STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105725	A. BUILDING _____ B. WING _____	**04/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HOME ASSOCIATION, THE	**1203 E 22ND AVE TAMPA, FL 33605**

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)
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on observation, record review, interviews, the facility failed to ensure that an allegation of abuse was reported in a timely manner for 2 (#1 and #2) of 3 sampled residents. Resident #1 and #2 were involved in a physical, resident to resident, altercation on 0[DATE]5/20. The facility failed to notify the Abuse Registry; did not submit an Immediate Federal Report or notify Law Enforcement as of the date of survey, 04/27/20. Findings include: An interview was conducted on 04/27/20 at 4:35 p.m. with the Director of Nursing (DON). She confirmed that the facility had had one event involving a resident to resident altercation within the last 5 days. She stated that the residents involved were Resident #1 and Resident #2. She stated that one man told the other to get the F** out of the way, one hit the other one, and Resident #1 fell and fractured his wrist. The DON reported that no staff witnessed the event, but, that another resident, Resident #3 was present during the altercation. The DON stated that the event happened at the end of the east hall, about breakfast time, she would have to look up the date of occurrence. She stated Resident #1 hit Resident #2 who fell and fractured his wrist. At 5:30 p.m., an interview was conducted with Resident #1, he was observed in the hall sitting in his wheelchair. He was asked what happened to his arm. He stated that, he got into it with another resident, that it was not their fault. He stated that it was his fault. He stated that he was comfortable living at the facility, the staff took care of him. He stated that it was a misunderstanding. He is receiving pain medication for his arm. At 6:00 p.m., an interview was conducted with the DON. She stated that she had completed an investigation, that she had interviewed the residents and the staff. She stated that Resident #3 had witnessed the event. The DON reported that Resident #3 stated that Resident #1 came out of his room where Resident #2 and Resident #3 were sitting in the hall (both in wheelchairs). According to Resident #3, Resident #1 said, Get the F*** out of my way. Resident #3 made a point to tell me that they were not even in his way and that there was plenty of room. And then, Resident #2 said, you can say excuse me, be nice about it. Then, Resident #1 said, I will say whatever I want, stood up and popped Resident #2 on the side of his face. And then, Resident #2 hit Resident #1 in the face. According to Resident #3, Resident #1 threw himself on the floor, he landed on his right arm, braced himself with it. According to Resident #3, it was an open hand slap. The DON confirmed that Resident #1 was subsequently transferred to the hospital. The DON stated that Resident #2 was assessed, he had no bruising, but he had a little scratch on his face. Resident #2 was discharged from the facility to home on 0[DATE]7/20. The DON was asked if she had called and reported the event to the Department of Children and Families, Adult services, abuse hotline; submitted an immediate federal report; or notify Law Enforcement. She stated no. When there are incidents like this, I reach out to corporate for guidance. I was directed not to call. A review of the facility Abuse policy, ABU.3.1, last revised 0[DATE]0/17, documented the policy: The facility prohibits the mistreatment, neglect, and abuse of residents and misappropriation of resident property by anyone including staff, family, friends, etc. The facility has implemented and designed processes which strive to ensure the prevention and reporting of suspected or alleged abuse, neglect mistreatment, and or misappropriation of property. The process included in section K, reporting, 3. All alleged violation involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source . are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury no later than 24 hours if the event that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law thru established procedures .

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE