STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965569	07/23/2015
NAME OF PROVIDER OR SUPPLIER **BROOKDALE BOCA RATON**	STREET ADDRESS, CITY, STATE, ZIP CODE **9591 YAMATO ROAD** **BOCA RATON, FL 33434**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

An unannounced Assisted Living Facility licensure complaint survey (CCR#2015006141) was conducted on and at Brookdale Boca Raton. The facility had deficiencies found at the time of the visit.

0010 Admissions - Continued Residency

Based on record review, interview and observations, it was determined that the facility failed to ensure a resident's physician had completed a face-to face reassessment of a resident upon significant behavior changes, in which the results of this examination were documented on the Resident Health Assessment form (AHCA form 1823), for 1 out 3 sampled residents ' records reviewed (Resident #1). The facility failed to have this assessment completed to ensure the resident met the criteria for continued residency and that the facility could provide the appropriate level of care and services (including supervision). This was evidence by facility failure to have Resident #1 reassessed by his/her healthcare provider immediately after the resident exhibited a major behavior change resulting in inappropriate behavior with visitors and other residents.

The findings include:

A review of the facility ' s policy and procedure entitled " Supervision and Monitoring of Residents " effective date applies to: Assisted Living, and Care - FL showed the following relevant information:

" Supervision and monitoring of residents will be done by associates as dictated by the service plan. Associates will be available in sufficient numbers with adequate training to ensure the well-being of residents while honoring resident rights and preferences "

Policy Detail
1. Residents will be assessed prior to move in and a temporary care plan will be implemented upon admission. A comprehensive service plan will be completed within 14 days after admission
2. Residents will be supervised to various degrees as identified in their assessment.
3. Supervision may include but is not limited to supervision of activities of activities of daily living, medications, assuring residents rights are met, participation in programs, meal intake, wandering and overall level of functioning.
4. If there are significant changes in a resident ' s physical, emotional or mental functioning, the service plan will be updated to reflect these changes as they occur.
5. As a result of the service plan, appropriate supervision and monitoring of residents will occur.

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Review of Resident #1 ' s record indicated that she was admitted to the facility (non-secured unit) on . Review of Resident #1 ' s Health Assessment form (AHCA form 1823) dated documented a diagnosis including , memory disturbance, , and . Further review of the form indicated that the resident ' s and behavioral status as follows: memory issues, unable to remember short term memories. Unable to make any decisions independently, daughter has power of attorney. The form also document service requirements: assistance with meals, medications, check on her whereabouts and well -being. Resident#1 ' s ADL levels noted to be independent. It is noted that the resident does not pose a danger to self or others and does not require 24 nursing or care.

Further record review revealed the Resident #1 was transferred from the non-secured ALF unit to the secured unit on due to various significant behavior changes. The following behaviors were noted within the residents file that contributed to the decision of the facility and family to move the resident to the memory care unit.

a) A review of Resident #1 ' s record revealed a personal service plan dated indicating that she previously attended an adult day care program on Tuesdays from 9:00 AM- 1:00PM. And that she will continue to attend the program.
b) A review of Resident #1 ' s record revealed a monthly progress note dated from the adult day care program indicating that she has periods of about going home. Sometimes she is very difficult to redirect. She is very flirtatious with men. She has over how she knows everyone here.
c) A review of Resident #1 ' s record revealed a monthly progress note dated from the adult day care program indicating that small group activities really seem to be most appropriate. She is redirected as needed away from flirtatious behavior.
d) A review of Resident #1 ' s record revealed a facility progress note on her resident log dated at 10:00 AM indicating an employee prospect was in the living area awaiting an interview, this resident sat next to him and touched his this incident was reported to the Executive Director and the family (Resident #1) was notified.
e) A review of Resident #1 ' s record revealed a facility progress note on her resident log dated at 1:00 PM indicating That Resident #1 transferred to the memory care unit on
Record review failed to indicate a new AHCA form 1823 was completed upon transfer to the secured unit and after aforementioned behavior changes for Resident #1. During an interview with the Health and Wellness Director and the Administrator(Executive Director), it was revealed the facility had not updated Resident #1's Health Assessment and that the facility did not have any documentation indicating a new assessment reflecting the resident current diagnosis, care needs and supervision needs. The Administrator acknowledged that the resident exhibited significant behavior changes and is still

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exhibiting behavior changes.

Review of the facility's service plan dated revealed the following. The resident is independent with all ADLs except showering and bathing in which the resident requires assistance. The resident ' s behavior is noted as wandering and requiring redirection.

In an interview conducted on at 10:07 AM with the daughter of Resident #1, she stated that Resident #1 was discharged from adult day care center in mid- 2015, due to not participating in activities, unable to stay focused and flirtatious behavior including touching others. She stated that Resident #1 was moved to the memory care unit in 2015, due to her wandering, flirtatious behavior and need for more supervision. She states that on the Executive Director called her while she was driving home at about 7:30 PM to inform her that she had just left the facility, an incident occurred at the facility involving Resident #1 and the husband of Resident #2 involving a encounter; that they would be placing an aide with Resident #1 from 8 AM- 8PM for 1 to 1 supervision and that she would have 45 days to look for a new place for Resident #1. She stated that she initiated an appointment with the Dr. and took Resident #1 to see her primary care physician on and he prescribed a new medication and recommended a referral to a psychiatrist, she has made an appointment with a psychiatrist. However, the resident has not been seen by the psychiatrist as of the date of the survey.

