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
	AL11969489	A. BUILDING: _____ B. WING _____	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASCAPE AT NAPLES	3490 DR NAPLES, FL 34109

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A 000	Initial Comments An unannounced complaint survey for complaints #2023003075, and #2023003313 was conducted on through at Seascape at Naples, an assisted living facility in Naples, Florida. Complaint #2023003313 was substantiated at A0025, A0030, and A0077 at Class I level. Complaint #2023003075 was substantiated at A0025, A0030 at Class I level, A0053, A0081, A0160, and A0165. The following is a description of the deficiencies. .	A 000		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall 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 must notify the resident's representative or designee of the need for health care services and must assist in making … … … … … for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition.	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 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (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 record reviewed, observation, and interviews, the facility failed to properly supervise to prevent . . . misconduct and , , ... to 2 (Residents #1, and #2) out of 2 residents reviewed. Failure to properly supervise residents resulted in staffs misconduct with Resident #1's	A 025		

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A 025	Continued From page 2 on . . . . . , and Resident #2 being left in bed without care, and meals for 20 hours on . . . . . into 23. Furthermore, failure to provide proper supervision resulted in Resident #2's . . . . . during a.m. care on . . . . . The lack of supervision included not reporting to the physician, or documenting in the record. The findings included: Review of Policy Name: /Neglect/Misappropriation/Crime, Policy Number 101, Effective date . . . . . Policy: The Charge Nurse will immediately respond to any and all allegations and /or reasonable suspicions of staff to resident, resident to resident, and /or visitor to resident, ... , neglect, mistreatment, , , misappropriation of resident property, or crime against a resident. Procedure: 1. Any staff observing or suspecting . . . . . , neglect or mistreatment will remove the resident from danger immediately and report to their immediate supervisor. 2. The Charge Nurse will assure resident safety by removing the accused employee, visitor, or other resident from the area. 3. The Charge Nurse will notify the Executive Director and/or Director of Clinical Services immediately. 4. The Charge Nurse will thoroughly document the incident, any injuries, and other findings on the Incident Report. 5. The Charge Nurse will notify the resident's attending physician and the responsible party. 6. The Executive Director or Director of Clinical Services will notify the Regional Vice President of Operations and the Vice President of Clinical Services and report on the status of the Community's immediate investigation and plans to notify AHCA {Agency for health Care	A 025		

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A 025	Continued From page 3 Administration]. 7. The Executive Director or designee must initiate an investigation within 24 hours of knowledge of the alleged incident. This investigation will include interviewing any staff, family, residents and/or visitors involved. . . 9. The Executive Director will immediately notify (within 24 business hours of knowledge of the allegation) Adult Protective Services Agency, the local ombudsman, and the appropriate local law enforcement authorities." 1. Record review revealed Resident #1 is an female who resides in the memory care unit, admitted to the facility on with diagnoses including 's , major , recurrent unspecified , and a right broken . Last Health Assessment Form 1823 was dated . The incident log revealed alleged to Resident #1 on . A "Late Entry" progress noted dated indicated Resident #1 was sent to a local hospital on at 6:00 p.m.. swab for kit was obtained by medical personnel in the emergency department. On at 10:00 p.m., a female caregiver (Staff B) was making safety check rounds and entered Resident #1's room. Staff B heard a shuffling noise in the closet. She tried to pull the door open, but someone was trying to hold it shut from the inside. Staff B was able to open the door and observed male (Medication Tech Staff A) staff member in the closet with his pants halfway down to his . Staff B made contact with Staff A and left the room. Staff B clocked out and went home for the night.	A 025		

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A 025	Continued From page 4 On at 12:14 p.m., Review of facility video surveillance showed: a. 10:00 p.m., Staff A (male Medication Tech (MT) was conducting rounds in the Memory Care Unit. b. 10:09 p.m., Staff A was seen going into Resident #1's room. c. 10:18 p.m., Staff B was seen going into Resident #1's room. d. 10:19 p.m., Staff B exited the room. Per her statement, Staff B did not inform any other staff or management of her observation and clocked out from her shift and went home, leaving Resident #1 and Staff A in the room for an additional 6 minutes. e. 10:25 p.m., Staff A is seen to look out the residents' door and scan the hallway. f. 10:26 p.m., Staff A leaves Resident #1's room and is seen talking on a cell phone. Per the schedule, Staff A continued to work. He worked an additional shift that night in the assisted living side of the facility from 11:00 p.m. to 7:00 a.m. Staff A was in Resident #1's room for a total of 16 minutes and was not assigned to Resident #1. On at 10:30 a.m., during an interview, the Executive Director confirmed on she received a report from Caregiver Staff B that while making safety checks on at about 10:00 p.m. she observed MT Staff A in Resident #1's room, in the closet, with his pants down around his , and Resident #1 lying in bed with her brief down to her . Staff B then clocked out at about 10:20 p.m. and went home and did not report her observation to any charge person or other staff. Executive Director confirmed that's not their policy and Staff B should have reported what she saw immediately to her supervisor. The Executive Director stated nothing has been done for the remaining	A 025		

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A 025	Continued From page 5 residents in the memory care unit; no assessments had been made of the residents remaining in the memory care. On . . . . . at 11:00 a.m., during an interview, the Vice President of Operations (VPO) said she reviewed the facility's video surveillance which showed Staff A entering Resident #1's room after 10:00 p.m. and was in the room for a total of 16 minutes and was in the room for 6 minutes after Staff B entered and exited the room. The Vice President of Operations confirmed Staff A was not assigned any care duties for Resident #1 that night, the care duties were assigned to Staff B. The Vice President of Operations confirmed Staff B left Resident #1 in the room with Staff A and clocked out and went home, which was wrong, as Staff B left Resident #1 in harms way, and did not report her observations to any other staff and or management. The Vice President of Operations said nothing had been done for the remaining residents who reside in the memory care unit. On at 11:58 a.m., during an interview, the Regional Director of Clinical Services (RDCS) said she is aware of the alleged assault report, and nothing has been done for the remaining residents who resides in the memory care unit. RCDS reviewed the facility staff schedule and confirmed Staff A worked a double shift . . . -7 on . . . . . On . . . . . at 12:26 p.m., during an interview, the Director of Clinical Service (DCS) said she received a report on . . . . . at about 2:45 p.m. that Staff B observed Staff A on around 10:00 p.m. in Resident #1's room's closet with his pants down to his and Resident #1 lying on the bed with her briefs down to her ; Staff B clocked out and went home and said nothing to	A 025		

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A 025	Continued From page 6 staff. The DCS said Staff B left Resident #1 in harms way as she did not remove Resident #1 from the room, and report immediately to her supervisor or management staff. DCS said nothing has been done with the remaining memory care residents, they are waiting on corporate to give them instructions on what to do next. Record review of Resident #1's progress note revealed that although the DCS was informed of the incident on , it was not documented in Resident #1's record until , further there is no documentation the family or attending physician were notified of the incident. On at 1:02 p.m., during an interview, Caregiver Staff B confirmed observing Staff A in Resident #1's room in the closet with his pants pulled down to his and Resident #1 laying on her bed with her briefs pulled down to her . Staff B confirmed leaving and going home without notifying any staff of what she observed. Staff B confirmed leaving Resident #1 in harms way when she exited the room leaving Staff A in the room after what she observed and going home without reporting her observation to staff or management. Staff B said Staff A was the medication technician (MT) on and was not assigned to Resident #1 for care services and had no reason to be in Resident #1's room at that time. On at 12:02 p.m., during an interview, MT Staff A originally denied being in Resident #1's room until told of the hall video; he then agreed he was in Resident #1's room. Staff A said was he watching television, and sleeping, and its normal for staff including himself to go into residents' rooms to sit and watch television and sleep. Staff	A 025		

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A 025	Continued From page 7 A said Licensed Practical Nurse (LPN) Staff F did call him and speak with him about the alleged allegation. Staff A said no one told him he was suspended, and confirmed he worked on on the shift, and until 12:20 when the DCS called him and instructed him to clock out and leave the facility as he is not to be working. Review of the timecard for showed Staff A continued to work on . Staff A worked the Assisted Living Unit 11:00 p.m. to 7:00 a.m., the night of into . Staff A worked on from 11:00 p.m. to 7:00 a.m. on the Assisted Living Unit. Staff A clocked in and started working on the 11:00 p.m. to 7:00 a.m. shift, and clocked out at 12:20 a.m. On at 3:00 p.m., during an interview, LPN Staff F said when she spoke with Staff A about the allegations, she did not tell him he was suspended, as she has no authority to suspend him. On at 11:08 a.m., during an interview, the DCS said she thought that Staff F had suspended Staff A, and during discussions with the VPO, Executive Director and the corporate office she was instructed not to have contact with Staff A, and never told him he was suspended. The DCS said she did call Staff A on after midnight as she was informed, he was working at the facility and told him to clock out and leave the premises as he is not to be working; and he would receive a call the following day to schedule to meet with him. The DCS confirmed Staff A did work his shift on . On at 3:10 p.m., during an interview, the Executive Director said she did not tell Staff A he	A 025		

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A 025	Continued From page 8 was suspended, as the DON as his direct supervisor should have been the one to suspended him. The Executive Director said when they met with Staff A on Tuesday, she told him that he is not allowed to be in the building as he is suspended. On at 3:20 p.m., Executive Director confirmed they have not reported Staff A's Certified Nursing Assistant (CNA) license to the regulatory agencies as yet. On at 4:04 p.m., the Executive Director said Staff A works in the Assisted Living Unit and Memory Care Unit; she confirmed they had not done any investigation in the Assisted Living Unit. On at 9:07 a.m., during an interview, the Regional Director of Clinical Services (RDCS) said they completed a full body examination on for 3 residents in the memory care unit that do not need care. She confirmed there were no assessments done for any of the other residents in the memory care unit. The RDCS said they have not reported the CNA license for Staff A to the regulatory authority as they have no direct proof that Staff A actually did anything. 2. Record review revealed Resident #2, is a female with a date of admission of Diagnoses included , left surgery. The last Health Assessment Form 1823 dated , noted the resident was . A. Incident Report review for Resident #2 found the following documentation: On at 1:00 p.m., Resident #2 was found by granddaughter still in bed and saturated in . Resident #2's bed was wet. Resident #2 did not receive care. Resident #2 did not receive breakfast or lunch on .	A 025		

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A 025	Continued From page 9 Caregiver Staff H told the Director of Clinical Services (DCS) that she attempted to get Resident #2 up but she was adamant about staying in bed. Staff H told the DCS that she had too many showers to give and forgot about Resident #2. Record review on revealed the incident was not documented in Resident #2's record from to , and their is no evidence the attending physician was informed of the incident. During an interview on at 10:10 a.m., Resident #2's daughter said some time in , (no specific date provided) her niece visited and found Resident #2 in bed covered with feces. The family had placed a facility approved video camera in Residents #2's bedroom. Resident #2's daughter viewed the video from the camera and saw her mother left in bed in her room for 21 hours from 5 p.m. until the next day at 1:00 to 1:30 pm. Per Resident #2's daughter during the course of the 21 hours Resident #2 did not receive care, meals and/or medications. During an interview on at 10:10 a.m., the DCS said she was at home when she was notified by the assistant director of nursing (ADON) that there was an issue related to Resident #2's care. The DCS said Resident #2 did not receive proper care. DCS went to the facility and had a meeting with Resident #2's family. The DCS said she took immediate action by meeting with staff and retraining them on resident care. The DCS said she had evidence of the in-service; however, no documentation of any in-service was provided.	A 025		

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A 025	Continued From page 10 B. During an interview on at 9:38 a.m., Resident #2's spouse discussed the 2 incidents which occurred with his wife. Resident #2's spouse said he observed on Resident 2's left and index on . He said he reported the injuries to the Director of Clinical Services (DCS), who excused the suggesting his wife "caught it in the bed," but did nothing further to find out what happened. Resident #2's spouse said he took her to the Emergency Clinic on and showed a of the left index . He said the family had placed an approved surveillance video camera in Resident #2's room. He said when the family reviewed the video surveillance recording it showed around 7:00 a.m. on , three staff members assisting Resident #2 to get dressed and showed a staff bending his wife's left index . He said his wife was heard screaming, "You're hurting my ." On , observation of the camera recording shows 3 staff (Staffs C, D, and E) in the resident's room. Staff E is observed holding Resident #2's right and squeezing it, Staff C is observed facing the resident and telling her they are trying to put her shirt on her. Staff D attempts to put a shirt over her and as Resident #2 bends forward to protect her , Staff D places her right on Resident #2's forehead and pushes her into the chair, once the shirt is on, Staff D is observed holding the left index . Resident #2 is heard throughout the video screaming, "You're hurting my . Ow ow ow." **Video evidence on file** The video was reviewed with the VPO, ED, and RDCS, on at 9:40 a.m. to ensure staff identification. At the time of the observation the	A 025		

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A 025	Continued From page 11 VPO, ED, RDCS,confirmed that is not the way they trained their staff to provide Activities of Daily Living (ADL) care to residents. During an interview on at 10:10 a.m., the DCS confirmed Resident #2's spouse showed her Resident #2's . The DCS confirmed the next day Resident #2's spouse informed her he was taking Resident #2 to the ER for evaluation. The DCS confirmed that Resident #2's spouse informed her of the . DCS confirmed there was no investigation related to the incident that took place on ; no staff were removed from service. DCS confirmed she did not file an adverse incident for the . DCS confirmed she did not report the incident to Department of Children and Families (DCF). During a telephone interview on at 10:44 a.m., CNA Staff E said Resident #2's husband came and told her someone mishandled his wife. Resident #2's spouse showed Staff E his wife's . Staff E acknowledged she saw the and did not report to anyone. Staff E stated "I had nothing to do with the . I did not do anything to Resident #2. I saw the . I did not tell anyone." Review of the written statement for Staff C was provided on , documented, "I was in the room getting [Resident #2] up on the right side of the bed along with [Staff D]. A third team member named [Staff E] came in and grabbed [Resident #2's] . [Resident #2] did not reply [unreadable word] and said 'Don't touch me, and My hurts.' I didn't know about the until the husband told me the next day." When Staff C was asked if she notified anyone after she was informed of the she said "No."	A 025		

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A 025	Continued From page 12 Staff D written statement provided on , documented, "[Staff E] had the assignment, she asked me to help her. Me and [Staff E] and [Staff C] were there. [She] was asking me to help. I said yes. [Staff E] grabbed [Resident #2] because she was fighting. When she was holding her I heard her crack. I told [Staff C] to let the nurse know about the . I don't know if [Staff C] told or not. I don't know what happened after that. The next day asked her husband if her was broken. I didn't report to anyone. I told [Staff C] to tell the nurse. I left early that day and didn't check with the nurse to see if [Staff C] told her or not." During an interview on at 3:31 p.m., the Executive Director said she had a meeting with Resident #'2's husband and he mention something about a lost . The ED assured Resident #2's husband they would find a new for Resident #2. The ED said she was notified from DCS of Resident #2's on . ED said she did not report the incident to Department of Children and Families. ED said she did not take any action or began an investigation after she became aware of Resident #'2's . Record review on revealed no documentation of the incident in Resident #2's record from to , further there is no documentation the facility informed Resident #2's attending physician of the incident and . Class I .	A 025		

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A 030	Continued From page 13	A 030		
A 030 SS=J	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (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 59A-36.006, F.A.C. (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. (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; , 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- 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. (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 59A-36.006, F.A.C. The rules and procedures must at a minimum address the	A 030		

Agency for Health Care Administration

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A 030	Continued From page 14 facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (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. (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. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State	A 030		

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A 030	Continued From page 15 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: (a) Live in a safe and decent living environment, free from . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (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. (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. (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. (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. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when	A 030		

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A 030	Continued From page 16 prevented by inclement weather. (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. (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. (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 must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. 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.	A 030		

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A 030	Continued From page 17 (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 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. (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.	A 030		

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A 030	Continued From page 18 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (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. This Statute or Rule is not met as evidenced by: Based on record review, and interview the facility failed to provide a safe living environment to prevent alleged assault, neglect, and , , for 2 (Resident # 1, # 2) of 2 residents sampled. The facility failed to follow its policy and procedure to document, investigate, respond, and follow up a reported incident for 1(Resident # 2) of 2 residents resulting in a The findings include: The facility's policy titled: Nursing Polices & Procedures Manual /Neglect/Misappropriation/Crime, Effective date . Policy: The charge nurse will	A 030		

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A 030	Continued From page 19 immediately respond to any and all allegations and/or reasonable suspicions of Staff to resident, resident to resident, and/or visitor to resident, , neglect, mistreatment, , , misappropriation of resident property, or crime against a resident. Procedure: 1. Any Staff observing or suspecting . . . . , neglect or mistreatment will remove the resident from danger immediately and report to their immediate supervisor. 2. The charge nurse will assure the resident safety by removing the accused employee, visitor, or other resident from the area. 3. The charge nurse will notify the Executive Director and or Director of Clinical Services immediately. 4. The charge nurse will thoroughly document the incident, any injuries, and other findings on the incident report. 5. The charge nurse will notify the resident's physician and the responsible party. 6. The Executive Director or Director of Clinical Services will notify the regional Vice President of Operation and the Vice President of Clinical Services and report on the status of the community's immediate investigation and plans to notify AHCA. The facility's policy titled: Nursing Polices & Procedures Manual - Nursing Documentation Incident Report, Effective date . Policy: A licensed nurse in charge of the resident's care and treatment is responsible for completing an incident report in point click care immediately following any reported or witnessed occurrence of an incident, accident, or injury involving a patient. Procedure: 1. A licensed nurse will complete the incident record as evaluation and appropriate treatment is initiated. 4. The completed incident report record will then be reviewed by the Wellness Director for follow up. 5. If the incident or accident is a reportable occurrence to the state regulatory agencies, the Wellness Director and	A 030		

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A 030	Continued From page 20 the Executive Director will be responsible for initiating timely and efficient investigative reporting and follow up concurrent with company policy. The facility's policy titled: Nursing Polices & Procedures Manual Emergency Care Unusual Occurrence, Effective date . Policy: All unusual instances or occurrences related to the care of the resident will be immediately reported. Procedure: 1. Nursing Staff will closely monitor and document the behavior and condition of the resident involved to check for any injury and to prevent recurrence of the incident. This is to be documented on an incident report. 2. The person in charge will notify the following for all resident involved in the incident: a. attending physician, b. responsible party, c. wellness director. 3. The Wellness Director or designee will notify the Executive Director of the incident. 4. An investigation by the Executive Director or Wellness Director will be initiated within 24 hours of their knowledge of the alleged incident. 1. Review of the clinical record revealed Resident #1 is an , female who resides in the memory care unit. The resident was admitted to the facility on with Diagnoses including 's , major , recurrent unspecified , and a broken right . Last Health Assessment was . The Incident Log revealed alleged to Resident #1 on . A progress note dated indicated Resident #1 was sent to Physicians Regional Pine Ridge Hospital on at 6:00 pm. swab for kit was obtained by medical personnel in the	A 030		

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A 030	Continued From page 21 emergency department. On at 10:00 p.m., Staff B (caregiver) was making safety check rounds and entered Resident #1's room (177). She observed Resident #1 prone in bed with her underwear pulled down. Staff B heard a shuffling noise in the closet. She tried to pull the door open, but someone was trying to hold it shut from the inside. Staff B was able to open the door and observed Staff A (med tech) in the closet with his pants halfway down to his . Staff B made contact with Staff A and left the room. Staff B clocked out and went home for the night. On at 10:30 a.m. during an interview, the Executive Director confirmed she received a report on from Staff B that while making safety checks on at about 10:00 p.m. Staff B observed Staff A in Resident #1's room in the closet with his pants down around his and Resident #1 lying in bed with her briefs down to her . Staff B then clocked out at about 10:20 p.m. and went home and did not report her observation to any charge person or other staff members. Executive Director confirmed that's not their policy and Staff B should have reported what she saw immediately to her supervisor. Executive Director states nothing has been done for the remaining residents in the memory care unit; that is, there was no assessment of the residents in memory care. On at 11:00 a.m. during an interview, the Vice President of Operations (VPO) said she reviewed the facility's video surveillance which showed Staff B entering Resident #1's room after 10:00 pm and was in the room for a total of 16 minutes, 6 of the minutes after Staff B entered and exited the room. Vice President of Operations confirmed Staff A was not assigned any care duties for Resident #1 that night. The	A 030		

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A 030	Continued From page 22 care duties were assigned to Staff B. Vice President of Operations confirmed Staff B left Resident #1 in the room with Staff A, clocked out and went home. She said this was wrong, as Staff B left Resident #1 in harm's way, and did not report her observations to any other staff and/or management. Vice President of Operations said nothing has been done for the remaining residents who resides in the memory care unit. On . . . . . at 11:58 a.m. in an interview, the Regional Director of Clinical services (RDCS) said she is aware of the alleged . . . . assault report and said nothing has been done for the remaining residents who reside in the memory care unit. RCDS reviewed the facility staffing schedule and confirmed Staff A worked a double shift & on and into . . On at 12:14 p.m., Review of facility video surveillance showed: a. 10:00 p.m., Staff A (male Medication Tech) was conducting rounds in the Memory Care Unit. b. 10:09 p.m., Staff A was seen going into Resident #1's room (177). c. 10:18 p.m., Staff B was seen going into Resident #1's room. d. 10:19 p.m., Staff B exited the room. Per her statement, Staff B did not inform any other staff or management of her observation. She clocked out from her shift and went home, leaving Resident #1 and Staff A in the room for an additional 6 minutes. e. 10:25 p.m., Staff A is seen to look out the residents' door and scan the hallway. f. 10:26 p.m., Staff A leaves Resident #1's room and is seen talking on a cell phone. Staff A continued to work. He worked an additional shift that night in the assisted living side of the facility from 11:00 p.m. to 7:00 a.m. Staff A	A 030		

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A 030	Continued From page 23 was in Resident #1's room for a total of 16 minutes and was not assigned to Resident #1. On at 12:26 p.m. during an interview, the Director of Clinical Service (DCS) said she received report on at about 2:45 pm that Staff B observed Staff A at around 10:00 p.m. on in Resident #1's room in the closet with his pants down to his and Resident #1 lying on the bed with her briefs down to her . DCS said it was reported Staff B clocked out and went home and said nothing to other staff members. The DCS said Staff B left Resident #1 in harm's way as she did not remove Resident #1 from the room and did not report immediately to her supervisor or management staff. DCS said nothing has been done for the remaining memory care residents; they are waiting on corporate to give them instructions on what to do next. On at 1:02 p.m. during an interview, caregiver Staff B confirmed observing Staff A in Resident #1' s room in the closet with his pants pulled down to his and Resident #1 laying on her bed with her briefs pulled down to her . Staff B confirmed leaving and going home without notifying any staff of what she observed. Staff B confirmed leaving Resident #1 in harm's way when she exited the room leaving Staff A in the room and going home without reporting her observation to staff or management. Staff B said Staff A was the medication technician on and was not assigned to Resident #1 for care services and had no reason to be in Resident #1's room at that time. On at 1:10 p.m., Executive Director confirmed Staff B left Resident #1 in harm's way as she did not report the observation and having clocked out went home leaving Resident #1 in the	A 030		

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A 030	Continued From page 24 room with Staff A. On ... at 4:04 p.m., Executive Director said Staff A works in the Assisted Living unit and memory care unit. Executive Director confirmed they have not done any investigation in the Assisted Living unit. On .. ... at 9:07 a.m., Regional Director of Clinical Services (RDCS) said they completed full body examination of 3 residents in the memory care unit that do not need care. She confirmed there was no assessment done for any of the other residents in the memory care unit. RDCS states they have not reported the license of Staff A as they have no direct proof that Staff A actually did anything. On .. ... at 10:53 a.m. in an interview, Licensed Practical Nurse (LPN) Staff F confirmed she did not do any exams or assessments on the remaining residents in the memory care unit and did not receive any instructions to complete assessments or exams. On at 12:02 p.m. in an interview, Med Tech Staff A confirmed he was in . Staff A said he was watching television, and sleeping, and its normal for staff including himself to go into residents' rooms to sit and watch television and sleep. Staff A said Staff F did call him and speak with him about the alleged allegation. Staff A said no one told him he was suspended, and confirmed he worked on shift, and on ... from 11:00 p.m. until 12:20 a.m. when the DCS called him on the telephone and instructed him to clock out and leave the facility as he is not to be working. Review of the timecard for showed Staff	A 030		

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A 030	Continued From page 25 A continued to work finishing the shift at 11:00 p.m. on . Staff A then worked on the Assisted Living unit from 11:00 p.m. to 7:00 a.m., the night of into on the Assisted Living unit. Staff A clocked in and started working on at 11:00 p.m., and clocked out at 12:20 a.m. on . On at 2:00 p.m. in an interview, the VPO and RDCS both reviewed the punch card for Staff A and confirmed he did work on shift. He punched in on at 10:51 p.m. and clocked at 12:20 a.m. On at 3:00 p.m. in an interview, LPN Staff F states when she spoke with Staff A about the allegations on , she did not tell him he was suspended, as she has no authority to suspend him. On at 11:08 a.m. in an interview, the DCS said she thought that Staff F had suspended Staff A, and said during discussions with the VPO, Executive Director and the corporate office she was instructed not to have contact with Staff A, so never told him he was suspended. DCS states she did call Staff A on after midnight having been informed he was working at the facility. She said she instructed him to clock out and leave the premises as he is not to be working, and told him she will call during the day to schedule a meeting with him. DCS confirmed Staff A did work his 11-7 shift on . On at 3:10 p.m. in an interview, Executive Director states she did not tell Staff A he was suspended, and the DON as his direct supervisor should have been the one to suspended him.	A 030		

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A 030	Continued From page 26 Executive Director said when they met with Staff A on Tuesday she told him that he is not allowed to be in the building as he is suspended. On at 3:20 p.m., Executive Director states they have not reported Staff A's license to the regulatory agency as yet. 2. Resident #2 was admitted . Review of the Health Assessment Form 1823 for Resident #2 documented diagnoses of left , surgery, or behavioral status: Review of an incident report for Resident #2 found the following documentation: On at 1:00 p.m. Resident #2 was found in her room by granddaughter. Resident #2 was still in bed and saturated in . Per incident report on record Resident #2's bed was wet. Per incident report Resident #2 did not receive care. Resident #2 did not receive breakfast or lunch on . Per note on record Staff H told the Director of Clinical Services (DCS) that Resident #2 refused to come out of the bed. Staff H told the DCS she left Resident #2 to go assist other residents. Staff H said she had many showers to give and forgot about Resident #2. On at 10:10 a.m. during an interview, Resident #2's daughter said sometime in , (no specific date provided) her niece visited Resident #2 and found the resident in bed with feces on the bed linens. Reviewing the video evidence from a facility approved video camera in Residents #2's bedroom, the daughter saw her mother had been left in bed for 21 hours. The daughter said during the course of the 21 hours	A 030		

