

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105205	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2024
NAME OF PROVIDER OR SUPPLIER Savoy at Fort Lauderdale Rehabilitation and Nursin		STREET ADDRESS, CITY, STATE, ZIP CODE 2121 E Commercial Blvd Fort Lauderdale, FL 33308	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39142</p> <p>Based on observations, interviews, and record review, the facility failed to protect the residents' right to be free from mental and physical abuse by staff for 3 of 3 cognitively impaired residents, Resident #1, #2, and #3. The residents who remained at the facility, Resident #2 and Resident#3, were unable to provide information regarding the events due to their cognition levels. Resident #1 has since passed away due to unrelated causes, per family interview. Based upon the video surveillance of the incident, a reasonable person would conclude the residents suffered physical and/or mental harm.</p> <p>The findings included:</p> <p>The facility's policy, titled, Identifying Types of Abuse (revised September 2020) had a section with the heading Policy Interpretation and Implementation. The following items pertain to the findings:</p> <p>1. Abuse of any kind against residents is strictly prohibited.</p> <p>4. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain or mental anguish.</p> <p>c. Abuse includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.</p> <p>Under the heading Physical Abuse the following apply:</p> <p>1. Physical Abuse includes, but is not limited to hitting, slapping, biting, punching or kicking.</p> <p>4. Examples of injuries that could indicate physical abuse include, but are not limited to:</p> <p>d. bite marks, scratches, skin tears, and lacerations with or without bleeding, including those that are in locations that would unlikely result from an accident .</p> <p>Under the heading Mental and Verbal Abuse the following apply:</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>1. Mental Abuse is the use of verbal or non-verbal conduct which causes (or has the potential to cause) the resident to experience humiliation, intimidation, fear, shame, agitation or degradation.</p> <p>2. Verbal Abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of verbal, written or gestured communications, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability.</p> <p>3. Examples of mental and verbal abuse include but are not limited to:</p> <p>c: yelling or hovering over a resident, with the intent to intimidate.</p> <p>Review of the record for Resident #1, who was admitted on [DATE], had a comprehensive assessment, dated 05/09/24, and was assessed with a Brief Interview for Mental Status (BIMS) score of 00/15, indicating he was severely cognitively impaired. Resident #1's active diagnoses included but were not limited to the following: Atrial Fibrillation (irregular heartbeat), Hypertension (High Blood Pressure), and Anxiety Disorder. Resident #1 was transferred to the hospital, due to an unrelated health issue, on 05/09/24. Resident #1 did not return from the hospital.</p> <p>On 05/08/24 at approximately 8:00 PM, Resident #1 had been brought to the third floor from the second floor because there were no other residents on the second floor who required direct observation during the timeframe that led up to and included the abuse incident. The facility has an initiative to protect residents who have cognitive issues and are at risk of falling. The moving of Resident #1 up to the third floor allowed him to be observed without having to add extra staff.</p> <p>Review of the record for Resident #2, who was admitted on [DATE], had a comprehensive assessment, dated 04/26/24, and was determined to have a BIMS score of 05/15, indicating he was severely cognitively impaired. Resident #2's active diagnoses included but were not limited to the following: Dementia, Parkinson's Disease, and Anxiety Disorder.</p> <p>Review of the record for Resident #3, who was admitted on [DATE], had a comprehensive assessment dated [DATE], and was determined to have a BIMS score 02/15, indicating she was severely cognitively impaired. Resident #3's active diagnoses included but were not limited to the following: Hypertension, Dementia, Anxiety Disorder, and Psychotic Disorder.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/20/24 at 10:18 AM, an interview was conducted with the Nursing Home Administrator (NHA), who had reported, via AHCA reporting system, an Abuse incident that occurred on 05/08/24 with Resident #1, #2 and #3. The NHA reported Abuse based upon video surveillance. The NHA explained that she was trying to determine how Resident #1 had gotten a laceration to his forehead, which occurred on 05/08/24 as reported by a Certified Nursing Assistant (CNA), Staff A. The NHA stated Staff A informed the NHA that Resident #1 had been in her care in the third floor dining / activities room on the day of the incident, 05/08/24. The NHA stated Staff A reported that Resident #1 banged his head on a table which caused Resident #1's injury. The NHA stated she was trying to verify the validity of the claim because the type of behavior described for Resident #1 was unusual. The NHA stated she reported the abuse incident within 24 hours of the discovery. The NHA stated she immediately suspended Staff A, who was observed in the video abusing the residents, and had the nurses fully assess the 3 residents for injuries. The NHA stated each resident's doctor and representative was contacted regarding the Abuse. The NHA stated she notified Department of Children and Families and the Sherrif's office, who both came to investigate. The NHA stated she had the Director of Nursing (DON) and Assistant DON (ADON) initiate abuse and neglect training for the entire staff.