During an interview conducted on at 1:25 PM with the Director of the Memory Care and Adult Day Care Center , she stated that Resident #1 was admitted to the daycare center because the daughter wanted her mother to receive additional stimulation, and since they are specific, that is where she wanted her to be. The reason for her discharge was due to her diminished cognition, they cater to mild to moderate level and Resident #1 could no longer stay focused and was unable to keep up with the activities, she was unable to engage and follow the activities. She was also starting to exhibit some touching behaviors towards the other participants especially the males.

During an interview conducted on at 10:00 AM with the Executive Director, she confirmed that the reason Resident #1 was moved to the memory care unit was because her behavior was changing, she began to wander and was looking for her cat , her husband and would go in the kitchen.

Observations of the resident on from 10 AM to 5PM and from 10 AM to 11:30 AM, revealed that the resident was and wandering throughout the unit. Attempted interview with the resident, at this time, revealed she was

Additional confidential interviews revealed that Resident #1 is still exhibiting increased inappropriate behaviors.

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During an exit conference with the Administrator on [redacted] at 4PM, she acknowledged aforementioned and stated the facility had no further documentation. She further confirmed that the facility had no documentation or evidence indicating the resident had been reassessed by her physician and that the facility had also completed an assessment to ensure the resident met the criteria for continued residency.

Please see A 0025, A 0030 and A 0077

Class II

0025 Resident Care - Supervision

Based on observation, interview and record review, it was determined that the facility failed to provide care and services appropriate to meet the needs of resident; who have been identified as requiring special care , due to a diagnosis of [redacted] by not supervising and not promoting the safety and well-being of 1 of 3 at- risk residents (Resident #1). This was evidenced by the facility ' s failure to maintain a general awareness of Resident #1 ' whereabouts within the unit, supervision based on recent behavioral changes, maintain a written record of significant changes and failure to implement the facility ' s own policies of "Supervision and Monitoring of Residents and [redacted] Neglect and [redacted]

The findings include:

A) A review of the facility ' s policy entitled " Supervision and Monitoring of Residents " effective date [redacted] revealed the following relevant information:

" Supervision and monitoring of residents will be done by associates as dictated by the service plan. Associates will be available in sufficient numbers with adequate training to ensure the well-being of residents while honoring resident rights and preferences "

A review of the Facility ' s policy entitled " [redacted] Neglect & [redacted] " effective date [redacted] and last revised on [redacted] revealed the following relevant information:

Policy Overview
" Our company policy is committed to maintaining a safe environment for each resident, visitor and associate. Instances or allegations of [redacted] neglect or [redacted] should be treated seriously and must be reported to the Executive Director or the supervisor on duty for investigation and appropriate follow-up " .

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Policy Detail

1. Definitions:

a) is defined in Florida as any willful act or threatened that causes or is likely to cause significant to a adult ' s physical, mental, or emotional health. includes acts and omissions.

b) Neglect is defined in Florida as the failure or omission on the part of the caregiver to provide care, supervision and services necessary to maintain the physical and mental health of the adult, including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services, that a prudent person would consider essential for the well-being of the adult. The term " neglect " also means the failure of a caregiver to make reasonable effort to protect a adult from neglect or by others. " Neglect " is repeated conduct or a single incident of carelessness which produces or could reasonably be expected to result in serious physical or injury or a substantial risk of .

2. Parties Potentially Involved:

a. Two or more residents.

b. One or more residents, family members and /or visitors

c. One or more residents and associates.

3. Internal Reporting:

a. Any associate who witnesses or becomes aware of alleged , neglect or should report such incident to the Executive Director.

b. The Executive Director should report the incident to the District/Regional Director of Operations immediately and should refer to the Reportable Events Policy and Reportable Events Categories/Reporting Time Frames Chart for specific timelines and internal reporting requirements.

4. Response to Incident:

a. Protection of Resident. Upon learning of alleged , neglect or , the Executive Director should attempt to take necessary steps to ensure that residents are protected from subsequent episodes of , neglect or while a determination on the matter is pending.

b. Provision of Medical Attention. Any person who is harmed during an incident should be provided medical attention, as appropriate.

c. Resident on Resident Contact. If an incident involves resident on resident contact, both residents should be separated and evaluated for a change in condition. Residents exhibiting aggressive behavior should be considered for continued appropriateness and interventions should be developed to address their behaviors. The Resident Assessment and Service Plan should be updated as appropriate.

5. Investigation:

a. Internal Investigation. . Upon receipt of an allegation of , neglect or , the Executive Director should conduct an internal investigation of the incident.

6. External Reporting/Notification

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a. Notifying Responsible Party.
b. Notifying Physician
c. Report to the Central Hotline. The Executive Director, in consultation with the District /Regional Director of Operations, should report known or suspected neglect or and all allegations of , neglect or to the Department of Children and Family Services Central Hotline.
d. Involvement of Law Enforcement. The Executive Director should notify local law enforcement when it appears that a crime has been committed.
7. and/or Procedure. In the event of suspected or , the following procedure should also occur in addition to the procedure above.
a. Develop Plan. A plan should be developed as soon as practible and implemented to protect the suspected victim.
b. Medical Examination. The suspected victim should have a medical examination as soon as possible. Prior notice should be given to the examining physician that the individual may have been raped or abused.

During the tour of the memory care unit conducted on at 11:30 AM with the Executive Director, an observation was made in the nurses station of a note on the white board stating to not let Resident #2 go out with husband. The son does not want his mom out with the husband.

