STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965789	09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE COMMUNITIES TEQUESTA ,	**400 NORTH US ONE TEQUESTA, FL 33469**

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

0000 - Initial Comments

An unannounced licensure complaint survey, CCR#2018012893, commenced on , 2018 and concluded on , 2018 at Terrace Communities Tequesta, License #10124. The facility had deficiencies at the time of the investigation.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review and interviews, the facility failed to provide adequate supervision to prevent resident to resident , for 2 out of 2 sampled residents (Residents #1 and #2).

The findings included:

On , an incident involving Resident #3 and Resident #1 on was reviewed. Resident #3 was alleged to have abused Resident #1 in her the early morning hours on . Both residents reside in the memory care unit and have .

1) Review of the observation notes for Resident #3 revealed the following:

a) (2:00 PM to 10:00 PM): Resident was going seeking
b) (2:00 PM to 10:00 PM): Resident is very in the evening hours, he becomes , goes from residents other residents during sleeping hours. Very exit seeking...very difficult to redirect. No PRN's (as needed medication) available to help calm resident. If resident continues to exhibit these same behaviors he can be a risk for harming himself and other residents. Please continue to monitor.
c) (6:00 AM to 2:00 PM shift): Attempts to go in other residents'
d) (6:00 AM to 2:00 PM shift): Had some agitation
e) 2:30 PM: Spoke with health care practitioner regarding behavioral issues over the weekend. An order for (medication) was faxed to pharmacy with a request to deliver the medication today.
f) (2:00 PM to 10:00 PM): Resident got at supper time but there is no improvement. Resident was very agitated combative, try to hit staff, refused to go to bed, try to push other resident. Please continue to monitor for safety.
g) 3:33 PM: Resident agitated, exit seeking and trying to get into other residents' apartments. Redirected. Nurses will monitor behavior.
h) (2:00 PM to 10:00 PM): Resident given 3rd dose of , . However, post administration resident still become agitated, combative, exit seeking and non-compliant, does not obey commands

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and becomes even more hostile when told what to do. Rattling every door knob searching for a way out. Continue to keep an eye on resident for the safety of others, he is restless and remained awake throughout the entirety of this writer's shift, needs sleep aid meds.
i) (2:00 PM to 10:00 PM shift): Writer was walking down hallway to find Resident #2 on the floor when she started yelling "Help me!". Resident #3 was standing over her yelling also. Resident #3 told me "I pushed her!". He was very agitated and angry. He also stated "I'll do it again if she bothers me!".
j) (2:00 PM to 10:00 PM): Telephone order from health care provider to increase , . Private aide in place from 6:00 PM to 6:00 AM for safety.

2) Review of the Adverse Incident report for the resident to resident that occurred on revealed the following documentation:

a) At 5:43 AM, the resident aide on duty heard noise coming from Resident #1's apartment.
b) The resident aide had checked Resident #1's apartment "just 15 minutes prior at 5:30 AM. Resident #1 was in bed. The male resident had never acted out prior to this incident."
c) entered the found Resident #1 on the floor in her . Resident #3 was standing over her. The resident was
visibly shaken up, Resident #3 was escorted out of the apartment.
d) Two LPNs (licensed practical nurses) assessed Resident #1 and found "no apparent visible injuries".
e) Resident #3's anti- , medication was adjusted. Resident doors are now locked at night to prevent other residents from entering.
f) "This is the first time Resident #3 showed any sign of aggression."

3) Review of the Adverse Incident report for the resident to resident that occurred on revealed the following documentation:
a) Resident #2 was found on the floor in the hallway at 7:15 PM. Resident #3 stated he had pushed her.
b) Resident #2 had a red nose and chin and complained of knee pain.
c) Resident #3's medications were adjusted and a private duty aide was provided by the resident's family for 12 hours a day, from 6:00 PM to 6:00 AM.

4) Review of the video footage showing Resident #3's actions against Resident #1 in her revealed the following:
a) The resident aide exited Resident #1's 4:18 AM.
b) Resident #3 entered Resident #1's 4:23 AM.
c) While Resident #1 was laying in bed at 4:40 AM, Resident #3 began pulling the blanket off and back on Resident #1, telling the resident to get up.
d) Resident #3 began nudging/pushing the resident's shoulder and hitting the resident with a pillow at

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4:47 AM.
e) At 5:00 AM, Resident #3 began pulling the resident by her arm and shoulder out of the bed, eventually pulling the resident across the her 5:23 AM.
f) At 5:43 AM, the resident aide entered the .

Based on Resident #3's identified wandering into other residents' and "a risk to harming others" prior to the incident in Resident #1's , the facility failed to provide adequate supervision to prevent the incident. Additionally, Resident #3 was not provided a private aide to prevent aggression to other residents until after pushing Resident #2 down on . These findings were discussed with the Administrator on at 12:30 PM.

Class III

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

Based on record review, the facility failed to ensure training certificates contained all required components, for 3 out of 3 sampled staff (Staff A, B and C).

The findings included:

On at 11:00 AM, the training certificates for Recognizing and Reporting , Neglect and , for Staff A, B and C were requested. Direct care staff must complete one hour of in-service training in Resident Rights and Recognizing and Reporting , Neglect and , . The certificates of this training for Staff A, B and C had the following missing information:

a) Staff A's certificate dated did not have the credentials of the trainor listed.
b) Staff B's certificate dated did not have the amount of time of the training documented.
c) Staff C's certificate dated did not have the credentials of the trainor listed; and, did not have the date of the training noted (only the month and year); and, did not have the subject of " , Neglect and , " documented (only "Recognizing and" was noted).

These findings were discussed with the Administrator on at 12:30 PM.

Class

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and interviews, the facility failed to submit an initial Adverse Incident report

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within one business day for two resident to resident incidents, involving 2 out of 2 sampled residents (Residents #1 and #2).

The findings included:

a) On , an incident involving Resident #3 and Resident #1 on was reviewed at the facility. Resident #3 was alleged to have abused Resident #1 in her the early morning hours on . An Adverse Incident report showing the facility's initiation of an investigation into the incident had not been initiated at this time. Review of the one and fifteen day Adverse Incident reports on revealed the one day report was submitted on , 7 business days after the incident.

b) On , an incident involving Resident #3 and Resident #2 on was reviewed at the facility. Resident #3 was alleged to have abused Resident #2 by pushing her on to the floor on . An Adverse Incident report showing the facility's initiation of an investigation into the incident had not been initiated at this time. Review of the one and fifteen day Adverse Incident reports on revealed the one day report was submitted on , 2 business days after the incident.

The facility failed to initiate and file Adverse Incident reports with the Agency for each of these occurrences within one business day as required. These findings were discussed with the Administrator on at 12:30 PM.

Class III