</p> <p>On 05/20/24 at approximately 10:30 AM, the surveyor viewed the video recording of the incident of 05/08/24. The date and time of the incident began was 05/08/24 at 20:31 (8:31 PM). To capture the appropriate time and sequence of events, the surveyor viewed the events from the time stamp of 20:23 (8:23 PM).</p> <p>The following paragraphs represent the events that occurred on 05/08/24 at the time indicated:</p> <p>At 20:23 (8:23 PM), the video showed Resident #1, #2, and #3 sitting around a table with 2 other residents and a CNA, not Staff A. The residents appeared to be engaged with the CNA. At 20:26, Staff A came into the room and the other CNA was observed taking two residents, one at a time out of the room. The remaining residents, Resident #1, Resident #2, and Resident #3, were left behind with Staff A. Staff A rearranged the tables in the room, putting tables together in the middle of the room.</p> <p>At 20:31 (8:31 PM), Staff A pushed Resident #1 in his wheelchair to the far-right table where Staff A pushed Resident #1 up to the table as close as possible but at an angle. Staff A then readjusted Resident #1 and when she could not adjust the wheelchair to a position she wanted, she pulled the wheelchair back and forcefully tipped the wheelchair up in the front. At this time, Resident #1's legs appeared to strike the underside of the table. The wheelchair was then pushed in as far as it could go with Resident #1 sitting close to the table. Resident #1 attempted to stand, and Staff A grabbed him by the back of his shirt and left shoulder. Staff A violently pushed Resident #1 forward toward the table and then pulled him back in his wheelchair. Resident #1 did not strike his head on the table.</p> <p>At 20:31 (8:31 PM), Resident #2 was noted at a table in the far-left corner of the room from the viewpoint of the camera. Staff A was observed roughly moving Resident #2's left arm back to the armrest of his wheelchair. Resident #2 leaned forward in his wheelchair and appeared to be reaching for something on the floor. Staff A then roughly pushed Resident #2 back into his wheelchair. Staff A then wheeled Resident #2 to the tables in the middle of the room. Staff A pushed Resident #2 as close to the table as physically possible locking the wheelchairs wheels.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>At 20:33 (8:33PM), Resident #1 attempted to rise from his wheelchair. Staff A was seen violently hitting Resident #1 in the back with her elbow and forearm to control Resident #1 and keep him from standing. Staff A then went and retrieved Resident #3 from the same area Resident #2 had been. Resident #3 was wheeled to the table group and was placed at the table group facing Resident #2. Resident #3 was pushed as close to the table as physically possible. Staff A locked Resident #3's wheelchair. Staff A then walked away from the residents but when Resident #3 attempted to push herself away from the table, Staff A went back to Resident #3 and stopped her from moving and made aggressive hand gestures close to Resident #3's face. Staff A went to a table and chair in the far-right corner of the room and was involved in her own activity instead of trying to engage the residents. The television was playing in the background.</p> <p>At 20:36 (8:36 PM) Resident #1 was seen attempting to stand again, when staff A made threatening gestures which caused Resident #1 to throw up his hands and try to bat Staff A away in a defensive manner. Then Staff A started poking Resident #1 in his arm and toward his face, with enough force to knock his glasses to the floor. After picking up the glasses and placing them on the table, Staff A was seen going to a table or cabinet to get an unidentified item to wipe Resident #1's face. This was done with a swift wipe up Resident#1's face and across his forehead. There was no attempt made to place a bandage and the video did not capture any nurse involvement at this time.</p> <p>On 05/20/24 at 12:18 PM, an interview was conducted with Staff D, CNA. Staff D stated she has [AGE] years on the job at the facility. Staff D stated that the facility had re-education on Abuse and Neglect. She stated the facility explained that the residents are to be treated kindly and with dignity. She stated that the staff must remember that the residents are in the facility because they need care and assistance. The CNA expressed that she reminds herself of this whenever she feels frustrated. She stated she refocuses herself and continues to provide the best care possible.</p> <p>On 05/20/24 at 12:35 PM, an interview was conducted with Staff B, Registered Nurse (RN) and Nursing Supervisor, who stated she was on duty the day the event occurred, but she did not witness the abuse. Staff B performed the first aid for Resident #1. Staff B stated Staff A never showed any signs or tendencies toward abusive behavior. Staff B stated the CNAs usually have between 10-11 residents to care for on the 3PM-11PM shift. Staff B stated that she did not note Staff A as being stressed on the day of the abuse. Staff B stated all staff were provided with education regarding Abuse and Neglect.