During an interview conducted on at 11:30 AM with the Executive Director, she was questioned as to why Resident #2 cannot go out with her husband, and she stated that an incident occurred on at 7:00 PM with the husband of Resident #2, and Resident #1, in which staff observed Resident #1 performing [o...] on the husband of Resident #2 in the day The Executive Director confirmed that she did not come to the memory care unit that evening after being notified of the incident, she also did not contact law enforcement, Adult Protective Services (APS) or conduct an internal investigation of the incident. She states that after the incident she called a home health agency to send an aide for 1 to 1 supervision of Resident #1, from 8AM-8PM, Friday - Tuesday on She also informed the family of Resident #1 of the incident.

In an interview conducted on at 11:55 AM with Private Duty Aide #1, she stated that on, Thursday at approximately 7:15 PM, she was heading from her resident 's the laundry she then observed in the passage way going to the front door the husband of Resident #2 was standing with his [p....] in his hand and Resident #1 had her mouth on it. She was the first one that saw it so she called out to the facility staff, there were 2 staff present at the time, Staff A and Staff B. The husband was trying to get his [p....] back in his pants. Staff A was cleaning up the dining Staff B was transporting the residents back to the TV dinner. She demonstrated to the surveyor, where the incident occurred and it was in the hallway going to the resident , around the corner

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from the day .

Immediately after the interviews surveyor attempted to conduct a record review to further evaluate the incident as revealed by above parties. However, record review revealed 1 note on a piece of paper that states the following : Resident #1 (...) was caught given [o..] to another resident ' s husband, dated Thursday 7:45 Pm 11, 2015 and unsigned. Further record review of the residents file and facility records revealed no further documentation or investigation of the incident that included at minimum the parties involved and witnessess, details regarding the incident, location of the incident , assessment for injuries and/or medical treatment and steps taken to prevent reoccurrence. Further interview with the Executive Director revealed the facility had no further documentation regarding the incident other than aforementioned note found in the file.

B) Review of Resident #1 record revealed the following information:
1) The resident was admitted to the facility (non-secured unit) on . Review of Resident #1 ' s Health Assessment dated documented a diagnosis including , memory disturbance, , and . Further review of the form indicated that the resident ' s and behavioral status as follows: memory issues, unable to remember short term memories. Unable to make any decisions independently, daughter has power of attorney. The form also document service requirements: assistance with meals, medications, check on her whereabouts and well -being. Resident#1 ' s ADL levels noted to be independent. It is noted that the resident does not pose a danger to self or others and does not require 24 nursing or care.

Further record review revealed the Resident #1 was transferred from the non-secured ALF unit to the secured unit on due to various significant behavior changes. The following behaviors were noted within the residents file that contributed to the decision of the facility and family to move the resident to the memory care unit.
2) A facility personal service plan dated indicating that she previously attended an adult day care program on Tuesdays from 9:00 AM- 1:00PM.
The following monthly progress notes from the adult day care program were reviewed:
3) Resident #1 has periods of about going home. Sometimes she is very difficult to redirect. She is very flirtatious with men. She has over how she knows everyone here.
4) small group activities really seem to be most appropriate. Resident #1 is redirected as needed away from flirtatious behavior.
The following facility progress notes were reviewed:
5) at 10:00 AM indicating an employee prospect was in the living area awaiting an interview, Resident #1 sat next to him and touched his this incident was reported to the Executive Director and the family was notified.
6) at 1:00 PM indicating That Resident #1 transferred to the memory care unit on .

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7) [redacted] at 2:00 PM indicating that Resident #1 was putting her hands under another resident ' s blouse and feeling her chest. Resident #1 was also kissing other females on the mouth.
8) [redacted] at 10:00 AM indicating that Resident #1 tried to kiss another female resident on the mouth, stating " I thought she was a man " .
9) [redacted] at 11:00 AM indicating that Resident #1 tried to kiss another female resident on the mouth.
10) A review of Resident #1 ' s record revealed a one page document dated [redacted] at 7:45 PM stating Resident #1 was caught giving [o...] to another resident ' s husband. Staff B confirmed that she was the author of the document, but the document was not signed. This document contained no further information.

C) The following staff interviews were conducted:
1) Staff B was interviewed on [redacted] at 2:27 PM , she stated on [redacted] she worked from 2:30 PM - 10:30 PM, Private Duty Aide #1 called her, at the time she was down the hall assisting another resident to her [redacted] she came over and observed the husband of Resident #2 pulling up his zipper and putting himself together, Resident #1 was with her back against the corner. She stated that she was unable to get in touch with the Executive Director, so she called the Business Office Manager, who advised her to call law enforcement. Subsequently, the Executive Director did call back, and advised to them to not call law enforcement and let him stay at the facility, but to supervise them. She stated the Executive Director did not come to the facility that evening and that the husband of Resident #2 never left the facility while she was working.
2) Staff A was interviewed on [redacted] at 5:10 PM, she stated on [redacted] she worked from 2:30 PM- 10:30 PM. Staff A stated at the time of the incident with Resident #1 and the husband of Resident #2 she was working in the kitchen and by the time she got to where they were at she did not observed anything. She confirmed that the husband of Resident #2 stayed at the facility and never left and that the Executive Director never came to the facility the evening of [redacted]
A review of the facility ' s staff schedule for [redacted] for the 2:30 PM- 10:30 PM shift revealed that Staff A and Staff B were the only staff scheduled to work.
3) Staff D was interviewed on [redacted] at 2:27 PM , she stated she normally works the 6:30 AM-2:30 PM shift she stated that Resident #1 is always exhibiting behaviors towards men, always attempting to touch them and is always attempting to kiss the other women residents. She feels that there is not enough staff for the residents.
4) Staff E was interviewed on [redacted] at 2:38 PM , she stated she normally works the 6:30 AM-2:30 PM shift. She stated that Resident #1 is always acting inappropriately towards men and sometimes towards women, anytime she sees a man she tries to kiss them. She feels there is not enough staff to supervise the residents.
5) During an interview conducted with the Health and Wellness Director on [redacted] at 4:02 PM , she stated that on [redacted] she was notified of the incident regarding Resident #1 and the husband of Resident #2. She attempted to call the Executive Director but was unable to contact her, so she called

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her supervisor, the regional nurse, who advised her to hire a private duty to sit with Resident #1 and for the husband of Resident #2 to leave the facility. She was on leave that day, she sent the Executive Director a message indicating the directions from regional and the Executive Director responded stating that she was just leaving the facility and that Resident #1 was in bed and the husband of Resident #2 was sitting in the lobby with Resident #2 and should be leaving shortly.

