Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965079	A. BUILDING: _____ B. WING _____	12/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDSAY'S ALTERNATIVE CARE, INC	5783 NW 48TH DRIVE CORAL SPRINGS, FL 33067

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced licensure complaint survey (#2020019446) was conducted on [redacted] to [redacted] at Lindsay's Alternative Care, Inc. The facility had deficiencies identified at the time of the survey. A Class I violation was identified which presented an imminent danger to a client of the provider. The violation was identified at A 0025-Resident Care-Supervision.	A 000		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making [redacted] for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide appropriate personal supervision of care and immediate emergency services, for 1 out of 4 sampled residents (Resident #1). As evidenced by Resident #1 suffering extensive injuries from falling out of a hospital bed and the facility's failure to obtain emergency care/services for	A 025		

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A 025	Continued From page 2 approximately 5 hours resulting in the resident's on . The findings included: Review of the facility's undated policy and procedure entitled, Safe Steppers- . Interventions revealed the following: Measures to be instituted for patient at potential risk for . -Call light placed within reach - Bed brake on - Bed in low position -Q2 hourly round checks Review of the facility's undated policy and procedure entitled, Communication regarding patient change in status revealed the following: It is the policy of Joan Lindsay's Alternative Care ALF to inform residents, family, health care providers, Case Managers, social workers or guardians (next of of kin) in the event of the following. -Accident/incident occurring -Residents needed to be transferred to a hosptial - An emergency or change in residents physical or mental status. The following procedure will be implemented: The staff in charge of the operation of the facility at any given time will perform the following in the order listed. A. Dial 911 for transfer to the nearest hospital in case of an emergency. A completed transfer must be sent with the resident. B. Contact the Resident's Physican A review of the facility's undated Policy & Procedure entitled, Responding to the Unresponsive Resident indicated the following: Purpose: To provide the best opportunity to	A 025		

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A 025	Continued From page 3 prevent . . . . by following accepted standards for . . . in accordance with the American Red Cross and American . . . Association. In the absence of a signed activated . . . . . Form, and/or Hospice, the staff is to perform the following steps: Procedure: 1) If a resident is found unresponsive the staff member will attempt to physically stimulate the resident by calling their name and gently shaking them by the . . . . If unresponsive, look, listen and feel for . . . . . and , . . . , the staff member is to call for help and dial 911. 2) Return to the resident and begin to follow . . protocol. 3) . . . is to continue until the EMT/Paramedics take over. Review of the facility's undated policy and procedure titled, Incident Reporting revealed the following. Purpose: To assure proper documentation of all incidents for reporting purposes, including investigation, analysis, and quality improvement or preventative action; to be administered by the Risk Manager. Policy: An incident shall be completed for an happening which is not consistent with the routine operation of the facility or routine care of a , ... resident/patient, this includes employees and visitors. Incidents are defined as accidents or untoward events that may eventuate in undesirable outcome. Procedure: It will be the responsibility of the employee, nursing or medical staff member mostly closely involved in the incident, having special information regarding the incident to complete a written incident report. Note: No one should fail to complete an incident report form simply because it is thought that someone else involved has done so or was more closely involved. It is the responsibiltiy of the employee's	A 025		

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A 025	Continued From page 4 immediate supervisor to see that it is accuratelty completed, and to complete the incident investigation Report. 3.The written incident report and incident investigation report form must be completed and received in the Risk Management Office within 24 hours. Review of the facility's undated job descriptions/work assignments indicated the following. Each direct care staff member must ensure the resident's welfare, and be "aware of the resident's whereabouts and condition" and perform "regular room/bed checks. A request was made by the Surveyor to the Assistant Administrator #1, a Registered Nurse (RN) on at 12:40 PM for the facility incident report regarding Resident #1's incident that occurred on for review. The report was not completed and provided to the surveyor until . The facility didn't provide any additional information regarding the interal investigation. Review of the facility's incident/accident report dated revealed the following. Resident #1 was found on the floor on at 7:50AM and the resident was moaning, not responsive to verbal/ stimulation, sustained a on her , had 8 , and an saturation of 60%. Further review of this report indicated, the resident was transported to the hospital on at 1:20PM by Emergency Medical Services ( ) and the facility was to re-educate its staff in -preventions, resident monitoring and emergency procedures to prevent reoccurrence of a similar event. During an interview with Staff B (direct care staff) on at 9:36 AM, she stated that on	A 025		

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A 025	Continued From page 5 , when she arrived to the facility at 7:00 AM for her shift. She saw Staff A (direct care staff), who worked the 7:00 PM - 7:00 AM shift on the previous day, in the laundry area of the facility. She explained, the laundry area is located at the front of the house on the opposite side of house of Resident #1's bedroom, immediately to the left when you enter the home, pass the door leading into the garage. The Resident's bedroom was on the opposite side of the laundry room. She stated that at this time, she heard someone falling (a loud bump, bump) in Resident #1's bedroom and she immediately yelled for Staff A that Resident #1 had in her room. She reported, upon opening the resident's bedroom door and entering the bedroom, Resident #1 was lying down on the floor, on the left side of the hospital bed, between the bed and the wall. She stated, she and Staff A rolled Resident #1 over, she was conscience but non-verbal with a on right side of her forehead. Staff B, indicated that she nor Staff A conducted an assessment (including checking of , and/or ,) of Resident #1 after rolling her over to determine the extent of the resident's injuries and condition. Then, Staff B retrieved the , (lift) from the garage and they placed Resident #1 in the lift to take the resident to the bathroom, so they could shower the resident. She stated, after showering Resident #1, she and staff B took Resident #1 to her bed to dry and dress the resident. She stated, after this they took Resident #1 to the living room area to sit down in the reclining chair at around 8:00am. An interview with Assistant Administrator #2 (AA2) on at 11:26 AM, he stated the following. Resident #1 was pretty sufficient up until about 4 months ago. In the latter days we have to assist her more. Just sitting in the	A 025		

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recliner, she would slouch, and we had to reposition her. In the bed, reposition her more than once, she would move to left to the right, that's how she has been the last couple of months. She would constant be rolling and moving in the hospital bed. She had half bed rails on the rightside of the bed. He further stated that he moved Resident #1's hospital bed against the wall near the east window of the room on from its previous location (free standing about 6 from the wall/window). He didn't adjust the of the bed to a low position (as stated in the policy). However, he placed a cushioned pillow against the right side rails and the left side(against the wall) for staff to use while resident was in bed, as a safety precaution.

