RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Emeritus At Ocala West
9070 SW 80th Ave
Ocala, FL 34481

Re: CCR #2013012103

Dear Administrator:

This letter reports the findings of a complaint inspection survey conducted on 2013 through 2013, by representatives of the Agency for Health Care Administration. Enclosed is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **five business days** of receipt of this hand delivered report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0030 - Failure to ensure a resident was free from ...
St - A - 0165 -Failure to file a one day Adverse Incident report.

Directed Corrective Actions:

1. Review and train all employees on the facility's ... Prevention, Identification and Reporting Policy emphazing the immediate removal of a resident from a dangerous situation. Create and maintain a list of all employees who participated in the training for Agency review.

2. Enforce the facility's guest policy, create and maintain a visitors log for the memory care unit, and have visitors sign the visitor's log before visitors are granted entry to the memory care unit. Have all visitors sign out when leaving the memory care unit.

3. Develop a policy and procedure for reporting Adverse Incidents to the Agency. The policy shall delegate responsible person(s) and time frames for reporting.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Emeritus At Ocala West
, 2013

Should you have any questions, please call Jasmine Hayes, Health Facility Evaluator Supervisor at (386) 462-6201.

Sincerely,

Kristie J. Mennella
Field Office Manager

KJM/jh

Received by:

Administrator

12/20/13
Date

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Alachua Field Office
14101 N W Hwy 441, Suite 800
Alachua, FL 32615-5669
Phone (386) 462-6201; Fax (386) 418-5300

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964969	**12/13/2013**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Ocala West	**9070 Sw 80th Ave Ocala, FL 34481**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= G
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Specific Tag Findings:

0000-Initial Comments

On . 2013 through , 2013 an unannounced compliance survey CCR# 2013012103 was conducted at Emeritus at Ocala West Assisted Living Facility located in Ocala, Florida. Deficiencies were identified as a result of this survey. The facility was not in compliance.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on interview and record review the facility failed to ensure 1 (Resident #3) of 5 residents sampled were free from by not immediately removing the resident from dangerous situation.

The findings include:

1. On at approximately 11:00 a.m. The Resident Care Director (RCD) was interviewed. The (RCD) stated the facility ' s policy if there is an allegation or suspicion of the staff must contact the RCD and if the RCD is not available the staff must contact the Executive Director before taking action. She stated the executive director or resident care director per policy are to report facility allegations of and neglect.

2. On at 4:45 AM an interview was conducted with the Executive Director (ED) and the RCD. Both stated that visitors are to sign-in and out when visiting a resident. Between 5:00 PM - 7:00 PM, there is not a staff person on-duty at the front desk to monitor visitation.

3. On at 8:40 AM another interview was conducted with the RCD. The RCD confirmed she received a phone call from facility regarding an issue in Resident #3 ' s resident #3 was heard screaming. The RCD stated it took her approximately 10 minutes to arrive to the facility. The RCD stated when she arrived to the facility she went to Resident #3 ' s with Staff A and Staff B. The RCD confirmed Resident #3 ' s male visitor was still in the that time.

4. On at approximately 8:50 PM an interview was conducted with Staff D. Staff D stated on she was passing the evening medication near Resident #3 ' s heard Resident #3 yelling, " That hurt. " Staff D stated she unlocked Resident #3 ' and entered the . Staff D described Resident #3 ' s dark. Staff D stated when she walked in the observed a male visitor with Resident #3 and added the male visitor threw covers over Resident #3 when she walked into the . Staff D stated this was a, " red flag " for her. Staff D stated she told Resident #3 she would return with the evening medications. Staff D admitted she left Resident #3 in the the male visitor and went to call the RCD. Staff D reported approximately 15 minutes elapsed between the

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time she contacted the RCD and the time it took for the RCD to arrive at the facility then go to Resident #3 ' s (along with Staff A and B). Staff D stated the facility ' s and neglect policy is to report all suspected and neglect to the RCD or call the hotline.