</p> <p>On 05/20/24 at 2:43 PM, an interview was conducted with Resident #4 regarding treatment by the staff and abuse. Resident #4 had a BIMS of 15, indication cognition was intact. Resident #4 stated she had not experienced any staff that made her feel uncomfortable or that were threatening to her or others, stating she would report it (abuse) to her nurse or other staff immediately.</p> <p>On 05/20/24 at 2:53 PM, an interview was conducted with Staff C, Licensed Practical Nurse (LPN), who stated she had been employed at the facility for [AGE] years. Staff C stated she was very surprised when she was informed who the person was that was alleged to have been abusing residents. Staff C stated the CNA (AP) was usually smiling and friendly with the residents. Staff C stated that if you see someone else who doesn't act right or doesn't look right, you try to help them. Staff C stated if she saw abuse, she would immediately contact the Administrator who is the Abuse Coordinator.</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>On 05/20/24 at 3:20 PM, an interview was conducted with Resident #5, who had a BIMS of 14/15, indicating he was cognitively intact. Resident #5 stated he had not had any issues with staff making him feel threatened. Resident #5 stated he had not heard of any staff threatening residents or witnessed any abuse like behaviors.</p> <p>On 6/14/24 at 9:20 AM, the Administrator confirmed that Staff A was suspended on 5/10/24, pending the outcome of the facility's investigation. Staff A was terminated on 05/13/24.</p> <p>On 06/17/2024 at 3:36 PM an interview with the Nursing Supervisor, Staff B. Staff B confirmed that the wound suffered by Resident #1 was small and did not require emergency intervention. Staff B stated she followed first aid protocol in cleaning and dressing the wound. Staff B stated she was informed by Staff A that Resident #1 struck his head on the table.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>39142</p> <p>Based on interview, record review, and observation, the facility failed to file an abuse report within 2 hours of being made aware of abuse, for 3 of 3 sampled residents, Resident #1, Resident #2, and Resident #3, reviewed for abuse.</p> <p>The findings included:</p> <p>The facility's policy, titled, Identifying Types of Abuse (revised September 2020) documented a section with the heading Policy Interpretation and Implementation, included the following:</p> <p>Under the heading Physical Abuse, the following was documented:</p> <ol style="list-style-type: none"> Physical Abuse includes, but is not limited to hitting, slapping, biting, punching or kicking. <p>Under the heading Mental and Verbal Abuse, the following was documented:</p> <ol style="list-style-type: none"> Mental Abuse is the use of verbal or non-verbal conduct which causes (or has the potential to cause) the resident to experience humiliation, intimidation, fear, shame, agitation or degradation. Verbal Abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of verbal, written or gestured communications, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. Examples of mental and verbal abuse include but are not limited to: <ul style="list-style-type: none"> c: yelling or hovering over a resident, with the intent to intimidate. <p>On 05/20/24 at 10:18 AM, an interview was conducted with the Nursing Home Administrator (NHA). The NHA stated that she was informed that Resident #1 had a laceration to his forehead that was caused by the resident banging his head on a table. The NHA explained the incident occurred on 05/08/24, and she was under the impression that Staff A was telling the truth regarding the matter. The NHA stated she did not report the injury as an injury of unknown origin because she believed the injury was not of unknown origin. The NHA stated she continued to investigate the incident because she realized that the behavior described was not common for Resident #1. The NHA stated that one of her nursing supervisors suggested reviewing the surveillance video to verify the incident. When the NHA reviewed the video, she discovered the abuse of Resident #1, Resident #2, and Resident #3 by Staff A, Certified Nursing Assistant (CNA). The NHA stated she immediately suspended Staff A, who was subsequently terminated.</p> <p>Further interview with the NHA at this time revealed she reported the abuse within 24 hours of the discovery of the abuse, but not within 2 hours of her being aware. The NHA admitted she had forgotten she needed to report within 2 hours of notification of abuse as required.</p> <p>(continued on next page)</p>

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Federal report filed by the NHA documented the NHA was made aware of the incident on 05/10/24 at 13:16 (1:16 PM). The Federal report was created by the Director of Nursing (DON) on 05/11/24 at 2:26 PM. The Federal report was submitted by the DON on 05/11/24 at 4:45 PM. On 05/20/24 at approximately between 10:30 AM and 11:00 AM, the surveyor reviewed the video surveillance recording of the abuse of Residents #1, #2 and #3, which was perpetrated by Staff A. It was noted in the video that the residents were physically and mentally abused by Staff A.		