During an interview with the Assistant Administrator #1 (AA #1) on at 12:13 PM, she stated that Staff A called her on at around 7:50 AM and described that Resident #1 had a . Staff A did not describe that the resident . She stated that she told Staff A, that she would come to the facility and would assess the resident's . She reported, Resident #1 began to exhibit behavioral issues and would not perform her normal activities of daily living(ADLs) about 2 months ago. She also thrashed and kicked a lot while in the hospital bed daily. Due to these changes the resident required more monitoring and supervision. We were using half side rails on the right side of the hospital bed only for her safety and had moved her bed the previous day) against the wall near the east window (moved by AA#2). Prior to this, Resident #1 was able to perform her ADLs with assistance with no behavioral issues. She stated, she received another call from Staff A on ,

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A 025	Continued From page 7 sometime after 12:00 PM. Staff A told her that Resident #1 didn't look well. She stated, when she arrived to the facility on shortly thereafter; she found Resident #1 sitting in the reclining chair in the living room and noticed that the resident had slow breathing. She stated, the resident's saturation was at 60% at that time and this device read the resident's rate to be 206, which she felt was an erroneous reading. She stated that she called 911 after this, which was sometime after 12:00 PM. She stated, afterwards she administered Resident #1 supplemental from the concentrator that belonged to another resident at the facility, Resident #3. She stated, at this time, she also noticed that Resident #1 had a hematoma (a or of confined to an organ, tissue or space) above her right , which was black and blue, and a red scratch-like scar beneath her . She stated, on after the paramedics left the facility to transport Resident #1 to the hospital and the police officers were conducting their investigation that afternoon, she learned that Resident #1 had off her bed earlier that day. She stated, that Staff B described to her how Resident #1 was found lying on the floor, flat on her earlier on and how she did not consider how this event involving Resident #1 was one that she needed to looked at right away and with urgency. During an interview with the AA #1 on at 12:34 PM, she stated that she was last in the facility on (previous night) at 10:00 PM for about 10 or 15 minutes conducting a check of the facility (to observe residents and staff). She stated upon arrival, she saw Staff A standing outside at the front door of the facility on her cellphone, no other facility staff members were	A 025		

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A 025	Continued From page 8	A 025		

present at the facility. She stated, she went inside and checked on the residents, including Resident #1. She stated Resident #1 was asleep in the hospital bed. She stated, she then left the facility and Staff A remained on duty to care for the residents that evening. She stated that she didn't say anything to Staff A regarding her lack of presence in the facility observing the residents at the time of her arrival. She agreed that Staff A should have been in the facility observing and monitoring the residents at all times. She further stated, she was not sure how long Staff A had been outside prior to her arrival. However, Staff A did come into the building shortly before she departed.

During an interview with Staff A on at 11:30am, the following was revealed. She stated, she worked in the facility for approximately 2.5 years and she usually took care of Resident #1 during her shifts in the facility from 7:00pm to 7:00am. She stated, she last checked on Resident #1 in her room around 10pm, the previous night ( ) and she was sleeping. She closed the room door and allowed the resident to continue to sleep. She stated, on around 7:00am, she was alerted (yelled for) by Staff B that Resident #1 in her bedroom and she found the resident on the floor on the left side of the hospital bed. She stated, that she called AA #1 at around 7:50am to describe that Resident#1 had some to her lower extremities. She stated, AA #1 did not instruct her to do anything in , and AA #1 told her she will be at the facility later in the day. She stated, she and Staff B picked the resident up from the floor and assisted the resident with a shower. She stated, she then assisted the resident to sit on the reclining chair in the living room and gave the resident some ginger tea,

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which the resident did not finish. She stated, on at around 11:45am, she noticed that Resident #1 was pale and unresponsive, and she picked up the resident's arm and it was limp. She stated that she didn't check the resident's , , , , or conduct any further assessment to determine if the resident was breathing. She stated, she notified AA #1 on at approximately 11:50am of Resident#1's condition and AA #1 told her that she was on her way to the facility. She stated, on , sometime from 11:50am to 12:45pm, she administered a treatment (a machine that provides a fine mist to assist with breathing) to the resident, and this did not improve the resident's unresponsive status. Staff A stated, the machine belonged to a former resident and that no physican ordered existed. She stated, AA #1 arrived onsite on at approximately 12:45pm, at this time, AA #1 administered , , to the resident and this did not improve the resident's status. Then, AA #1 called 911 and Emergency Medical Services ( ) showed up shortly thereafter and they performed on the resident and then took the resident to the hospital.

Further interview with Staff A on at 11:45am revealed, Staff A reported she did not monitor Resident #1 on at approximately 11:00pm until at 7:00am. She stated that she went to sleep on at about 11:00pm until about 7:00am on and that she was not aware that she needed to monitor any of the facility residents overnight. She stated, she felt like she should have called 911 on Resident #1 on at 7:00am, when she identified that the resident sustained injuries after having falling from her bed. She reported, she was trained to initiate

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A 025	Continued From page 10 First-Aid and without having to receive specific orders from the Administrator or Assistant Administrator. During further interview with Staff B on at 2:06 pm, she stated on around 7:00am, when Resident #1 was discovered on the floor, she or Staff A did not immediately call 911. She stated, AA #1 called 911 on , sometime after 12:00pm for the emergency medical personnel to evaluate and treat resident #1. During an interview with Assistant Administrator #2 (AA #2) on at 2:23 PM, he stated it was the facility's procedure for every resident experiencing an emergency, for the staff members to assess the resident, call 911 and perform for any resident who did not have a , and to contact AA #2 after this. He stated that Staff A and B, who were present at the facility on did not adequately intervene when Resident #1 was found on the floor and sustained injuries due to this accident, which required for either of these staff members to have immediately called 911. In an interview with Staff B on at 2:26pm, she stated that she did not know when Resident #1 was last checked on, as she did not work the previous night shift on . During an observation at this time, Staff B demonstrated what happened on from 7:00am to approximately 12:00pm. During this observation, Staff B placed Resident #1's hospital bed as it was found when she first responded to the resident on (photographic evidence was obtained) and how the resident was found lying down on the floor between the left side of the bed and the wall.	A 025		

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A 025	Continued From page 11 She also raised the 2 half bed rails on the right side of the bed and as they were on . She also stated, the bed was not lowered and the facility does not have any call-lights or pendants. During observation of the bed rails at this time, it was determined that the 2 half-bed rails were applied to provide a full rails on the right side of the resident's hospital bed. (Photographic evidence was obtained). During an interview with the Administrator, a Licensed Pratical Nurse (LPN) on at 2:39 pm, she stated that Resident #1's health status had declined recently and the resident required a greater amount supervision and assistance with her activities of daily living and that she thrashed around a lot while in bed. She stated, the resident started being more a few months ago. She stated that she relied on AA #1 and AA #2 to operate the facility on a daily basis since she was not able to go onsite that frequently. She stated, Staff A informed her of the incident involving Resident #1 on . . . . . at approximately 11:50am. At this time, she described the resident as not looking well and having earlier. She stated, she told Staff A to call 911 and that AA #1 was on her way to the facility. During an interview with the Administrator on . . . . . at 3:02 pm, she stated that the staff members are required to call 911 during every resident emergency and this was the first thing to do. She stated, the staff were trained to call 911, whenever there is a change in status of any resident and not to call an Administrator first. She stated, the staff members did not need instruction for this to happen and to perform First Aid. She stated, Staff A described that Resident #1 was not responding to verbal commands.	A 025		

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A 025	Continued From page 12 During an interview with AA #1 on at 12:55pm; she stated, Resident #1 did not have a supplemental order and that she used Resident #3's concentrator machine on Resident #1 because she found Resident #1 being and with a faint when she arrived on around 12:00pm. She stated, she administered about 2 liters of to Resident #1 with Resident #3's mask and the police arrived on around 12:15pm and arrived shortly thereafter. She reported, performed on the resident immediately after they arrived to the facility and she didn't know how long personnel remained in the facility before they transported the resident to the hospital. She stated, that the resident had a hematoma on her forehead, had shallow and almost no when she assessed the resident on . She stated, she worked in the facility as the assistant administrator for about 22 years. She stated, she was in the facility on at about 10:00pm and that AA #2 was at the facility on at 3:00pm to move Resident #1's bed from being about 2 from the wall to placing the bed immediately next to the wall. She stated, this was done because the resident began having "thrashing" movements on or about and the resident's physician ordered medications for the resident and half bed rails. During interview with AA #1 on at 1:16 PM she stated, it was expected that the direct care staff members must monitor the residents throughout the night, at least once per hour, and the staff must not sleep during the overnight shift. She stated, Staff A and B should have called 911 on when it was determined that Resident #1 and injured herself, as the staff	A 025		