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	AL11969489	A. BUILDING: _____ B. WING _____	03/02/2023

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A 030	Continued From page 27 Resident #2 did not receive care, meals, or medications. On at 10:10 a.m. in an interview, Director of Clinical Services (DCS) confirmed the incident on of lack of care. The DCS said she was at home when notified by the assistant director of nursing (ADON) that there was an issue related to Resident #2's care. DCS said Resident #2 did not receive proper care. DCS went to the facility and had a meeting with Resident #2's family. DCS said she took immediate action. DCS said she had a meeting with staff and provided in-service education specific to resident care. DCS said she would provide evidence of in-service. No evidence of in-service was provided. 3. On Resident #2's spouse observed on the resident's left and index . Resident #2's spouse reported the injuries to the Director of Clinical Services (DCS). The spouse took Resident #2 to the Emergency Room on where taken and showed a of the left- index . Resident #2 had an approved surveillance video camera in the room. Review of the video surveillance recording showed three staff members assisting Resident #2. Resident #2 can be heard screaming "You're hurting my " while staff were providing care. Review of the video evidence from a facility approved video camera in Residents #2 bedroom showed 3 staff members (C, D, E) present. Staff E was observed extending the resident's left- to control her. Resident #2 can be seen screaming out in several times, saying "my , my ." Staff E was observed shoving Resident #2's forehead with her right ,	A 030		

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A 030	Continued From page 28 pushing Resident #2 . . . on the chair. On . . . . at 10:10 a.m. in an interview, the DCS said Resident #2's spouse came to her and showed her Resident #2's . . . . DCS confirmed the next day Resident #2's spouse informed her he was taking the resident to the Emergency Room (ER) for evaluation. DCS confirmed Resident #2's spouse informed her of the . DCS confirmed she did not conduct an investigation related to . . . . of unknown origin and subsequent that took place on . . . . . DCS confirmed she did not report the incident to Department of Children and Families (DCF). The DCS stated: "I am not going to sit here and lie to you. No, I did not do anything. I don't know why." On . . . . at 10:44 a.m. during a telephone interview, Staff E said Resident #2's husband came and told her someone mishandled his wife. Resident #2's spouse showed Staff E his wife's . . . . Staff E acknowledged she saw the . and did not report it to anyone. Staff E stated, "I had nothing to do with the . I did not do anything to Resident #2. I saw the . I did not tell anyone." On . . . . Staff C provided a written statement, "I was in the room getting Resident #2 up on the right side of the bed along with Staff D. Staff E came and grabbed Resident #2's . Staff C reported that Resident #2 said, "Don't touch me" and "my , my ". Staff C said she didn't know about the . . . . . until the husband told her the next day. Staff C said she did not notify anyone after she was informed of the . On Staff D provided a statement, "Staff E	A 030		

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A 030	Continued From page 29 had the assignment and asked me to help her. Myself, Staff E and Staff C were there. Staff E grabbed Resident #2 because she was fighting. Staff E was holding Resident #2. I heard Resident #2's ⌣ crack. I told Staff C to let the nurse know about the ⌣. I don't know if Staff C told or not. I don't know what happened after that. The next day I asked Resident #2's husband if Resident #2's ⌣. was broken. I didn't report it to anyone. I told Staff C to tell the nurse." Reviewed video with Vice President Operations (VPO), Executive Director (ED), and Resident Care Director (RCD), on at 9:40 a.m. to ensure Staff identification. At the time of the observation VPO, ED, RCD, confirmed that is not the way staff are trained to provide Activities of Daily Living (ADL) care to residents. On at 3:31 p.m. during an interview, the Executive Director (ED) said she had a meeting with Resident #2's husband and he mention something about a lost ⌣. The ED assured the husband they will find a new ⌣ for Resident #2. She said she was notified by the DCS of Resident #2's on . ED said she did not report the incident to Department of Children of families (DCF). ED said she did not take any action or began an investigation after she became aware of Resident #2 . Class I	A 030		
A 053 SS=D	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to	A 053		

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A 053	Continued From page 30 administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record. (c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Chapter 483, Part I, F.S. A valid copy of the federal CLIA Certificate must be maintained in the facility. A federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the federal CLIA Certificate is available from the Laboratory and In-Home Services Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on record reviewed, and staff interview, the facility failed to follow physician orders for 1 (Resident #2) out of 3 residents reviewed.	A 053		

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A 053	Continued From page 31 Findings included: Review of "Policy #800A, Policy Name: Medication Management and Services. Effective date: . Under #4. All new medication orders will be transcribed to the electronic MAR [medication administration record] in PCC [point and click care-software] within 24 hours of receiving the order. A licensed nurse will verify that all new orders for the previous 24 hours have been transcribed timely on a daily basis." Emergency Clinic record review revealed a physician's note dated the word and L (for Left) were circled and Impression noted FX ( ) (unknown word) , phalanx index . (small bone in the index .). Also the physician order for Resident #2 dated ordering, "HEAT ON AND OFF, RECHECK IN 4 DAYS, USE x 3 weeks." Record review for Resident #2 found no evidence that staff applied heat to Resident #2's broken left index . During an interview on at 10:53 a.m., the facility's Director of Clinical Services stated, "No one put heat on her . I am not going to sit here and make up a story. No, we did not do it. " Class III .	A 053		
A 077 SS=J	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If,	A 077		

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A 077	Continued From page 32	A 077		

during the 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 meets educational requirements and 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.

429.52
(4) A facility administrator must complete the required core training, including the competency test, within 90 days after the 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. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule.
(5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years.

59A-36.010
(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 chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter.
(a) An administrator must:
1. Be at least [illegible];
2. If employed on or after [illegible],

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A 077	Continued From page 33 have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. 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. (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 subparagraph (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: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise	A 077		

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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.
(d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as 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.
(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-09393.