6) Interview conducted on at 11:09 AM with the facility ' s Regional Nurse, she states that the Health and Wellness Director, called her on and explained the situation in respect to Resident #1 and the husband of Resident #2 as an adverse incident. She advised her that the husband needed to leave the facility, and that he would be unable to return until administration, decides on the next steps to take. This is what needed to be communicated to staff; she did not advise them to contact LE. She is aware that the facility did not take her advice. She does know that the Executive Director was made aware and was at the facility on at that point it became an operational issue. She spoke to the Regional Operational Director on and he stated he was aware of the situation, but come to find out it was about another situation that occurred at the facility on the same day.

7) Staff C was interviewed on at 11:40 AM, who worked on from 10:30 PM - 6:30 AM, from 2:30 Pm - 6:30 AM and again on from 2:30 Pm - 10:30 PM and on Monday from 4:30 PM -10:30 PM; she confirmed that the husband of Resident #2 did spend the night a couple of nights while she was working, she could not remember which night it was. She did not speak to the Executive Director, but the other staff told her he had stayed the night before, and that he was going to move in. That is the reason she did not report it to management. She stated she was present on Sunday when the husband came out of Resident #2's coming after Resident #2, they were both naked.

8) Staff F was interviewed on at 11:58 AM , who worked on from 2:30 PM- 6:30 AM and from 10:30 AM- 6:30 AM, she observed the husband of Resident #2 spend 2 nights at the facility. She asked him why he was there and he told her that he moved in. She thought it was true, and thought it was ok for him to be there. She did report to the day staff that he was there.

9) Subsequent interview conducted on at 4:47 PM with Staff A, she states that on the next evening after dinner , in the dining saw Resident #1 and the husband of Resident #2 sitting next to each other. He had a blanket over himself, she was sitting next to him, she came over and asked what was going on , but by that time all she observed was Resident #1's hand come up. She separated them and stated that Resident #1 did not have a private duty aide with her at that time. On she observed the husband of Resident #2 come out of Resident #2's after his wife, both were naked. She did call the Executive Director that night and she advised them to keep them separate and keep an eye on them.

10) During an interview conducted on at 10:20 AM with the facility ' s Memory Care Coordinator, she stated that she worked on and came in at about 7:45 AM, at that time she observed the husband of Resident #2 in the his wife naked, he had spent the night. She states that the night staff told her he had spent the night and that the Executive Director was aware, the Executive

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Director came over that day at about 10:30 AM and observed him. She states that the staff reported to her that he was involved in activities with the wife in her When the Executive Director came over that morning she went into the Resident #2 and when she came out she told staff that he would be bringing his wife out shortly. He was eating 3 meals a day there that weekend, and that day he did have breakfast. Staff also told her that he had been there all weekend, and all the staff knew he had been there all weekend. She came in on her day off on and he was there in bed naked with his wife. She states that the Executive Director knew he had been there all weekend. She states that the Executive Director told staff that he could stay at the facility.

11) In an interview conducted on at 10:35 AM with Private Duty Aide #2, she stated that she has been with Resident #1 since last week; she works from 7:30am- 8:00 PM. She states that the most Resident #1 does is try to kiss the other residents and that is why she was hired, she states she worked the first time the agency was hired, for a couple of days and at that time she did see the husband of Resident #2 on that weekend, but she has not seen him since she came back to work.

12) In an interview conducted on at 10:00 AM, with the Health and Wellness Director, she stated she was off the weekend of , but when she came in on Monday ; she was notified by staff that the husband of Resident #2 was at the facility all weekend. At approximately 10:30 AM on , she went to conduct her rounds at the memory care unit, and that is when she observed the husband of Resident #2 still at the facility. She called her regional nurse, who advised her that the husband of Resident #2 needed to leave the facility immediately, she went up to the husband of Resident #2 who told her that he was told he could live there, but she informed him that he was not a resident and assisted him in packing up his things and escorted him out of the building. She could not remember which staff told her he had been staying the weekend.

D) A review of the record of Resident #2 ' s resident log revealed the following relevant progress notes:

1) at 8 IS as follows: I was informed that this resident's husband has been staying the night here. I was informed he has been inappropriate. He swore at me but in fact took the items and placed them in the trunk of his car. I advised him he was welcome to visit during the day but must sleep at home. He states he was told he could live here. I advised he was not a resident of this community. This was written by the health and wellness director.

2) at 4:30 PM as follows: per administration, the business office manager and myself we spoke with husband of Resident #2 and per our order escorted him out of the community. I assisted him in packing his personal belongings and he left. He did become angry and swore to us but was not physical. This was written by the health and wellness director.