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	AL11965079	A. BUILDING: _____ B. WING _____	12/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDSAY'S ALTERNATIVE CARE, INC	5783 NW 48TH DRIVE CORAL SPRINGS, FL 33067

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A 025	Continued From page 13 was trained to do. During an interview with Police Detective #1 on at 2:25pm she stated, when she performed her investigation regarding Resident #1's on , Staff A described that she last saw Resident #1 on at 10:00pm and Staff A found the resident on the floor on after 7:00am. She stated, she was informed that the resident's bed presented to have slid or rolled on its wheels, despite Staff A's account that the bed wheels were in the locked position. She stated, the resident was found to have extensive physical injuries on , including a considerable gash on her and some other injuries to her and . She stated, Staff A waited for the AA #1 to arrive to the facility for over 4 hours before 911 was called and the resident was found by with 8 breaths per minute. She stated, the facility staff should have contacted 911 immediately after the resident was found after her the /accident to activate the first aid and emergency response. Review of the ambulance response record dated on indicated that the emergency medical services ( ) response was initiated from a facility telephone call on at 12:31pm, was dispatched at 12:32pm and arrived to the facility at 12:35pm. Review of this ambulance response record indicated that the personnel reached Resident #1 at 12:38pm, departed the facility at 12:54pm and arrived to the hospital at 12:59pm. Review of this ambulance response record indicated Staff A communicated to the personnel that Resident #1 went unresponsive and her breathing started to decrease, that the resident approximately 3 hours prior. personnel found the resident sitting in the chair, unresponsive, pulseless and	A 025		

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A 025	Continued From page 14 apneic (temporary cessation of breathing). This record indicated that the resident had a hematoma above her right , , to right and a and to the right . Further review of this ambulance response record indicated that personnel provided , , ( ) to resident #1 at 12:38pm, the resident had a 0/0 , , 0 , and 0 , at 12:39pm, applied supplemental , at 12:43pm, the resident had a , , at 12:44pm, applied 1mg of , , intraosseously (injection directly into the bone) at 12:48pm, 12:51pm, 12:54pm and 12:58pm, the resident had 0 , and 0 , at 12:48pm and , , at 1:01pm. Review of police photographs discussed and provided by the Police Dectective #1 revealed the following. Review of Resident #1's police photographs #1 and 20 indicated that the resident's bed was found with dark red stains/splatters on the mattress fitted sheets, located at the and left side of the bed. Review of the confidential photographs #2, #13 and #22 indicated that the wall next to Resident #1's bed had -like stains/splatters on its surface. Review of the confidential photographs #3 -#5, #7, #9 - #19 and 21 showed that Resident #1 appeared to have suffered extensive physical injuries on involving her , /lower extremities, right , right /forehead and left . Review of the confidential photographs #23 and #24 indicated that a staff member sent a photograph of resident #1 depicting the injury she received to her , on at 10:36am and was received or "seen" by AA #1 on at 12:52pm. Review of Resident #1's hospital records	A 025		

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A 025	Continued From page 15 indicated that the resident arrived to the hospital's emergency room by way of the local fire rescue transportation on at 1:05pm with a diagnosis of . Review of this record indicated that the resident had a certification of on at 1:12pm with no cause of listed and the resident's body was released to the medical examiner's office. Further review of this record indicated that the resident was in (absence of) before arriving to the hospital and was in process of receiving by for approximately 20 minutes and that the resident earlier that morning and hit her . This record indicated that the resident presented to be in with no , and no spontaneous breath sounds, was unresponsive, had to the , the right , and periorbital regions, had no , and was in . Review of Resident #1's health assessment form (AHCA Form 1823) dated on indicated that the resident's diagnoses were listed as: , , , , , , and Legally . Review of this health assessment indicated that the resident had , Unsteady Gait and required assistance with Ambulation, Bathing, , Grooming, Toileting and Transfers. Review of the resident's record titled, "monthly assessment notes" indicated that on the resident was starting to show increased and agitation, and was very restless. Further review of this record indicated that the resident underwent a change in level of function and her walking capability was decreased. During an interview with AA #2 on at 2:45pm, he stated, the overnight staff was	A 025		

Agency for Health Care Administration

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A 025	Continued From page 16 required to check on the residents every hours and that the staff was not allowed to sleep during the overnight shifts. He stated, there was presently no method to log the direct care staff members monitoring the residents every hours during the night and that the facility did not have specific policies and procedures regarding resident bed rail use or resident monitoring. In an interview with AA #1 on at 1:00pm, she stated that after the event involving Resident #1 on , she wanted to implement a system that required the staff to monitor all the residents every hour during the overnight shifts, but presently did not have anything in place to ensure this was being done by the staff. She stated, the facility also did not have any method to presently document any resident monitoring or supervision by the staff. During an interview with the Administrator on at 3:45pm, she stated that she was aware that the First Aid/ certifications for AA #1, Staff A and Staff B were expired on . She acknowledged that none of the responding Staff members involved in Resident #1's incident were current with First Aid and training, She reported, the facility did not immediately implement the re-education of staff in -prevention, resident monitoring and emergency procedures to prevent a reoccurrence of a similar event involving Resident #1 on . Review of Staff B's employee record indicated that the staff member was hired on and received First aid/ training on which expires on . Review of this record indicated that the staff member's previous First aid/ training was done in , and it	A 025		

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A 025	Continued From page 17 expired in . Review of this record did not indicate that this staff member was certified to provide First aid/ services on . Review of Staff A's employee record indicated that the staff member was hired on and received First aid/ training on which expires on . Review of this record indicated that the staff member's previous First aid/ training was done in and it expired in . Review of this record did not indicate that this staff member was certified to provide First aid/ services on . Review of the Assistant Administrator 1's (AA#1) employee record indicated that the staff member was hired on and received First aid/ training in and it expired in . Further review of this staff member's record indicated that she had a State of Florida Registered Nurse (RN) license and no other documentation of an updated training was in place. Class I	A 025		
A 053 SS=D	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care	A 053		

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A 053	Continued From page 18 provider. The contact with the health care provider must also be documented in the resident's record. (c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and chapter 483, part I, F.S. A valid copy of the State Clinical Laboratory License, if required, and the federal CLIA Certificate must be maintained in the facility. A state license or federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a State Clinical Laboratory License or a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the State Clinical Laboratory License and federal CLIA Certificate is available from the Laboratory Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to only administer physician order medications to residents, for 1 out of 3 sampled residents (Resident #1). As evidenced of the facility staff members (licensed and unlicensed) administering a treatment and treatment to Resident #1 on without a physician order.	A 053		