This Statute or Rule is not met as evidenced by:
Based on observation, record review, and interviews, the facility's Executive Director failed to perform her duties as required. Failed to oversee the Director of Clinical Services and ensure appropriate care for 1 (Resident #2) of 2

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A 077	Continued From page 35 residents reviewed. Failure to properly supervise and oversee the Director of Clinical Services resulted with resident not receiving appropriate healthcare for injury, which resulted in a , investigating and documenting injury of unknown origin. Failure to properly supervise facility's Director of Clinical Services resulted to lack of investigation, and documentation of injury of unknown injury resulting in as a result of alleged , . (Refer to A0030 Residents care- Rights and facility procedures). The failure of the Executive Director to ensure systems were in place and being followed to ensure all residents lived in a safe living environment and provided appropriate supervision for 2 (Residents #1 and #2) of 2 reviewed, created a likelihood of serious immanent danger to the current residents at the facility. Furthermore, the facility's Executive Director failed to provide evidence of 12 hours continuing education every 2 years as required. The findings included: Review of the job description for Community Director (Executive Director) signed and dated revealed: Summary: The Executive Director is, "Responsible for the efficient and profitable day-to-day operations of the community. Ensures that high quality resident services are provided according to Retirement Unlimited Inc. Standards. Advises and takes recommendations regarding the operation and activities of the community. . . Functions: POLICY/PROCEDURES/ADMINISTRATION: Recommends policies and procedures which will produce maximum utilization of resources and ability of staff at minimum costs. Carries out policies and procedures effectively. Establishes	A 077		

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A 077	Continued From page 36 and/or follows policies and procedures for move in and move out of residents, resident records, resident financial files, etc. . . . Reviews the status of residents and professional staff in order to provide maximum resident services. . . RESIDENTS: Creates a social, emotional, and physical environment conducive to the best interest of all residents. Ensures that quality resident services are provided in accordance with RUI standards and applicable policies and procedures. Analyzes the structure of resident charges and recommends necessary adjustments to maintain and improve profit STAFF: Directs the recruitment, hiring, and in-service training of qualified staff capable of adhering to RUI standards and accomplishing the community objectives. Coordinates the training and development of other secondary administrative personnel. Directs the implementation of RUI personnel policies and procedure. The facility's Policy Name: QA/Risk Meeting Policy Number: 207. Effective Date . POLICY: RUI communities will conduct weekly QA/Risk meetings and will be led by the Wellness Director or designee. PROCEDURE: 1. The QA Risk Meeting will include discussion of (at minimum): a. b. c. d. ER visits e. Resident significant changes and/or Care Level changes 2. The Wellness Director or designee will document the meeting on the RUI QA/Risk Meeting Agenda forms. 3. The RUI QA/Risk Meeting Agenda form will be kept and filed in the Wellness Director's office for 2 years. 1. Record review of the personnel record for the	A 077		

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A 077	Continued From page 37 facility's Executive Director (ED) found she was hired on . The ED obtain a passing score for the CORE exam on . There was no evidence of 12 hours continuing education every two years since 2014 in Administrator's record. During an interview on at 3:45 p.m., the ED said she had evidence of continuing education and will email to the office. No evidence of continuing education received from administrator by . Record review revealed the Registered Nurse Director of Clinical Services (DCS) was hired on . 2. Record review revealed Resident #1 is an , female who resides in the memory care unit, admitted to the facility on with diagnoses including 's , major , , recurrent unspecified , and a right broken . Last Health Assessment Form 1823 was dated . The incident log revealed alleged to Resident #1 on . A "Late Entry" progress noted dated indicated Resident #1 was sent to a local hospital on at 6:00 p.m.. swab for , kit was obtained by medical personnel in the emergency department. On at 10:00 p.m., a female caregiver (Staff B) was making safety check rounds and entered Resident #1's room. Staff B heard a shuffling noise in the closet. She tried to pull the door open, but someone was trying to hold it shut from the inside. Staff B was able to open the door and observed male (Medication Tech Staff A) staff member in the closet with his pants halfway	A 077		

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A 077	Continued From page 38 down to his . . . . Staff B made , contact with Staff A and left the room. Staff B clocked out and went home for the night. On . . . . . at 12:14 p.m., Review of facility video surveillance showed: a. 10:00 p.m., Staff A (male Medication Tech (MT) was conducting rounds in the Memory Care Unit. b. 10:09 p.m., Staff A was seen going into Resident #1's room. c. 10:18 p.m., Staff B was seen going into Resident #1's room. d. 10:19 p.m., Staff B exited the room. Per her statement, Staff B did not inform any other staff or management of her observation and clocked out from her shift and went home, leaving Resident #1 and Staff A in the room for an additional 5 minutes. e. 10:25 p.m., Staff A is seen to look out the residents' door and scanning the hallway. f. 10:26 p.m., Staff A leaves Resident #1's room and is seen talking on a cell phone. Per the schedule Staff A continued to work. He worked an additional shift that night in the assisted living side of the facility from 11:00 p.m. to 7:00 a.m. Staff A was in Resident #1's room for a total of 16 minutes and was not assigned to Resident #1. On . . . . . at 10:30 a.m., during an interview, the Executive Director confirmed on she received a report from Caregiver Staff B that while making safety checks on at about 10:00 p.m. she observed MT Staff A in Resident #1's room in the closet with his pants down around his . . . and Resident #1 lying in bed with her brief down to her . Staff B then clocked out at about 10:20 p.m. and went home and did not report her observation to any charge person or other staff. The Executive Director confirmed that's not their policy and Staff B	A 077		

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A 077	Continued From page 39 should have reported what she saw immediately to her supervisor. The Executive Director stated nothing has been done for the remaining residents in the memory care unit, no assessments had been made of the residents remaining in the memory care. On at 3:10 p.m., during an interview, the Executive Director said she did not tell Staff A he was suspended, as the Director of Clinical Services (DCS), as his direct supervisor the DCS should have been the one to suspended him. The Executive Director said when they met with Staff A on Tuesday, she told him that he is not allowed to be in the building as he is suspended. On at 3:20 p.m., Executive Director confirmed they have not reported Staff A's Certified Nursing Assistant (CNA) license to the regulatory agencies as yet. On at 4:04 p.m., the Executive Director said Staff A works in the Assisted Living Unit and Memory Care Unit; she confirmed they had not done any investigation in the Assisted Living Unit. Review of the timecard for showed Staff A continued to work on . Staff A worked the Assisted Living Unit 11:00 p.m. to 7:00 a.m., the night of into . Staff A worked on from 11:00 p.m. to 7:00 a.m. on the Assisted Living Unit. Staff A clocked in and started working on the 11:00 p.m. to 7:00 a.m. shift, and clocked out at 12:20 a.m. 3. Record review revealed Resident #2, is a female with a date of admission of . Diagnoses included , left , surgery. The last Health Assessment Form 1823 dated , noted the resident was	A 077		

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	AL11969489	A. BUILDING: _____ B. WING _____	03/02/2023

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A 077	Continued From page 40 A. Incident Report review for Resident #2 found the following documentation: On at 1:00 p.m., Resident #2 was found by granddaughter still in bed and saturated in . Resident #2's bed was wet. Resident #2 did not receive care. Resident #2 did not receive breakfast or lunch on . Caregiver Staff H told the Director of Clinical Services (DCS) that she attempted to get Resident #2 up but she was adamant about staying in bed. Staff H told the DCS that she had too many showers to give and forgot about Resident #2. Record review on revealed the incident was not documented in Resident #2's record from to , and their is no evidence the attending physician was informed of the incident. During an interview on at 10:10 a.m., Resident #2's daughter said some time in , (no specific date provided) her niece visited and found Resident #2 in bed covered with feces. The family had placed a facility approved video camera in Residents #2 bedroom. Resident #2's daughter viewed the video from the camera and saw her mother was left in bed in her room for 21 hours from 5 p.m. until the next day at 1:00 to 1:30 pm. Per Resident #2's daughter during the course of the 21 hours Resident #2 did not receive care, meals and/or medications. B. During an interview on at 9:38 a.m., Resident #2's spouse discussed the 2 incidents which occurred with his wife. Resident #2's spouse said he observed on Resident 2's	A 077		