E) In an interview conducted on at 10:07 AM with the daughter of Resident #1, she stated that Resident #1 was discharged from adult day care center in mid- 2015, due to not participating in activities, unable to stay focused and flirtatious behavior including touching others. She stated that Resident #1 was moved to the memory care unit in 2015, due to her wandering, flirtatious

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behavior and need for more supervision. She states that on the Executive Director called her while she was driving home at about 7:30 PM to inform her that she had just left the facility, an incident occurred at the facility involving Resident #1 and the husband of Resident #2 involving a encounter, and that they would be placing an aide with Resident #1 from 8 AM- 8PM for 1 to 1 supervision and that she would have 45 days to look for a new place for Resident #1. She stated that she initiated an appointment with the Dr. and took Resident #1 to see her primary care physician on and he prescribed a new medication and recommended a referral to a psychiatrist, she has made an appointment with a psychiatrist. They did not mention anything about the husband of Resident #2. She states that one of the aides told her that she observed the husband of Resident #2 running down the hall naked. All she knows about him was that he would come to the facility and have breakfast, lunch and dinner.

In an interview conducted on at 10:00 AM with the Executive Director, she confirmed that on she did not deal with the situation involving Resident #1 and the husband of Resident #2, as she was involved in another situation with another resident at the same time. She received the first call letting her know about the incident, she asked where Resident #1 and the husband of Resident are #2 now, and instructed staff to keep them apart and make sure they are safe. She confirmed she did not go over to the memory care unit. She then received a second call from staff informing her that Resident #1 was in bed and that Resident #2 and her husband were on the couch watching TV, so she assumed he would do as he normally does and leave after the visit. She stated that on she went over to the memory care unit at about 10:30 AM and the staff reported to her, the husband was not allowing staff to get Resident #2 ready. So she went to their talked to them and he stated he would bring her out. She also stated that the reason that Resident #1 was moved to the memory care unit was because her behavior was changing, she began to wander and was looking for her cat, her husband and would go in the kitchen.

During an exit conference with the Administrator on at 4PM, she acknowledged aforementioned and stated no further documentation was available for review. She also confirmed that the facility should have reported the incident to local law enforcement and Department of Children and families. She also stated " I take full responsibility for the incident and that it was not handle appropriately".

Please see A 0010, A 0030 and A 0077

Class II

0030 Resident Care - Rights & Facility Procedures

Based on record review and interview, it was determined the facility failed to ensure residents ' reside in

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a safe living environment free from and neglect. This was evidence by the facility staff's failure to implement their own , neglect policy and to report to law enforcement and DCF any signs of and neglect for all residents residing in the secured unit. And to protect a resident who did not have the ability to make an independent judgement and suffered from from her own dangerous behavior and to protect other residents residing in the secured unit from this resident's behavior.

The findings include:

A review of the Facility ' s policy entitled " , Neglect & " effective date and last revised on revealed the following relevant information:

Policy Overview
" Our company policy is committed to maintaining a safe environment for each resident, visitor and associate. Instances or allegations of neglect or should be treated seriously and must be reported to the Executive Director or the supervisor on duty for investigation and appropriate follow-up " .
Policy Detail
1. Definitions:
a) is defined in Florida as any willful act or threatened that causes or likely to cause significant to a adult ' s physical, mental, or emotional health. includes acts and omissions.
b) Neglect is defined in Florida as the failure or omission on the part of the caregiver to provide care, supervision and services necessary to maintain the physical and mental health of the adult, including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services, that a prudent person would consider essential for the well-being of the adult. The term " neglect " also means the failure of a caregiver to make reasonable effort to protect a adult from neglect or by others. " Neglect " is repeated conduct or a single incident of carelessness which produces or could reasonably be expected to result in serious physical or injury or a substantial risk of

2. Parties Potentially Involved:
a. Two or more residents.
b. One or more residents, family members and /or visitors
c. One or more residents and associates.
3. Internal Reporting:
a. Any associate who witnesses or becomes aware of alleged , neglect or , should report such incident to the Executive Director.

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b. The Executive Director should report the incident to the District/Regional Director of Operations immediately and should refer to the Reportable Events Policy and Reportable Events Categories/Reporting Time Frames Chart for specific timelines and internal reporting requirements.
4. Response to Incident:
a. Protection of Resident. Upon learning of alleged , neglect or , the Executive Director should attempt to take necessary steps to ensure that residents are protected from subsequent episodes of , neglect or while a determination on the matter is pending.
b. Provision of Medical Attention. Any person who is harmed during an incident should be provided medical attention, as appropriate.
c. Resident on Resident Contact. If an incident involves resident on resident contact, both residents should be separated and evaluated for a change in condition. Residents exhibiting aggressive behavior should be considered for continued appropriateness and interventions should be developed to address their behaviors. The Resident Assessment and Service Plan should be updated as appropriate.
5. Investigation:
a. Internal Investigation. . Upon receipt of an allegation of , neglect or , the Executive Director should conduct an internal investigation of the incident.
6. External Reporting/Notification
a. Notifying Responsible Party.
b. Notifying Physician
c. Report to the Central Hotline. The Executive Director, in consultation with the District /Regional Director of Operations, should report known or suspected , neglect or and all allegations of , neglect or to the Department of Children and Family Services Central Hotline.
d. Involvement of Law Enforcement. The Executive Director should notify local law enforcement when it appears that a crime has been committed.
7. and/or Procedure. In the event of suspected or , the following procedure should also occur in addition to the procedure above.
a. Develop Plan. A plan should be developed as soon as practible and implemented to protect the suspected victim.
b. Medical Examination. The suspected victim should have a medical examination as soon as possible. Prior notice should be given to the examining physician that the individual may have been raped or abused.