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A 053	Continued From page 19 The findings include: A request was made by the Surveyor to the Assistant Administrator #1, a Registered Nurse (RN) on at 12:40 PM for the facility incident report regarding Resident #1's incident that occurred on for review. The report was not completed and provided to the surveyor until . The facility didn't provide any additional information regarding the interal investigation. Review of the facility's incident/accident report dated revealed the following. Resident #1 was found on the floor on at 7:50AM and the resident was moaning, not responsive to verbal/ stimulation, sustained a on her , had 8 , and an saturation of 60%. Further review of this report indicated, the resident was transported to the hospital on at 1:20PM by Emergency Medical Services ( ) and the facility was to re-educate its staff in -preventions, resident monitoring and emergency procedures to prevent reoccurrence of a similar event. During an interview with the Assistant Administrator #1 (AA #1) on at 12:13 PM, she stated that Staff A called her on at around 7:50 AM and described that Resident #1 had a . Staff A did not describe that the resident . She stated that she told Staff A, that she would come to the facility and would assess the resident's . She stated, she received another call from Staff A on , sometime after 12:00 PM. Staff A told her that Resident #1 didn't look well. She stated, when she arrived to the facility on shortly thereafter; she found Resident #1 sitting in the reclining chair in the living room and noticed	A 053		

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A 053	Continued From page 20 that the resident had slow breathing. She stated, the resident's ,ᵥ saturation was at 60% at that time and this device read the resident's rate to be 206, which she felt was an erroneous reading. She stated that she called 911 after this, which was sometime after 12:00 PM. She stated, afterwards she administered Resident #1 supplemental ,ᵥ from the ,ᵥ concentrator that belonged to another resident at the facility, Resident #3. She stated, at this time, she also noticed that Resident #1 had a hematoma (a ᵥ or of confined to an organ, tissue or space) above her right ,, which was black and blue, and a red scratch-like scar beneath her ,. She stated, on after the paramedics left the facility to transport Resident #1 to the hospital and the police officers were conducting their investigation that afternoon, she learned that Resident #1 had off her bed earlier that day. She stated, that Staff B described to her how Resident #1 was found lying on the floor, flat on her earlier on and how she did not consider how this event involving Resident #1 was one that she needed to looked at right away and with urgency. During an interview with Staff A (unlicensed direct care staff) on at 11:30am, the following was revealed. She stated, on around 7:00am, she was alerted (yelled for) by Staff B that Resident #1 in her bedroom and she found the resident on the floor on the left side of the hospital bed. She stated, that she called AA #1 at around 7:50am to describe that Resident#1 had some ᵥ to her lower extremities. She stated, AA #1 did not instruct her to do anything in , and AA #1 told her she will be at the facility later in the day.	A 053		

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A 053	Continued From page 21 She stated, she and Staff B picked the resident up from the floor and assisted the resident with a shower. She stated, she then assisted the resident to sit on the reclining chair in the living room and gave the resident some ginger tea, which the resident did not finish. She stated, on [illegible] at around 11:45am, she noticed that Resident #1 was pale and unresponsive, and she picked up the resident's arm and it was limp. She stated that she didn't check the resident's [illegible] or conduct any further assessment to determine if the resident was breathing. She stated, she notified AA #1 on [illegible] at approximately 11:50am of Resident#1's condition and AA #1 told her that she was on her way to the facility. She stated, on [illegible], sometime from 11:50am to 12:45pm, she administered a [illegible] treatment (a machine that provides a fine mist to assist with breathing) to the resident, and this did not improve the resident's unresponsive status. Staff A stated, the [illegible] machine belonged to a former [illegible] resident and that no physican ordered existed. She stated, AA #1 arrived onsite on [illegible] at approximately 12:45pm, at this time, AA #1 administered [illegible] to the resident and this did not improve the resident's status. Then, AA #1 called 911 and Emergency Medical Services ([illegible]) showed up shortly thereafter and they performed [illegible] on the resident and [illegible] then took the resident to the hospital. During an interview with AA #1 on [illegible] at 12:55pm she stated, resident #1 did not have a supplemental [illegible] order and that she used Resident #3's [illegible] concentrator machine on Resident #1 because she found Resident #1 being [illegible] and with a faint [illegible] when she arrived on [illegible] around 12:00pm. She	A 053		

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A 053	Continued From page 22 stated, she administered about 2 liters of to Resident #1 with Resident #3's mask and the police arrived on around 12:15pm and arrived shortly thereafter. Review of Resident #1's health assessment form (AHCA Form 1823) dated on indicated that the resident's diagnoses were listed as: and Legally . Review of this health assessment indicated that the resident had , Unsteady Gait and required assistance with Ambulation, Bathing, , Grooming, Toileting and Transfers. Further record review failed to indicate any physican orders for the use of treatment or treatment. Class III	A 053		
A 083 SS=D	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies	A 083		

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A 083	Continued From page 23 this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to ensure one staff member with a current ( ) certification was present in the facility at all times, for 3 of 4 sampled staff members (Assistant Administrator #1, Staff A and B) as required, thus placing Residents at risk of not receiving life-saving interventions. The findings include: A review of the facility's undated Policy & Procedure titled: "Responding to the Unresponsive Resident" indicated the following: Purpose: To provide the best opportunity to prevent by following accepted standards for in accordance with the American Red Cross and American Association. In the absence of a signed activated Form, and/or Hospice, the staff is to perform the following steps: Procedure: 1) If a resident is found unresponsive the staff member will attempt to physically stimulate the resident by calling their name and gently shaking them by the . If unresponsive, look, listen and feel for and , the staff member is to call for help and dial 911. 2) Return to the resident and begin to follow protocol. 3) is to continue until the EMT/Paramedics take over. On at 10:49 AM a review of the	A 083		

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A 083	Continued From page 24 National . Foundation's website at www.nationalcprfoundation.com was conducted. Review indicated " . stands for , , , and it is a series of techniques that are designed to restore a heartbeat to those who have drowned, experienced a . . . . or . . . . . , or had a ." Through a combination of . . . . . and . . . -to- . . . . . , those administering . hope to restore a , and regular breath to those who have . . . It further stated: " certification is simply the document that attests to you being trained and allows you to perform on those in need. Since these life-or- . . . . situations require fast action, having an in-depth understanding of the techniques is essential." On . . . . at 10:54 AM, a review of the American Red Cross website at www.redcross.org was conducted. Review of the website indicated "According to the American Red Cross Scientific Advisory Council, . skill retention declines within a few months of initial training - and continues to decline as time goes by. In addition, the council found that less than half of course participants can pass a skills test one year after training. This means that just one year into your two-year . certification, you may not remember how to help when you're needed most." Review of Staff 's A personnel file, revealed a hire date of as a Direct Care Staff member. Review of Staff A's . . . . . ( ) certification on file revealed it expired . . . . . Further review of the file revealed that Staff A did not obtain her current certification of . . . . . - . . . . . until . Staff A works alone on the 7:00 PM -	A 083		

