

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968678	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2020
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOME SWEET HOME

**1613 MONROE SHEFFIELD RD
CHIPLEY, FL 32428**

(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
A 000	Initial Comments An unannounced complaint survey was conducted at Home Sweet Home assisted living facility in Chipley, FL on _____ to review the allegation contained within complaint number 2020003633. Deficient practice was identified at the time of the survey. A Class I deficiency was identified on _____ at N0025, Resident Care and Supervision, for facility failure to provide supervision to ensure resident safety which resulted in the _____ of resident #1, who _____ on _____ after she was _____ by dogs found on the facility premises. The facility Administrator was notified via telephone of the Class I deficiencies at 3:03 PM on _____. At the time of the survey, the facility census was 8.	A 000		
A 025 SS-J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of _____ or _____ or has a change of condition _____ in order to rule out the presence of an underlying physiological condition that may be contributing to such _____ or _____. 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. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 025	Continued From page 1 (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (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. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (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. This Statute or Rule is not met as evidenced by: Based on observation, record reviews, resident interviews, staff interviews, law enforcement interviews, and county animal control interview, the facility failed to provide adequate supervision for 1 of 9 sampled residents to ensure awareness of resident safety, when facility staff had knowledge of threatening dogs on and around facility property. The facility's failure to provide adequate	A 025			

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A 025	Continued From page 2 supervision for resident #1 on the early evening of _____, resulted in the resident being found laying on the ground outside the facility with several _____ injuries to her upper and lower extremities and surrounded by several aggressive dogs known to facility staff and residents. This failure resulted in the _____ of the resident and a Class I deficiency. The facility Administrator was notified via telephone of the Class I deficiency at 3:03 PM on _____. Eight residents were identified as at risk for injury prior to the removal of the dogs on _____. The findings include: Review of the county sheriff department incident report revealed on _____ at approximately 4:21 PM, an officer arrived at 1621 Monroe Sheffield Road, Chipley, FL in response to a reported animal bite. The report indicated upon arrival resident #1 was laying on _____ covered grass and was covered in _____. She was wearing a shirt and was covered by another article of clothing. She had underwear on and her blue pants were laying off to the side. Resident #1 was rolling in obvious _____ on the ground and tried to get up a couple of times. She was missing chunks of flesh from her _____, arms, _____ and _____. Her left _____ from the _____ down was missing flesh and the bone was all that was left. The _____ were missing from her _____. While the officer waited for emergency medical services the dogs were still close by under structures. He noticed approximately dogs in the area. He spoke with staff B (owner's brother), D (caregiver), and E (caregiver). They stated they saw resident #1 on adjoining property and then they went into the fields. They returned approximately 20-30 minutes later. Staff B and E came up on resident #1 laying on the ground with	A 025		

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A 025	Continued From page 3 dogs around her. Review of the hospital records for resident #1 dated revealed she was brought in for severe to lower and upper extremities. was in progress upon arrival to hospital. The resident expired at the hospital on at 5:25 PM. An interview was conducted with the facility owner/Administrator on at 9:39 AM. She stated resident #1 had been a resident of the assisted living facility for about 25 years. The incident occurred when the resident went for a walk off the facility property and she was by dogs. A telephone interview was conducted with staff B (Administrator's brother) on at 9:43 AM. He stated he saw resident #1 around 5 PM on . She was talking on the porch. He went down the road to feed his cows and about 15-20 minutes later, resident #1 had walked down the road through the "park" and dogs had her. He saw the dogs and something on the ground; he did not know what was on the ground until he got closer and saw it was resident #1 and she had been by dogs. He called 911. He stated he had called animal control many times about the dogs, to include a call last Monday. He usually got no answer. He bought bullets for his gun because they would not respond. An interview was conducted with staff A (caregiver) on at 9:48 AM. Staff A stated on at about 4:15 PM, she ran down and saw the resident after the , her uncle was there. Around 3:50 PM, prior to the incident, resident #1 asked her to watch her Yorkie dog while she walked over to grandmother's next door. She saw resident #1 on the porch. Staff A's uncle called at about 4:15 PM and asked her to step outside to see if a worker was still working on the property out . When she went outside, someone yelled at her that dogs	A 025		

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A 025	Continued From page 4 had resident #1. She began running to the site where the resident was and heard gunshots. She saw dogs running. Resident #1 was laying on the ground, her and were ate up. The police covered her up. She did not hear dogs barking or anyone yelling. She stated the dogs have been around the area for at least a week and the facility has called animal control. She stated the dogs were coming around because resident #8 fed them. An interview was conducted with staff F (Administrator's mother) on at 10:23 AM. She stated the dogs had been on the property more than a month and her son (staff B) had called animal control. At this time law enforcement officer AA stated the department did a records search and have no evidence the family called animal control. Further interview was conducted with the facility owner on at 10:45 AM. She stated she and her brother had called animal control many times. At times the dogs would be in the facility yard. Surveyor asked the owner if she could provide a call log to show attempts to contact animal control, but no evidence was provided. An interview was conducted with resident #9 on at 11:05 AM. He stated the dogs that resident #1 were the assisted living facility's dogs. He stated the dogs would bark and lunge at times and were aggressive prior to the Staff did not instruct him to stay away from the dogs. A telephone interview was conducted with law enforcement officer BB on at 10:26 AM. He stated he observed 3 dogs upon arrival to the facility and 2 he can describe. One dog was a mixed pit bull and the other a brindle brown pit bull. He had observed dogs on the property	A 025			