In an interview conducted on at 11:55 AM with Private Duty Aide #1, she stated that on, Thursday at approximately 7:15 PM, she was heading from her resident ' s the laundry she then observed in the passage way going to the front door the husband of Resident #2 was standing with his [p...] in his hand and Resident #1 had her mouth on it. She was the first one that saw it so she called out to the facility staff, there were 2 staff present at the time, Staff A and Staff B. The

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husband was trying to get his [p....]back in his pants. Staff A was cleaning up the dining . Staff B was transporting the residents back to the TV dinner. She demonstrated to the surveyor, where the incident occurred and it was in the hallway going to the resident around the corner from the day .

The Executive Director confirmed that she did not come to the memory care unit that evening after being notified of the incident, she also did not contact law enforcement, Adult Protective Services (APS) or conduct an internal investigation of the incident. She states that after the incident she called a home health agency to send an aide for 1 to 1 supervision of Resident #1, from 8AM-8PM, Friday - Tuesday . She also informed the family of Resident #1of the incident.

Immediately after the interviews surveyor attempted to conduct a record review to further evaluate the incident as revealed by above parties. However record review revealed 1 note on a piece of paper that states the following: Resident #1 (...) was caught given [o.....] to another resident ' s husband, dated Thursday 7:45 Pm 11, 2015 and unsigned. Further record review of the residents file and facility records revealed no further documentation or investigation of the incident that included at minimum the parties involved and witnesses, details regarding the incident, location of the incident , assessment for injuries and/or medical treatment and steps taken to prevent reoccurrence. Further interview with the Executive Director revealed the facility had no further documentation regarding the incident other than aforementioned note found in the file.

B) Review of Resident #1 record revealed the following information:
1) she was admitted to the facility (non-secured unit) on . Review of Resident #1 ' s Health Assessment dated documented a diagnosis including , memory disturbance, , and . Further review of the form indicated that the resident ' s and behavioral status as follows: memory issues, unable to remember short term memories. Unable to make any decisions independently, daughter has power of attorney. The form also document service requirements: assistance with meals, medications, check on her whereabouts and well -being. Resident#1 ' s ADL levels noted to be independent. It is noted that the resident does not pose a danger to self or others and does not require 24 nursing or care.

Further record review revealed the Resident #1 was transferred from the non-secured ALF unit to the secured unit on due to various significant behavior changes. The following behaviors were noted within the residents file that contributed to the decision of the facility and family to move the resident to the memory care unit.
2) Resident #1 has periods of about going home. Sometimes she is very difficult to redirect. She is very flirtatious with men. She has over how she knows everyone here.
3) small group activities really seem to be most appropriate. Resident #1 is redirected as

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needed away from flirtatious behavior.
The following facility progress notes were reviewed:
4) at 10:00 AM indicating an employee prospect was in the living area awaiting an interview, Resident #1 sat next to him and touched his [g.....], this incident was reported to the Executive Director and the family was notified.
5) at 1:00 PM indicating that Resident #1 transferred to the memory care unit on .
6) at 2:00 PM indicating that Resident #1 was putting her hands under another resident ' s blouse and feeling her chest. Resident #1 was also kissing other females on the mouth.
7) at 10:00 AM indicating that Resident #1 tried to kiss another female resident on the mouth, stating " I thought she was a man " .
8) at 11:00 AM indicating that Resident #1 tried to kiss another female resident on the mouth.

A review of Resident #1 ' s record revealed a one page document dated at 7:45 PM stating Resident #1 was caught giving [o....] action to another resident ' s husband. Staff B confirmed that she was the author of the document, but the document was not signed.
In an interview conducted on at 2:27 PM with facility Staff B, she stated on she worked from 2:30 PM - 10:30 PM , Private Duty Aide #1 called her , at the time she was down the hall assisting another resident to her she came over and observed the husband of Resident #2 pulling up his zipper and putting himself together, Resident #1 was with her back against the corner. She stated that she was unable to get in touch with the Executive Director, so she called the Business Office Manager, who advised her to call law enforcement. Subsequently the Executive Director did call back, and advised to them to not call law enforcement and let him stay at the facility, but to supervise them. She stated the Executive Director did not come to the facility that evening and that the husband of Resident #2 never left the facility while she was working.

In an interview conducted on at 5:10 PM with facility Staff A, she stated on she worked from 2:30 PM- 10:30 PM, at the time of the incident with Resident #1 and the husband of Resident #2 she was working in the kitchen, and by the time she got to where they were at she did not observed anything. She confirmed that the husband of Resident #2 stayed at the facility and never left and that the Executive Director never came to the facility the evening of
A review of the facility ' s staff schedule for for the 2:30 PM- 10:30 PM shift revealed that Staff A and Staff B were the only staff scheduled to work.

In an interview conducted on at 4:02 PM with the Health and Wellness Director, she stated she on she was notified of the incident regarding Resident #1 and the husband of Resident #2. She attempted to call the Executive Director but was unable to contact her, so she called her supervisor, the regional nurse, who advised her to hire a private duty to sit with Resident #1 and for the husband of Resident #2 to leave the facility. She was on leave that day, she sent the Executive Director a message

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indicating the directions from regional and the Executive Director responded stating that she was just leaving the facility and that Resident #1 was in bed and the husband of Resident #2 was sitting in the lobby with Resident #2 and should be leaving shortly.

In an interview conducted on at 11:09 AM with the facility ' s Regional Nurse, she states that the Health and Wellness Director, called her on , and explained the situation in respect to Resident #1 and the husband of Resident #2 as an adverse incident. She advised her that the husband needed to leave the facility, and that he would be unable to return until administration, decides on the next steps to take. This is what needed to be communicated to staff; she did not advise them to contact LE. She is aware that the facility did not take her advice. She does know that the Executive Director was made aware and was at the facility on : at that point it became an operational issue. She spoke to the Regional Operational Director on and he stated he was aware of the situation, but come to find out it was about another situation that occurred at the facility on the same day.