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A 083	Continued From page 25 7:00 AM shift on Sunday, Monday, Wednesday, Thursday and Friday's as indicated by the Staff Schedule provided by Assistant Administrator #2 (AA #2). Review of Staff B's personnel file revealed she was hired on as a Direct Care Staff Member. Review of Staff B's ( ) certification in file revealed it expired . Further review of the file revealed that Staff B obtained her current recertification of - on . Staff B works the 7:00 AM - 7:00 PM shift alone on Sunday - Thursday as indicated by the Staff Schedule presented by Assistant Administrator 2. During the review of Assistant Administrator #1 (AA #1) facility file revealed, she was hired on , and is a Registered Nurse (her nurse license expires). Review of the file also revealed the presence of a ( ) certificate with a certification of - . Further review revealed Assistant Administrator #1 obtained her current certification of - on . In an interview with Staff A on at 11:45AM, she stated that she was not sure when she was last certified in . She stated that she felt like she should have called 911 for Resident #1 on at 7:00AM, when she identified that the resident sustained injuries after having from her bed. She stated that she was trained to initiate first aid and without having to receive specific orders from the Administrator or Assistant Administrator. In an interview with Staff B on at 2:06 PM, she stated that on around 7:00	A 083		

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	AL11965079	A. BUILDING: _____ B. WING _____	12/16/2020

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A 083	Continued From page 26 AM when Resident #1 was discovered on the floor and the resident was likely to have been injured, she or Staff A should have immediately called 911. In an interview with the Administrator on [redacted] at 3:45 PM, she stated she was aware that the First Aid/ certifications for Assistant Administrator #1, Staff A and B were expired on [redacted]. In an interview with Assistant Administrator #2 on [redacted] at 2:23 PM, he stated that the facility's policy regarding a Resident emergency is for staff to assess the resident, perform [redacted] if there is no Do Not Resuscutate ( ) order, call 911 and contact Assistant Administrator #1. Review of facility records to include policies and procedures, resident records and interviews conducted on [redacted] through [redacted] with the Administrator, Assistant Administrator #1 and #2, Staff A and B, the following was revealed, Resident #1 was found on the floor on [redacted] at 7:50AM and the resident was moaning, not responsive to verbal/ stimulation, sustained a [redacted] on her [redacted], had 8 [redacted] per minute and an [redacted] saturation of 60%. The resident's condition worsened from the time of the incident until sometime after 12:00PM. Emergency Medical Services ( ) was contacted by Assistant Adminstrator #1 on [redacted] at 12:31PM. Upon arrival of at 12:35PM on to the facility, the resident was noted to be unresponsive. The resident was transported to the hospital on [redacted] at around 12:54PM by Emergency Medical Services ( ). Resident #1 arriving condition to the hospital was documented as [redacted], injuries noted to the resident.	A 083		

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A 083	Continued From page 27 Resident #1 , ... , shortly after being transported to the hospital around 1:12 PM on . . . . . . At the time of the Incident of Resident #1, all responding facility staff (Staff A, B and the Assistant Administrator #1) was noted to have expired and First Aid certification. Class III	A 083		
A 165 SS=D	429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident ' s condition and results in: 1. ; 2. . . or , . damage; 3. Permanent . . ; 4. . . or . . . . . of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her	A 165		

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A 165	Continued From page 28 consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency ' s online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility ' s investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency ' s online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility ' s investigation into the adverse incident. (6) . . , neglect, or . , ... must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which	A 165		

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A 165	Continued From page 29 case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. 59A-36.016 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1), above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting.	A 165		

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A 165	Continued From page 30 This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to submit an Adverse Incident Report as required for any condition that requires the transfer of the resident from the facility to a unit providing more acute care within one (1) day of the incident, and a full report within fifteen (15) days following the incident. The findings include: A review of facility's undated Policy/Procedure, Incident Reporting section documents the following: Purpose: To assure proper documentation of all incidents for reporting purposes, including investigation, analysis, and quality improvement or preventative actions; to be administered by the Risk Manager. Policy: An Incident Report shall be completed on any happening which is not consistent with the routine operation of the facility or routine care of a resident/patient, this includes employees and visitors. Incidents are defined as accidents or untoward events that may eventuate in undesirable outcome. Further review of the Policy/Procedure states: NOTE: If the incident is one with serious injury, or of an otherwise significant nature, immediately contact the Executive Director or Assistant Executive Director during business hours or on weekends or holidays, and they will notify the Risk Manager. If appropriate a 1 Day and 15 Day Adverse Incident Report is to be completed. In an interview with Staff B on . . . . . at 9:36 AM, she stated that on , she arrived at the facility at 7:00 AM and she saw Staff A, who worked the 7:00 PM - 7:00 AM shift, in the	A 165		

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A 165	Continued From page 31 laundry area of the facility. She stated that at this time, she heard someone falling in Resident #1's bedroom and she immediately alerted Staff A that Resident #1 had . She stated that upon opening the resident's bedroom door and entering the bedroom, Resident #1 was lying down on the floor between the bed and the wall. She stated that she and Staff A rolled Resident #1 over and Staff B retrieved the (lift) and they placed Resident #1 in the lift to take the resident to the bathroom so they could shower the resident. She stated that after showering Resident #1, she and Staff B took Resident #1 to her bed to dry and dress the resident. She stated that after this, they took Resident #1 to the living room area to sit down in the reclining chair around 8:00am. She stated that the resident remained in the reclining chair until around 11:30am and she observed the resident being okay and breathing. In an interview with the Assistant Administrator #1 (AA1) on at 12:13 PM, she stated that Staff A called her on around 7:50 AM and described that Resident #1 had a and Staff A did not describe that the resident had . She stated, she told Staff A that she would come to the facility and would assess the resident's . She stated that Resident #1 began to exhibit behavioral issues and would not perform her activities of daily living about 2 months ago. She stated that she received another call from Staff A on sometime after 12:00 PM, and Staff A told her that Resident #1 didn't look well. She stated that when she arrived at the facility on shortly thereafter, she found Resident #1 sitting on the reclining chair in the living room and noticed that the resident had slow breathing. She stated that the resident's saturation was at 60% at that time and this device read the	A 165		

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A 165	Continued From page 32	A 165		

resident's rate to be 206, which she felt was an erroneous reading. She stated that she called 911 after this, which was sometime after 12:00 PM. She stated, afterwards, she administered resident #1 supplemental from the concentrator that belonged to another resident, resident #3 and she also noticed that resident #1 had a hematoma above her right , which was black and blue, and a red scratch-like scar beneath her . She stated that on after the paramedics left the facility to transport resident #1 to the hospital and the police officers were conducting their investigation that afternoon, she learned that resident #1 had off her bed earlier that day. She stated, Staff B described to her how resident #1 was found lying on the floor, flat on her earlier on and how she did not consider how this event involving resident #1 was one that she needed to look at right away and with urgency.

In an interview with Assistant Administrator #1(AA #1) on at 1:31 PM she stated, she attempted to log into the Adverse Incident Reporting System (AIRS) to submit the one (1) day report, but it would not allow her to. She stated she received an error message. AA #1 stated they did not have documentation of the error messages received during the stated attempts to submit the report.