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A 025	Continued From page 5 during previous visits to the facility. A telephone interview was conducted with county animal control on _____ at 10:48 AM. She stated she picked up one dog on _____, 2 more on _____, and one on _____ from the facility or surrounding area. She picked up the 1st dog at 1621 Monroe Sheffield Road, he was in a kennel and she was not sure who put the dog in the kennel. She picked up the 2nd dog at 1613 Monroe Sheffield Road near an old trailer. All dogs she obtained were pit bull mixes. They all showed fear. The first dog was a puppy about _____ months old and it had been shot by someone. The 2 dogs she picked up on _____ were described: one was a large pit bull with cropped _____ someone had placed in a kennel, the second dog growled and ran, the deputy had to shoot the dog. The dog she picked up on _____ was extremely aggressive. She had been to the facility previously when the owner's brothers' cattle would get loose. The black and white dog had growled, barked and charged her during the previous visits. Resident #8 told her the black and white dog had been at the facility 2 years. She has been to the facility about 12 times and the black and white dog was always at the facility. The black and white dog would guard resident #8. She stated that neither the owner's brother nor the facility staff have ever called animal control regarding the dogs. An observation on _____ at 09:30 AM, upon arrival to the facility revealed a Washington County Animal Control pick-up truck on the side of the driveway next to the covered smoking patio. An animal control officer was standing next to the pick-up and advised the surveyor to be careful as there was a dog with a gunshot in a chair on the patio. Observation of the patio area revealed an upholstered office chair facing	A 025			

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A 025	Continued From page 6 away from the pick-up. Over the right armrest the of a black and white Pit Bull was visible. The dog was trembling, and the animal control officer stated that the dog was likely in from the injury. Resident #8 was seated in his wheelchair facing the dog approximately 7 to 8 away. The animal control officer stated she was keeping tabs on the dog while she awaited backup to help remove the dog which she reported to be aggressive. On at 09:36 AM, an interview was conducted with the owner who had come outside to meet the surveyors. She informed the surveyor that resident #1 goes on walks and that the incident occurred off the property down the road. When asked if anyone was with the resident at the time the incident occurred, she stated "No, she goes alone." During the interview a Sergeant from the Washington County Sheriff's Office arrived onsite. An observation on at 09:40 AM revealed that the injured black and white dog had jumped down from the chair and approached the animal control officer growling with a lowered The Sergeant drew his gun and the animal control officer wielded a dart gun. The surveyor and resident #8 were instructed to get Resident #8 expressed discontent with the dog being shot and animal control explained that the intent was to . . . it, not kill it. Animal control successfully struck the dog with a dart and it walked over and sat at the of resident #8's wheelchair acting protective of the resident. The animal control officer instructed resident #8 not to . . . the dog, which would stimulate it and to allow it to asleep. Once the dog was asleep the animal control officer and Sergeant loaded the dog into a crate in the bed of the pickup truck	A 025			

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A 025	Continued From page 7 and animal control left the property. On at 1:40 PM, a telephone interview was conducted with Employee A, a caregiver, who stated that she had never called animal control but thought her grandmother, who lived next door, had called the previous week, but no one had showed up. She stated that she believed there had been 8 or 9 dogs some of which stayed outside the facility "under the gazebo". She went on to say the dogs had been there for a "few weeks" and that one had been dropped off at the facility and one at her uncle's house, a few houses down from the facility. She then stated the dogs had a litter of puppies but confirmed the dogs that resident #1 were "big dogs". She stated that one of the dogs, the black and white one, was very protective of resident #8, who would feed the dogs every morning. This protectiveness was demonstrated by barking and growling. When asked what was being done to protect the residents from any unaccounted-for dogs as well as the black and white one which was observed distressed with a gunshot and in close proximity to residents this morning, she stated residents were encouraged to stay inside. On at approximately 10:30 AM, an interview was conducted with resident #6. When asked how long the dogs had been living at the house, he stated that they'd been there since he moved in two months ago. When asked how many dogs lived there, he stated that one little dog lived in the house and three big dogs lived outside the house. When asked where the dogs slept, he stated they slept under the front porch. When asked to describe what the dogs living outside looked like, he stated there was a black Pit Bull, white and brown Pit Bull. He stated that one morning when he woke up, the black dog	A 025		

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A 025	Continued From page 8 was actually in the house. He also stated that resident #8 buys dog food. Class I	A 025		
A 165 SS=D	429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements. (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. _____; 2. _____ or _____ damage; 3. Permanent _____; 4. _____ or _____ of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or	A 165		

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A 165	Continued From page 9 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6), neglect, or must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of	A 165			

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A 165	Continued From page 10 s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. 59A-36.016 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1), above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on law enforcement report review and review of the internal adverse incident reporting system, the facility failed to file an adverse incident report for 1 of 1 residents sampled for elopement. (resident #6)	A 165			

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A 165	Continued From page 11 The findings include: Review of the sheriff's office call record revealed on _____ at 8:36 AM a report was received from the assisted living facility regarding resident #6. The report indicated resident #6 walked off the property to highway 77 and was possibly a harm to himself or other residents in the home. The resident was picked up from the highway by law enforcement and made a threat. Review of the internal adverse incident reporting system revealed as of _____ no adverse incident had been filed regarding resident #6 eloping from the facility. Class III	A 165		