In an interview conducted on at 11:40 AM with Staff C, who worked on from 10:30 PM - 6:30 AM, from 2:30 PM - 6:30 AM and again on from 2:30 PM - 10:30 PM and on Monday from 4:30 PM -10:30 PM, she confirmed that the husband of Resident #2 did spend the night a couple of nights while she was working, she could not remember which night it was. She did not speak to the Executive Director, but the other staff told her he had stayed the night before, and that he was going to move in. That is the reason she did not report it to management. She stated she was present on Sunday when the husband came out of Resident #2's coming after Resident #2, they were both naked.

In an interview conducted on at 11:58 AM with Staff E, who worked on from 2:30 PM- 6:30 AM and from 10:30 AM- 6:30 AM, she observed the husband of Resident #2 spend 2 nights at the facility. She asked him why he was there and he told her that he moved in. She thought it was true, and thought it was ok for him to be there. She did report to the day staff that he was there.

In a subsequent interview conducted on at 4:47 PM with Staff A, a facility med tech, she states that on the next evening after dinner , in the dining saw Resident #1 and the husband of Resident #2 sitting next to each other, and he had a blanket over himself, she was sitting next to him, she came over and asked what was going on , but by that time all she observed was Resident #1's hand come up. She separated them and stated that Resident #1 did not have a private duty aide with her at that time. On she observed the husband of Resident #2 come out of Resident #2's after his wife, both were naked. She did call the Executive Director that night and she advised them to keep them separate and keep an eye on them.

In an interview conducted on at 10:20 AM with, the facility ' s Memory Care Activities Director,

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she stated that she worked on and came in at about 7:45 AM, at that time she observed the husband of Resident #2 in the his wife naked, he had spent the night. She states that the Executive Director knew he had been there all weekend. She states that the Executive Director told staff that he could stay at the facility.

In an interview conducted on at 10:35 AM with a Private Duty Aide #2, she stated that she has been with Resident #1 since last week; she works from 7:30am- 8:00 PM. She states that the most Resident #1 does is try to kiss the other residents and that is why she was hired, she states she worked the first time the agency was hired, for a couple of days and at that time she did see the husband of Resident #2 on that weekend, but she has not seen him since she came back to work.

In an interview conducted on at 10:00 AM, with the Health and Wellness Director, she stated she was off the weekend of but when she came in on Monday she was notified by staff that the husband of Resident #2 was at the facility all weekend. At approximately 10:30 AM on she went to conduct her rounds at the memory care unit, and that is when she observed the husband of Resident #2 still at the facility. She called her regional nurse, who advised her that the husband of Resident #2 needed to leave the facility immediately, she went up to the husband of Resident #2 who told her that he was told he could live there, but she informed him that he was not a resident and assisted him in packing up his things and escorted him out of the building. She could not remember which staff told her he had been staying the weekend.

In an interview conducted on at 10:00 AM with the Executive Director, she confirmed that on she did not deal with the situation involving Resident #1 and the husband of Resident #2, as she was involved in another situation with another resident at the same time. She received the first call letting her know about the incident, she asked where is Resident #1 and the husband of Resident #2 now, and instructed staff to keep them apart and make sure they are safe. She confirmed she did not go over to the memory care unit. She then received a second call from staff informing her that Resident #1 was in bed and that Resident #2 and her husband were on the couch watching TV, so she assumed he would do as he normally does and leave after the visit. She stated that on she went over to the memory care unit at about 10:30 AM and the staff reported to her, the husband was not allowing staff to get Resident #2 ready. So she went to their talked to them and he stated he would bring her out.

During an exit conference with the Administrator on at 4PM, she acknowledged aforementioned and stated no further documentation was available for review. She also confirmed that she should have reported the incident to local law enforcement and Department of Children and Families. She also confirmed she didn't have any documentation/evidence to support steps taken to prevent reoccurrence of Resident #1's behavior with the visitor and other residents and that she implemented the facility's

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policy on and neglect and supervision. She further stated she takes full responsibility for everything.

Please see A 0025, A 0010 and A 0077

Class II

0077 Staffing Standards - Administrators

Based on interview and record review, the Assisted Living Facility Administrator(Executive Director) failed to perform her duties in a manner in which staff members are supervised and provided appropriate guidance when dealing with and neglect to ensure the safety and well-being of the residents in the secured unit/memory care unit; and it was also determined the facility's Administrator also failed to ensure provisions are in place to ensure appropriate supervision is provided to all residents residing in the secured unit when concerns have been identified with respect to the resident's well-being, safety and when signs of and are present .

The findings include:

A review of the facility ' s policies on Supervision and Monitoring of Residents and Neglect and revealed that the Executive Director failed to immediately establish and implement steps and procedures necessary to provide a safe environment to the residents in the memory care unit, after becoming aware of an incident that occurred on in the memory care unit of and neglect.

During the tour of the memory care unit conducted on at 11:30 AM with the Executive Director, an observation was made in the nurses station of a note on the white board stating to not let Resident #2 go out with husband. The son does not want his mom out with the husband.

In an interview conducted on at 11:30 AM with the Executive Director, she was questioned as to why Resident #2 cannot go out with her husband, and she stated that an incident occurred on at 7:00 PM with the husband of Resident #2, and Resident #1, in which staff observed Resident #1 performing [o...] on the husband of Resident #2 in the day The Executive Director confirmed that she did not come to the memory care unit that evening after being notified of the incident, she also did not contact law enforcement, Adult Protective Services (APS) or conduct an internal investigation of the incident. She states that after the incident she called a home health agency to send an aide for 1 to 1 supervision of Resident #1, from 8AM-8PM, Friday - Tuesday She also informed the family of Resident #1 of the incident.