In an interview with Assistant Administrator #2 (AA# 2) on at 1:52 PM, he stated he tried to submit the AIRS the same day of the incident on but the system would not allow him to and that he got an error message when attempting to submit the report. He further stated, he called the Agency for Health Care Administration's (AHCA) and was told to refresh the page as there must be something wrong with

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A 165	Continued From page 33 the server. AA #2 stated he could not remember who he spoke with on the telephone call but that it was the same day of the incident when he called. He further stated, he did not take photo of the screen. AA #2 scrolled through entries on his cellular phone to find the call but stated the call log only went . . . to Wednesday. On .... at 12:01 PM a review of the AIRS by the Local Field Office revealed an entry by the facility for an incident on . . . . . with a report submission date of . No other entries were observed. The facility failed to submit the Initial Adverse Incident Report required within one (1) day of the incident and the Full Adverse Incident Report within fifteen (15) days of the incident occurring on . . . . . . Class III	A 165		

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A 000	Initial Comments An unannounced licensure complaint survey (#2020019446) was conducted on [redacted] to [redacted] at Lindsay's Alternative Care, Inc. The facility had deficiencies identified at the time of the survey. A Class I violation was identified which presented an imminent danger to a client of the provider. The violation was identified at A 0025-Resident Care-Supervision.	A 000		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making [redacted] for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide appropriate personal supervision of care and immediate emergency services, for 1 out of 4 sampled residents (Resident #1). As evidenced by Resident #1 suffering extensive injuries from falling out of a hospital bed and the facility's failure to obtain emergency care/services for	A 025		

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A 025	Continued From page 2 approximately 5 hours resulting in the resident's on . The findings included: Review of the facility's undated policy and procedure entitled, Safe Steppers- . Interventions revealed the following: Measures to be instituted for patient at potential risk for . -Call light placed within reach - Bed brake on - Bed in low position -Q2 hourly round checks Review of the facility's undated policy and procedure entitled, Communication regarding patient change in status revealed the following: It is the policy of Joan Lindsay's Alternative Care ALF to inform residents, family, health care providers, Case Managers, social workers or guardians (next of of kin) in the event of the following. -Accident/incident occurring -Residents needed to be transferred to a hosptial - An emergency or change in residents physical or mental status. The following procedure will be implemented: The staff in charge of the operation of the facility at any given time will perform the following in the order listed. A. Dial 911 for transfer to the nearest hospital in case of an emergency. A completed transfer must be sent with the resident. B. Contact the Resident's Physican A review of the facility's undated Policy & Procedure entitled, Responding to the Unresponsive Resident indicated the following: Purpose: To provide the best opportunity to	A 025		

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A 025	Continued From page 3 prevent . . . . by following accepted standards for . . . in accordance with the American Red Cross and American . . . Association. In the absence of a signed activated . . . . . Form, and/or Hospice, the staff is to perform the following steps: Procedure: 1) If a resident is found unresponsive the staff member will attempt to physically stimulate the resident by calling their name and gently shaking them by the . . . . If unresponsive, look, listen and feel for . . . . . and , . . . , the staff member is to call for help and dial 911. 2) Return to the resident and begin to follow . . protocol. 3) . . . is to continue until the EMT/Paramedics take over. Review of the facility's undated policy and procedure titled, Incident Reporting revealed the following. Purpose: To assure proper documentation of all incidents for reporting purposes, including investigation, analysis, and quality improvement or preventative action; to be administered by the Risk Manager. Policy: An incident shall be completed for an happening which is not consistent with the routine operation of the facility or routine care of a , ... resident/patient, this includes employees and visitors. Incidents are defined as accidents or untoward events that may eventuate in undesirable outcome. Procedure: It will be the responsibility of the employee, nursing or medical staff member mostly closely involved in the incident, having special information regarding the incident to complete a written incident report. Note: No one should fail to complete an incident report form simply because it is thought that someone else involved has done so or was more closely involved. It is the responsibiltiy of the employee's	A 025		

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A 025	Continued From page 4 immediate supervisor to see that it is accuratelty completed, and to complete the incident investigation Report. 3.The written incident report and incident investigation report form must be completed and received in the Risk Management Office within 24 hours. Review of the facility's undated job descriptions/work assignments indicated the following. Each direct care staff member must ensure the resident's welfare, and be "aware of the resident's whereabouts and condition" and perform "regular room/bed checks. A request was made by the Surveyor to the Assistant Administrator #1, a Registered Nurse (RN) on at 12:40 PM for the facility incident report regarding Resident #1's incident that occurred on for review. The report was not completed and provided to the surveyor until . The facility didn't provide any additional information regarding the interal investigation. Review of the facility's incident/accident report dated revealed the following. Resident #1 was found on the floor on at 7:50AM and the resident was moaning, not responsive to verbal/ stimulation, sustained a on her , had 8 , and an saturation of 60%. Further review of this report indicated, the resident was transported to the hospital on at 1:20PM by Emergency Medical Services ( ) and the facility was to re-educate its staff in -preventions, resident monitoring and emergency procedures to prevent reoccurrence of a similar event. During an interview with Staff B (direct care staff) on at 9:36 AM, she stated that on	A 025		

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A 025	Continued From page 5 , when she arrived to the facility at 7:00 AM for her shift. She saw Staff A (direct care staff), who worked the 7:00 PM - 7:00 AM shift on the previous day, in the laundry area of the facility. She explained, the laundry area is located at the front of the house on the opposite side of house of Resident #1's bedroom, immediately to the left when you enter the home, pass the door leading into the garage. The Resident's bedroom was on the opposite side of the laundry room. She stated that at this time, she heard someone falling (a loud bump, bump) in Resident #1's bedroom and she immediately yelled for Staff A that Resident #1 had in her room. She reported, upon opening the resident's bedroom door and entering the bedroom, Resident #1 was lying down on the floor, on the left side of the hospital bed, between the bed and the wall. She stated, she and Staff A rolled Resident #1 over, she was conscience but non-verbal with a on right side of her forehead. Staff B, indicated that she nor Staff A conducted an assessment (including checking of , and/or ,) of Resident #1 after rolling her over to determine the extent of the resident's injuries and condition. Then, Staff B retrieved the , (lift) from the garage and they placed Resident #1 in the lift to take the resident to the bathroom, so they could shower the resident. She stated, after showering Resident #1, she and staff B took Resident #1 to her bed to dry and dress the resident. She stated, after this they took Resident #1 to the living room area to sit down in the reclining chair at around 8:00am. An interview with Assistant Administrator #2 (AA2) on at 11:26 AM, he stated the following. Resident #1 was pretty sufficient up until about 4 months ago. In the latter days we have to assist her more. Just sitting in the	A 025		

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A 025	Continued From page 6 recliner, she would slouch, and we had to reposition her. In the bed, reposition her more than once, she would move to left to the right, that's how she has been the last couple of months. She would constant be rolling and moving in the hospital bed. She had half bed rails on the rightside of the bed. He further stated that he moved Resident #1's hospital bed against the wall near the east window of the room on from its previous location (free standing about 6 from the wall/window). He didn't adjust the of the bed to a low position (as stated in the policy). However, he placed a cushioned pillow against the right side rails and the left side(against the wall) for staff to use while resident was in bed, as a safety precaution. During an interview with the Assistant Administrator #1 (AA #1) on at 12:13 PM, she stated that Staff A called her on at around 7:50 AM and described that Resident #1 had a . Staff A did not describe that the resident . She stated that she told Staff A, that she would come to the facility and would assess the resident's . She reported, Resident #1 began to exhibit behavioral issues and would not perform her normal activities of daily living(ADLs) about 2 months ago. She also thrashed and kicked a lot while in the hospital bed daily. Due to these changes the resident required more monitoring and supervision. We were using half side rails on the right side of the hospital bed only for her safety and had moved her bed the previous day) against the wall near the east window (moved by AA#2). Prior to this, Resident #1 was able to perform her ADLs with assistance with no behavioral issues. She stated, she received another call from Staff A on ,	A 025		