5. A Review of Resident #3 Event First Responder Worksheet report revealed staff D had to contact the RCD (Resident Care Director) before intervening in the incident dated . Written statement from the RCD indicated that she received a phone call that Resident #3 was heard saying to her male visitor "Stop, stop that hurts." The statement revealed that the direct-care staff went into the "all the lights were off except residents TV." The statement revealed the staff person "walked into the resident ' s male visitor threw residents blankets over her." The statement revealed that the direct-care staff person contacted the RCD via telephone. According to the written statement the RCD came to the facility, entered Resident #3's two direct care staff and discovered that the resident did not have on her undergarments. The facility was unable to provide a written protocol for reporting on

6. A review of a written statement from Staff D (dated revealed Staff D ' s action on

Staff D wrote, " I was outside the door of the Resident #3 and I heard her yelling and saying, " ' that hurt ' ", and the gentleman in the , " ' just stay still ' ", than he said, " ' let me go wash my hands. ' " Than I unlock her it was very dark in the threw the blanket over Resident #3, and I told Resident #3 I will be in to give her 8 PM meds. I told the other med tech and the two . What I heard and observed. I call the RCD. I informed her of what is going on and what I heard and observe. She said that she is calling the EDD, Than she call back shortly and said she was on her way. "

7. A review of the local sheriff ' s office report revealed on Staff D was interviewed by a detective. The detective wrote, " She (Staff D) Advised that she observed the suspect, now known as the defendant, with his hands on the victim ' s . She advised the victim did not have any under garments on. She then told the victim that she was going to provide her with her 2000 hours (8:00 PM) medications. She left the I contacted other personnel so she could report this. "

8. A review of a written statement from Staff B (dated revealed Staff B ' s observations of Resident #3 and the male visitor on after Staff D left Resident #3 and the male visitor in the Staff B wrote, " I walked in her [Resident #3 ' s] another co-worker and seen Resident #3 ' s [male visitor] with his hand on her (Resident #3 ' s) private area and he covered her up real fast and we pulled the cover back Resident #3 had on no underwear. " The statement revealed Staff A, then got Resident #3 out of bed and too her into the " Resident #3 " ask me to stay with her and she wanted that man out of her "

9. A review of the facility ' s policy on Prevention, Identification and Reporting (Provided on revealed the facility ' s policy is to, " Protect residents from physical, mental fiduciary

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(financial), [illegible] and [illegible]." The facility's policy states immediate action in response to alleged [illegible] is to remove resident(s) from immediate danger. A continued review of the policy revealed the facility defines [illegible] as:

"Any form of non-consensual contact including but not limited to unwanted or inappropriate touching, [illegible], sodomy, [illegible] coercion, [illegible] explicit photographing and [illegible] harassment. This includes any [illegible] contact between a staff person and a resident, whether or not it is consensual.

10. Review of the facility's guest policy requires visitors to sign in and out when visiting the facility. There is not a staff person at the front desk between the hours of 5:00 PM - 7:00 PM, and at 7:00 PM, the facility doors are locked. Review of the visitors log revealed that guests are not signing in and out after 5:00 PM.

Class II

0165-Risk Mgmt & QA; Adverse Incident Report 429.23 FS; 58A-5.0241 FAC
Based on record review and interview the facility failed to file an initial adverse incident report within 1 business day of the occurrence for 1 (Resident #3) of 5 residents sampled.

The findings include:

1. Review of the resident record for Resident #3 revealed an incident occurred on [illegible] and law enforcement was called out to the facility to invesitigate the incident. A Review of the resident record for Resident #3 revealed that the resident was seen by [illegible] Assault Registered Nurse on [illegible] Resident #3 was examined by her gynecologist on [illegible].

2. A Review of facility records on [illegible] revealed that there were no an initial adverse incident report filed with Agency for Health Care Administration between [illegible] and [illegible].

3. During an interview with the Executive Director on [illegible] at 11:20 AM, revealed that she did not file an adverse incident report. She stated that she was not aware that she was required to submit a 1-Day Adverse Incident Report to the Agency within one business day of the occurrence of the incident.

Class III