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Immediately after the interview with the Executive Director, the surveyor attempted to conduct a record review to further evaluate the incident as revealed by above parties. However, record review revealed 1 note on a piece of paper that states the following: Resident #1 (...) was caught given [o....] to another resident ' s husband, dated Thursday 7:45PM . . . . 11, 2015 and unsigned. Further record review of the residents file and facility records revealed no further documentation or investigation of the incident that included at minimum the parties involved and witnesses, details regarding the incident, location of the incident , assessment for injuries and/or medical treatment and steps taken to prevent reoccurrence. Further interview with the Executive Director revealed the facility had no further documentation regarding the incident other than aforementioned note found in the file.

In a subsequent interview conducted on . . . . . at 10:00 AM with the Executive Director, she confirmed that on she did not deal with the situation involving Resident #1 and the husband of Resident #2, as she was involved in another situation with another resident at the same time. She received the first call letting her know about the incident, she asked where Resident #1 and the husband of Resident #2 are now, and instructed staff to keep them apart and make sure they are safe. She confirmed she did not go over to the memory care unit. She then received a second call from staff informing her that Resident #1 was in bed and that Resident #2 and her husband were on the couch watching TV, so she assumed he would do as he normally does and leave after the visit.

Subsequent interviews with the facility's staff revealed that the Executive Director allowed the spouse of Resident #2 to stay overnight in the secured unit after aforementioned incident occurred in which this visitor had continuous direct contact with Resident #1 and other resident's in the unit with little or no supervision at time.

During an exit conference with the Administrator on . . . . . at 4PM, she acknowledged aforementioned and stated the facility had no further documentation. She also confirmed that the facility should have reported the incident to local law enforcement and Department of Children and Families. She also stated " I take full responsibility for the incident and that it was not handle appropriately".

Please see A 0010, A 0025, A 0030

Class II

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Brookdale Boca Raton
9591 Yamato Road
Boca Raton, FL 33434

RE: CCR #2015006141

Dear Administrator:

This letter reports the findings of a complaint inspection survey conducted on , 2015- , 2015, 2015 and , 2015, by a representative of the Agency for Health Care Administration (Agency). Attached 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 **ten business days** of receipt of this faxed report.

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

St - A - 0010 - 429.26(1&9) Fs; 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= Class II
St - A - 0025 - 429.26(7) Fs; 58a-5.0182(1) Fac - Resident Care - Supervision S-S= Class II
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= Class II
St - A - 0077 - 429.176 Fs; 58a-5.019(1) Fac - Staffing Standards - Administrators S-S= Class II

Directed Corrective Actions:

1. The Assisted Living Facility is required to develop and implement a policy and procedure which reflects how the facility will address allegations of and neglect to facility residents and what steps facility staff must take to protect residents from neglect and This shall be completed within 10 days of the date of this letter. The facility staff must be trained on the facility's policy within 48 hours after the policy is developed and documentation of the training must be maintained and available for review by the agency.

2. The Assisted Living Facility is required to ensure that all facility staff having contact with and providing care to residents must be re-trained on resident rights and recognizing and reporting and neglect. This training must be provided by a representative of the Department of Elder Affairs or Ombudsman Program or the Department of Children and Families or an approved provider of one of the two agencies. Your facility must have documentation indicating the training was completed and documentation of the training must be maintained and available for review by the agency. This training shall be scheduled within 10 days of the date of this letter.

3. The Assisted Living Facility is required to have the current Administrator/Executive Director retake the CORE Training class. This training shall be scheduled within 10 days of the date of this letter.

4. The Assisted Living Facility is required to assess all residents residing in the memory care unit for continued residency appropriateness as well as for abnormal behavioral issues, including aggression and hyper- activity. These assessments are to be completed within 48 hours by a Healthcare Provider. These assessments will be retained in each resident's file and be updated when the resident experiences a significant change.

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com

Brookdale Boca Raton
, 2015

5. The Assisted Living Facility is required to provide training within 48 hours to all staff on dealing with persons with and related as well as dealing with persons who exhibit aggressive behaviors, including hyper- activity. The facility must maintain documentation (certificate) of this training within each staff member's personnel file. The training must be provided by a trainer approved by the Department of Elder Affairs or the Agency for Health Care Administration. The prospectus and original certificates for this training must be retained by the facility in the employees' records and are to be available for review no more than thirty days from the receipt of this letter.

6. The Assisted Living Facility is required to increase staffing on each shift in all areas of the facility where residents who were identified as having abnormal behavioral issues, including aggression and hyper- activity, reside. This staff increase must be at a level to ensure that a dedicated staff person is available in each area to provide continuous line of sight monitoring of each resident identified as having behavioral issues. This staffing increase will take place no later than 48 hours after residents having these behavioral issues are identified and/or before any new residents identified as having these behavioral issues are admitted. The facility administrative staff will provide onsite monitoring to ensure that additional staff is present and line of site supervision is taking place. This monitoring will take place on all shifts.

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

Should you have any questions, please contact Tikel Wedges-Phoenix, Health Facility Evaluator Supervisor, at (561) 381-5846, Laura Manville, Survey and Certification Support Branch, at (727) 552-1955 or Arlene Mayo-Davis, Field Office Manager, at (561) 381-5840

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD

D7JR

Acknowledgement of receipt of the above Directed Plan of Correction (DPOC):

Provider Representative's Signature | Title | Date