mg twice a day. Memantine is used to lessen the symptoms of Alzheimer's disease. Common side effects include increased confusion, headaches, and vomiting. Resident 3 was given fluoxetine 20 mg every day. Fluoxetine is used to treat people with depression and anxiety. There was no assessment of its effectiveness. Common side effects are increased anxiety, panic attacks, and hives/rashes. On 08/23/2023 at 9:33 AM, Surveyor interviewed Regional Administrator (RA) A. RA A stated the quarterly and monthly reviews were to be reviewed by the director and the regional nurse.	N 407		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for	N 408		

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administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that each resident prescribed a psychotropic medication on an as needed basis had, at least monthly, a review to determine if the individual service plan (ISP) had a detailed description of why and when to give the medication. The review is to determine if the drug was given contrary to its intended use and review any negative side effects. This information is to be documented.

Findings Include:

On 08/17/2023 at 10:00 AM, Surveyor asked Director B for a list of residents prescribed a mood altering or behavior altering medication on an as needed basis. At 1:20 PM, Surveyor asked for the monthly psychotropic reviews for 3 sampled residents: Resident 1, Resident 2, and Resident 3. Director B indicated s/he was not aware of the need for a monthly review and thought it was just quarterly.

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N 408	Continued From page 12 Resident 1 had an order for hydroxyzine 25 milligrams (mgs) as needed daily around 4:00 PM for itching and anxiety. Hydroxyzine is an antihistamine that can also be used to treat anxiety and tension. Surveyor reviewed Resident 1's ISP and found no mention of the drug and no description of Resident 1's behaviors that indicated when to administer the medication and what to try in terms of non-pharmacological interventions. Common side effects of this medication include coughing, fainting and a change in a person's heartbeat. Resident 2 also had an order for hydroxyzine 25 milligrams (mgs) as needed daily twice a day for anxiety. Surveyor reviewed Resident 2's ISP and found no mention of the drug and no description of Resident 2's behaviors that indicated when to administer the medication and what to try in terms of non-pharmacological interventions. Common side effects of this medication include coughing, fainting and a change in a person's heartbeat. Resident 3 had an order for lorazepam 0.5 mg as needed every 6 hours for anxiety. Lorazepam is an anti-anxiety medication. Surveyor reviewed Resident 3's ISP and found no mention of the drug and no description of Resident 3's behaviors that indicated when to administer the medication and what to try in terms of non-pharmacological interventions. Common side effects of this medication include sedation, weakness, and feeling unsteady. On 08/23/2023 at 9:33 AM, Surveyor interviewed Regional Administrator (RA) A. RA A stated a plan was put in place to ensure the monthly reviews were completed.	N 408		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 491	Continued From page 13	N 491		
N 491	83.44(2)(c) Interior floors, walls and ceilings. Every interior floor, wall and ceiling shall be clean and in good repair. This Rule is not met as evidenced by: Based on observation and interview, the providers did not ensure the carpet in the common areas was clean. Findings include: On 08/17/2023 at approximately 9:00 AM, Surveyor observed the condition of the carpet in the common activity lounge and the hallways. The carpeted areas directly outside the dining room were heavily soiled. The carpet was black where the medication carts were parked for the staff passing medications. The blackened areas were approximately 4 feet in diameter. There were also three areas approximately 1 foot in diameters in the lounge area in front of the chairs and at the front door next to the entrance rug. At 2:50 PM, Surveyor interviewed Director B about the schedule to clean the carpet. Director B stated there was no routine carpet cleaning and the carpet was cleaned when s/he fills out a maintenance form. Director B stated s/he recalled the maintenance staff cleaning a couple of rooms due to odors but stated there was nothing about the common areas of the hallways and lounge area. Director B stated s/he had not noticed the condition of the carpet. On 08/23/2023. Surveyor received an email from Regional Administrator (RA) A. RA A reported that maintenance staff were going to be in the building on 08/28/2023 to clean the room carpets for #13 and #15. RA A stated the maintenance staff would	N 491		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015263	A. BUILDING: _____ B. WING _____	C 08/23/2023

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N 491	Continued From page 14 also address the black areas. RA A indicated the maintenance staff was not made aware of the black areas.	N 491		