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A 077	Continued From page 41 left [redacted] and index [redacted] on [redacted]. He said he reported the injuries to the Director of Clinical Services (DCS), who excused the [redacted] suggesting his wife "caught it in the bed," but did nothing further to find out what happened. Resident #2's spouse said he took her to the Emergency Clinic on [redacted] and [redacted] showed a [redacted] of the left index [redacted]. He said the family had placed an approved surveillance video camera in Resident #2's room. He said when the family reviewed the video surveillance recording it showed around 7:00 a.m. on [redacted], three staff members assisting Resident #2 to get dressed and showed a staff bending his wife's left index [redacted]. He said his wife was heard screaming, "You're hurting my [redacted]." He said the DCS did nothing, she did not investigate, assess his wife, nor follow up with him for any findings of the [redacted] on his wife's [redacted]. On [redacted], observation of the camera recording shows 3 staff (Staffs C, D, and E) in the resident's room. Staff E is observed holding Resident #2's right [redacted] and squeezing it, Staff C is observed facing the resident and telling her they are trying to put her shirt on her. Staff D attempts to put a shirt over her [redacted] and as Resident #2 bends forward to protect her [redacted], Staff D places her right [redacted] on Resident #2's forehead and pushes her [redacted] into the chair, once the shirt is on Staff D is observed holding the left index [redacted]. Resident #2 is heard throughout the video screaming, "You're hurting my [redacted]. Ow ow ow." **Video evidence on file** Review of Emergency records from the emergency clinic revealed visit on [redacted] for Resident #2, [redacted] were conducted with results of Left- [redacted] index phalanx [redacted], with discharge orders of heat on and off for 4 days	A 077		

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A 077	Continued From page 42 and , placed on for 3 weeks. During an interview on at 10:10 a.m., the DCS confirmed Resident #2's spouse showed her Resident #2's . The DCS confirmed the next day Resident #2's spouse informed her he was taking Resident #2 to the ER for evaluation. The DCS confirmed that Resident #2's spouse informed her of the . DCS confirmed there was no investigation related to the incident that took place on ; no staff were removed from service. DCS confirmed she did not file an adverse incident for the . DCS confirmed she did not report the incident to Department of Children and Families (DCF). On at 1:30 p.m., the Executive Director (ED) states she had no information about Resident #2 having the on her left and index or that the were broken. The ED states the DON did not communicate with her of the incident being reported to her for Resident #2. The ED said the DCS should have followed facility policy upon receiving the report of the unexplained and assessed Resident #2, examined the injury and completed an incident report, an investigation, interviewed the staff and followed up with the husband for the findings of the investigation. The ED confirmed the DCS did not follow facility policy. The ED said she is the immediate supervisor to the DCS and they would meet daily for morning meetings but did not know about Resident #2's index . The video was reviewed with the VPO, ED, and RDCS, on at 9:40 a.m. to ensure staff identification. At the time of the observation the VPO, ED, RDCS,confirmed that is not the way they trained their staff to provide Activities of Daily	A 077		

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A 077	Continued From page 43 Living (ADL) care to residents. On at 4:20 p.m., during an interview, the Executive Director confirmed upon review of the surveillance video in Resident #2 room for the date of , the staff (Staff C, D and E) in the video are currently still employed at the facility and were providing care to Resident #2 in an inappropriate manner. The ED said Resident #2's / could have occurred from the treatment by the staff in the video. The ED confirmed no in-services were completed with staff after the incident. On at 3:20 p.m., during an interview, the Executive Director said she waited to suspend the staff as they were trying to do due diligence and investigate the issues. Record review of the clinical record for Resident #2 revealed no documentation of the injury to Resident #2's , no documentation of being seen by the physician, physcian notification, no incident report of the injury, and no investigation completed. Review of the facility incident log/incident reports for the month of , and , revealed no documentation of the incident on . On at 3:30 p.m., during an interview, the Executive Director said on Resident #2's husband did mention to her about his wife's , coming lose to see what needed to be done. The ED said she went and spoke with DCS, regarding Resident #2, the , and what occurred. She said the DCS told her she looked into to it, and informed the DCS when she got the details to please follow up with her and let her know the details. The ED said she waited for the DCS	A 077		

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A 077	Continued From page 44 to follow up with her and the DCS never came with the details for Resident #2 and the . The ED said she never followed up with the DCS and a had Department of Children and Family (DCF) investigator in the building for another allegation. The Executive Director confirmed she did not follow up with the DCS about Resident #2 and her of the left- index . On at 3:50 p.m., during an interview, the Regional Director of Clinical Service (RDCS) said the facility has a Quality Assurance (QA) program. She said the Director of Clinical Services (DCS) would document weekly any issues they were having during that period and QA would meet to discuss the issues. The RDCS said the weekly monitoring would be documented on an analysis form by the DCS. On at 5:35 p.m., during an interview, the Vice President of Operations (VPO) said the DCS takes the notes for the QAA meeting and is the risk manager. The VPO states the DCS runs the meetings and takes the minutes and is responsible for the QA for the nursing department. The VPO confirmed the QA/Risk management policy and procedures were not followed. Class I .	A 077		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee	A 081		

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A 081	Continued From page 45 who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice	A 081		

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A 081	Continued From page 46 orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when	A 081		

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A 081	Continued From page 47 offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review, and staff interview, the facility failed to ensure staff completed a 1 hour in-service training within 30 days of employment that covers resident rights in an assisted living facility, recognizing and reporting resident , neglect, and , for 1 (Staff D) out of 6 staff reviewed. Findings included:	A 081		

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A 081	Continued From page 48 1. Record review found Staff D was hired as a caregiver on [redacted]. 2. Further review found no evidence that Staff D had an 1-hour in-service training covering resident rights in an assisted living facility, recognizing and reporting resident [redacted], neglect, and [redacted]. 3. During an interview on [redacted] at 2:00 p.m., the Executive Director confirmed Staff D lacked the required training. Class III .	A 081		
A 160 SS=D	59A-36.015(1) FAC Records - Facility The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if	A 160		

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A 160	Continued From page 49 applicable, a notation indicating that the resident was admitted with a ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in rule 59A-36.007, F.A.C. (j) All food service records required in rule	A 160		

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A 160	Continued From page 50 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to section 429.41, F.S., and rule chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to section 381.031, F.S., and chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review, and staff interview, the facility failed to complete a grievance for 1 (Resident #2) out of 2 residents reviewed for grievances. Findings included: Record review of the Policy titled: Handling of Resident Grievances. Policy #630. Effective date:	A 160		