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A 025	Continued From page 7 sometime after 12:00 PM. Staff A told her that Resident #1 didn't look well. She stated, when she arrived to the facility on shortly thereafter; she found Resident #1 sitting in the reclining chair in the living room and noticed that the resident had slow breathing. She stated, the resident's saturation was at 60% at that time and this device read the resident's rate to be 206, which she felt was an erroneous reading. She stated that she called 911 after this, which was sometime after 12:00 PM. She stated, afterwards she administered Resident #1 supplemental from the concentrator that belonged to another resident at the facility, Resident #3. She stated, at this time, she also noticed that Resident #1 had a hematoma (a or of confined to an organ, tissue or space) above her right , which was black and blue, and a red scratch-like scar beneath her . She stated, on after the paramedics left the facility to transport Resident #1 to the hospital and the police officers were conducting their investigation that afternoon, she learned that Resident #1 had off her bed earlier that day. She stated, that Staff B described to her how Resident #1 was found lying on the floor, flat on her earlier on and how she did not consider how this event involving Resident #1 was one that she needed to looked at right away and with urgency. During an interview with the AA #1 on at 12:34 PM, she stated that she was last in the facility on (previous night) at 10:00 PM for about 10 or 15 minutes conducting a check of the facility (to observe residents and staff). She stated upon arrival, she saw Staff A standing outside at the front door of the facility on her cellphone, no other facility staff members were	A 025		

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A 025	Continued From page 8	A 025		

present at the facility. She stated, she went inside and checked on the residents, including Resident #1. She stated Resident #1 was asleep in the hospital bed. She stated, she then left the facility and Staff A remained on duty to care for the residents that evening. She stated that she didn't say anything to Staff A regarding her lack of presence in the facility observing the residents at the time of her arrival. She agreed that Staff A should have been in the facility observing and monitoring the residents at all times. She further stated, she was not sure how long Staff A had been outside prior to her arrival. However, Staff A did come into the building shortly before she departed.

During an interview with Staff A on at 11:30am, the following was revealed. She stated, she worked in the facility for approximately 2.5 years and she usually took care of Resident #1 during her shifts in the facility from 7:00pm to 7:00am. She stated, she last checked on Resident #1 in her room around 10pm, the previous night ( ) and she was sleeping. She closed the room door and allowed the resident to continue to sleep. She stated, on around 7:00am, she was alerted (yelled for) by Staff B that Resident #1 in her bedroom and she found the resident on the floor on the left side of the hospital bed. She stated, that she called AA #1 at around 7:50am to describe that Resident#1 had some to her lower extremities. She stated, AA #1 did not instruct her to do anything in , and AA #1 told her she will be at the facility later in the day. She stated, she and Staff B picked the resident up from the floor and assisted the resident with a shower. She stated, she then assisted the resident to sit on the reclining chair in the living room and gave the resident some ginger tea,

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A 025	Continued From page 9	A 025		

which the resident did not finish. She stated, on at around 11:45am, she noticed that Resident #1 was pale and unresponsive, and she picked up the resident's arm and it was limp. She stated that she didn't check the resident's , , , , or conduct any further assessment to determine if the resident was breathing. She stated, she notified AA #1 on at approximately 11:50am of Resident#1's condition and AA #1 told her that she was on her way to the facility. She stated, on , sometime from 11:50am to 12:45pm, she administered a treatment (a machine that provides a fine mist to assist with breathing) to the resident, and this did not improve the resident's unresponsive status. Staff A stated, the machine belonged to a former resident and that no physican ordered existed. She stated, AA #1 arrived onsite on at approximately 12:45pm, at this time, AA #1 administered , , to the resident and this did not improve the resident's status. Then, AA #1 called 911 and Emergency Medical Services ( ) showed up shortly thereafter and they performed on the resident and then took the resident to the hospital.

Further interview with Staff A on at 11:45am revealed, Staff A reported she did not monitor Resident #1 on at approximately 11:00pm until at 7:00am. She stated that she went to sleep on at about 11:00pm until about 7:00am on and that she was not aware that she needed to monitor any of the facility residents overnight. She stated, she felt like she should have called 911 on Resident #1 on at 7:00am, when she identified that the resident sustained injuries after having falling from her bed. She reported, she was trained to initiate

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A 025	Continued From page 10 First-Aid and without having to receive specific orders from the Administrator or Assistant Administrator. During further interview with Staff B on at 2:06 pm, she stated on around 7:00am, when Resident #1 was discovered on the floor, she or Staff A did not immediately call 911. She stated, AA #1 called 911 on , sometime after 12:00pm for the emergency medical personnel to evaluate and treat resident #1. During an interview with Assistant Administrator #2 (AA #2) on at 2:23 PM, he stated it was the facility's procedure for every resident experiencing an emergency, for the staff members to assess the resident, call 911 and perform for any resident who did not have a , and to contact AA #2 after this. He stated that Staff A and B, who were present at the facility on did not adequately intervene when Resident #1 was found on the floor and sustained injuries due to this accident, which required for either of these staff members to have immediately called 911. In an interview with Staff B on at 2:26pm, she stated that she did not know when Resident #1 was last checked on, as she did not work the previous night shift on . During an observation at this time, Staff B demonstrated what happened on from 7:00am to approximately 12:00pm. During this observation, Staff B placed Resident #1's hospital bed as it was found when she first responded to the resident on (photographic evidence was obtained) and how the resident was found lying down on the floor between the left side of the bed and the wall.	A 025		

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A 025	Continued From page 11 She also raised the 2 half bed rails on the right side of the bed and as they were on . She also stated, the bed was not lowered and the facility does not have any call-lights or pendants. During observation of the bed rails at this time, it was determined that the 2 half-bed rails were applied to provide a full rails on the right side of the resident's hospital bed. (Photographic evidence was obtained). During an interview with the Administrator, a Licensed Pratical Nurse (LPN) on at 2:39 pm, she stated that Resident #1's health status had declined recently and the resident required a greater amount supervision and assistance with her activities of daily living and that she thrashed around a lot while in bed. She stated, the resident started being more a few months ago. She stated that she relied on AA #1 and AA #2 to operate the facility on a daily basis since she was not able to go onsite that frequently. She stated, Staff A informed her of the incident involving Resident #1 on ... at approximately 11:50am. At this time, she described the resident as not looking well and having earlier. She stated, she told Staff A to call 911 and that AA #1 was on her way to the facility. During an interview with the Administrator on ... at 3:02 pm, she stated that the staff members are required to call 911 during every resident emergency and this was the first thing to do. She stated, the staff were trained to call 911, whenever there is a change in status of any resident and not to call an Administrator first. She stated, the staff members did not need instruction for this to happen and to perform First Aid. She stated, Staff A described that Resident #1 was not responding to verbal commands.	A 025		

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A 025	Continued From page 12 During an interview with AA #1 on at 12:55pm; she stated, Resident #1 did not have a supplemental order and that she used Resident #3's concentrator machine on Resident #1 because she found Resident #1 being and with a faint when she arrived on around 12:00pm. She stated, she administered about 2 liters of to Resident #1 with Resident #3's mask and the police arrived on around 12:15pm and arrived shortly thereafter. She reported, performed on the resident immediately after they arrived to the facility and she didn't know how long personnel remained in the facility before they transported the resident to the hospital. She stated, that the resident had a hematoma on her forehead, had shallow and almost no when she assessed the resident on . She stated, she worked in the facility as the assistant administrator for about 22 years. She stated, she was in the facility on at about 10:00pm and that AA #2 was at the facility on at 3:00pm to move Resident #1's bed from being about 2 from the wall to placing the bed immediately next to the wall. She stated, this was done because the resident began having "thrashing" movements on or about and the resident's physician ordered medications for the resident and half bed rails. During interview with AA #1 on at 1:16 PM she stated, it was expected that the direct care staff members must monitor the residents throughout the night, at least once per hour, and the staff must not sleep during the overnight shift. She stated, Staff A and B should have called 911 on when it was determined that Resident #1 and injured herself, as the staff	A 025		