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A 160	Continued From page 51 . . . . . . Policy: "The resident has the right to voice/file grievances/complaints (orally, in writing or anonymously) without fear of discrimination or reprisal. The Executive Director serves as the grievance official of the Community and is responsible for overseeing the grievance process and to receiving and tracking to their conclusion. Procedure: 1. Resident grievances/complaints filed with the Executive Director will be processed and tracked via the RUI Grievance Form. The Executive Director will make every reasonable effort to resolve grievances/complaints regarding the rights of the resident as promptly as possible. The review process by the Executive Director is , . . . to be complete no later than five (5) business days from the Executive Director receiving the filed grievance. 2. The RUI Grievance Form will be completed by the Executive Director. The resident will be provided a written response from the Executive Director regarding his or her grievance via the completed RUI Grievance Form. 3. The Executive Director is responsible for maintaining the confidentiality of the information associated with the grievance and will coordinate and take action with state and federal agencies as necessary in light of specific allegations. 4. The Executive Director will maintain an administrative file for tracking and referencing grievances received and responses provided. These forms are to be maintained on file for a period of three (3) years. 1. Record review of the incident log for the last 3 months revealed on there was an incident of . . . . . and neglect related to Resident #2.	A 160		

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A 160	Continued From page 52 Record review revealed Resident #2 was admitted on . The Health Assessment Form 1823s dated and for Resident #2 documented diagnoses of left , surgery, and . Under or Behavioral Status: is noted. Review of an Incident Report for Resident #2 documented an incident reported on at 2:00 p.m. On at 1:00 p.m., Resident #2 was found by her granddaughter still in bed. Resident #2 and the bed were saturated with . Resident #2 had not been gotten up, and did not get breakfast or lunch. Per an investigation note Staff H (responsible for Resident #2's care on) documented that Resident #2 ". . . didn't want get up off the bed. I went took another residence. I was busy this morning because I gave a lot shower this morning." Staff H told the Director of Clinical Services (DCS) that she had too many showers to give and forgot about Resident #2. 2. During an interview on at 10:10 a.m., Resident #2's daughter said some time in , (not specific date provided) her niece visited Resident #2 and found her in bed, not dressed and with feces. Resident #2's family had placed a facility approved video camera in Resident #2's room. Resident #2's daughter said she viewed the video from the camera and saw that her mother was left in the bed in her room for 21 hours. Per Resident #2's daughter during the course of the 21 hours Resident #2 did not receive care, meals and medications. Resident #2's daughter went to the facility. The nurse in charge called the DCS who came to the	A 160		

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	AL11969489	A. BUILDING: _____ B. WING _____	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 160	Continued From page 53 facility. There was a meeting conducted related to Resident #2's care. Resident #2's daughter said there was no follow up since then. During an interview on at 10:10 a.m., the DCS said she was at home when she was notified by the Assistant Director of Nursing (ADON) that there was an issue related to Resident #2's care. The DCS said Resident #2 did not receive proper care. The DCS said she went to the facility and had a meeting with Resident #2's family. The DCS said they discussed care issues related to Resident #2. The DCS said she did not fill out a grievance related to incident that took place on . During an interview on 1:30 p.m., the Executive Director (ED) confirmed there was no grievance for Resident #2's incident on . In a follow up interview on at 9:10 a.m., the ED said she had a follow up meeting with the DCS after the incident that took place on , but did not have a formal grievance related to Resident #2. Class III .	A 160		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 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	A 165		

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A 165	Continued From page 54 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 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, through the agency's online portal, or if the portal is offline, by electronic 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, through the agency's online portal, or if the	A 165		

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A 165	Continued From page 55 portal is offline, by electronic 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 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.	A 165		

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A 165	Continued From page 56 (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review, and staff interview, the facility failed to file an adverse incident for 1 (Resident #2) out of 2 residents reviewed. Further the facility failed to follow their Incident Report Policy and Procedure. Findings included: Record review of the facility "Policy Name: Incident Report. Policy Number: 1003. Effective Date: Policy: A Licensed Nurse in charge of the resident's care and treatment is responsible for completing an Incident Report in point and click care (software program) immediately following any reported or witnessed occurrences of an incident, accident or injury involving a patient. Procedure: . . . 1. A licensed nurse will complete the Incident Record as evaluation and appropriate treatment is initiated. . . 5. If the incident or accident is a reportable occurrence to the State Regulatory Agencies, the Wellness Director and the Executive Director will be responsible for initiating timely and efficient investigative reporting and follow up concurrent with company policy." 1. Record review revealed Resident #2, is a female with a date of admission of . Diagnoses included , left surgery. The last Health Assessment Form 1823 dated , noted the resident was During an interview on at 9:38 a.m.,	A 165		

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A 165	Continued From page 57 Resident #2's spouse discussed 2 incidents which occurred with his wife. Resident #2's spouse said he observed [redacted] on Resident 2's left [redacted] and index [redacted] on [redacted]. He said he reported the injuries to the Director of Clinical Services (DCS), who excused the [redacted] suggesting his wife "caught it in the bed," but did nothing further to find out what happened. Resident #2's spouse said he took her to the Emergency Clinic on [redacted] and [redacted] showed a [redacted] of the left [redacted] index [redacted]. He said the family had placed an approved surveillance video camera in Resident #2's room. He said when the family reviewed the video surveillance recording it showed around 7:00 a.m. on [redacted] three staff members assisting Resident #2 to get dressed and showed a staff bending his wife's left index [redacted]. He said his wife was heard screaming, "You're hurting my [redacted]." On [redacted], observation of the camera recording shows 3 staff (Staffs C, D, and E) in the resident's room. Staff E is observed holding Resident #2's right [redacted] and squeezing it, Staff C is observed facing the resident and telling her they are trying to put her shirt on her. Staff D attempts to put a shirt over her [redacted] and as Resident #2 bends forward to protect her [redacted], Staff D places her right [redacted] on Resident #2's forehead and pushes her [redacted] into the chair, once the shirt is on, Staff D is observed holding the left index [redacted]. Resident #2 is heard throughout the video screaming, "You're hurting my [redacted]. Ow ow ow." **Video evidence on file** During an interview on [redacted] at 10:10 a.m., the DCS confirmed Resident #2's spouse showed her Resident #2's [redacted]. The DCS confirmed the next day Resident #2's spouse informed her he was taking Resident #2 to the ER for evaluation.	A 165		

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A 165	Continued From page 58 The DCS confirmed that Resident #2's spouse informed her of the . DCS confirmed there was no investigation related to the incident that took place on ; no staff were removed from service. DCS confirmed she did not file an adverse incident for the . DCS confirmed she did not report the incident to Department of Children and Families (DCF). During an interview on at 9:10 a.m., the Executive Director confirmed that no adverse incident was filed related to the incident that involved Resident #2's index . A report was not filed until 8 days later. Class III .	A 165		