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A 025	Continued From page 13 was trained to do. During an interview with Police Detective #1 on at 2:25pm she stated, when she performed her investigation regarding Resident #1's on , Staff A described that she last saw Resident #1 on at 10:00pm and Staff A found the resident on the floor on after 7:00am. She stated, she was informed that the resident's bed presented to have slid or rolled on its wheels, despite Staff A's account that the bed wheels were in the locked position. She stated, the resident was found to have extensive physical injuries on , including a considerable gash on her and some other injuries to her and . She stated, Staff A waited for the AA #1 to arrive to the facility for over 4 hours before 911 was called and the resident was found by with 8 breaths per minute. She stated, the facility staff should have contacted 911 immediately after the resident was found after her the /accident to activate the first aid and emergency response. Review of the ambulance response record dated on indicated that the emergency medical services ( ) response was initiated from a facility telephone call on at 12:31pm, was dispatched at 12:32pm and arrived to the facility at 12:35pm. Review of this ambulance response record indicated that the personnel reached Resident #1 at 12:38pm, departed the facility at 12:54pm and arrived to the hospital at 12:59pm. Review of this ambulance response record indicated Staff A communicated to the personnel that Resident #1 went unresponsive and her breathing started to decrease, that the resident approximately 3 hours prior. personnel found the resident sitting in the chair, unresponsive, pulseless and	A 025		

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A 025	Continued From page 14 apneic (temporary cessation of breathing). This record indicated that the resident had a hematoma above her right [illegible] to right and a and to the right [illegible]. Further review of this ambulance response record indicated that personnel provided [illegible] ( ) to resident #1 at 12:38pm, the resident had a 0/0 [illegible], 0 [illegible] and 0 [illegible] at 12:39pm, applied supplemental [illegible] at 12:43pm, the resident had a [illegible] at 12:44pm, applied 1mg of [illegible] intraosseously (injection directly into the bone) at 12:48pm, 12:51pm, 12:54pm and 12:58pm, the resident had 0 [illegible] and 0 [illegible] at 12:48pm and [illegible] at 1:01pm. Review of police photographs discussed and provided by the Police Dectective #1 revealed the following. Review of Resident #1's police photographs #1 and 20 indicated that the resident's bed was found with dark red stains/splatters on the mattress fitted sheets, located at the and left side of the bed. Review of the confidential photographs #2, #13 and #22 indicated that the wall next to Resident #1's bed had [illegible]-like stains/splatters on its surface. Review of the confidential photographs #3 -#5, #7, #9 - #19 and 21 showed that Resident #1 appeared to have suffered extensive physical injuries on [illegible] involving her [illegible] /lower extremities, right , right [illegible] /forehead and left [illegible]. Review of the confidential photographs #23 and #24 indicated that a staff member sent a photograph of resident #1 depicting the injury she received to her , on [illegible] at 10:36am and was received or "seen" by AA #1 on at 12:52pm. Review of Resident #1's hospital records	A 025		

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A 025	Continued From page 15 indicated that the resident arrived to the hospital's emergency room by way of the local fire rescue transportation on at 1:05pm with a diagnosis of . Review of this record indicated that the resident had a certification of on at 1:12pm with no cause of listed and the resident's body was released to the medical examiner's office. Further review of this record indicated that the resident was in (absence of) before arriving to the hospital and was in process of receiving by for approximately 20 minutes and that the resident earlier that morning and hit her . This record indicated that the resident presented to be in with no , and no spontaneous breath sounds, was unresponsive, had to the , the right , and periorbital regions, had no , and was in . Review of Resident #1's health assessment form (AHCA Form 1823) dated on indicated that the resident's diagnoses were listed as: , , , , , and Legally . Review of this health assessment indicated that the resident had , Unsteady Gait and required assistance with Ambulation, Bathing, , Grooming, Toileting and Transfers. Review of the resident's record titled, "monthly assessment notes" indicated that on the resident was starting to show increased and agitation, and was very restless. Further review of this record indicated that the resident underwent a change in level of function and her walking capability was decreased. During an interview with AA #2 on at 2:45pm, he stated, the overnight staff was	A 025		

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A 025	Continued From page 16 required to check on the residents every hours and that the staff was not allowed to sleep during the overnight shifts. He stated, there was presently no method to log the direct care staff members monitoring the residents every hours during the night and that the facility did not have specific policies and procedures regarding resident bed rail use or resident monitoring. In an interview with AA #1 on at 1:00pm, she stated that after the event involving Resident #1 on , she wanted to implement a system that required the staff to monitor all the residents every hour during the overnight shifts, but presently did not have anything in place to ensure this was being done by the staff. She stated, the facility also did not have any method to presently document any resident monitoring or supervision by the staff. During an interview with the Administrator on at 3:45pm, she stated that she was aware that the First Aid/ certifications for AA #1, Staff A and Staff B were expired on . She acknowledged that none of the responding Staff members involved in Resident #1's incident were current with First Aid and training, She reported, the facility did not immediately implement the re-education of staff in -prevention, resident monitoring and emergency procedures to prevent a reoccurrence of a similar event involving Resident #1 on . Review of Staff B's employee record indicated that the staff member was hired on and received First aid/ training on which expires on . Review of this record indicated that the staff member's previous First aid/ training was done in , and it	A 025		

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LINDSAY'S ALTERNATIVE CARE, INC	5783 NW 48TH DRIVE CORAL SPRINGS, FL 33067

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 17 expired in , ... Review of this record did not indicate that this staff member was certified to provide First aid/ . services on . . . . . . Review of Staff A's employee record indicated that the staff member was hired on and received First aid/ _ training on . . . . . which expires on . Review of this record indicated that the staff member's previous First aid/ training was done in , and it expired in , ... Review of this record did not indicate that this staff member was certified to provide First aid/ . services on . . . . . . Review of the Assistant Administrator 1's (AA#1) employee record indicated that the staff member was hired on . . . . . and received First aid/ training in , and it expired in , ... Further review of this staff member's record indicated that she had a State of Florida Registered Nurse (RN) license and no other documentation of an updated training was in place. Class I	A 025		
A 053 SS=D	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care	A 053		

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A 053	Continued From page 18 provider. The contact with the health care provider must also be documented in the resident's record. (c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including waived testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and chapter 483, part I, F.S. A valid copy of the State Clinical Laboratory License, if required, and the federal CLIA Certificate must be maintained in the facility. A state license or federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a State Clinical Laboratory License or a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the State Clinical Laboratory License and federal CLIA Certificate is available from the Laboratory Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to only administer physician order medications to residents, for 1 out of 3 sampled residents (Resident #1). As evidenced of the facility staff members (licensed and unlicensed) administering a treatment and a treatment to Resident #1 on [redacted] without a physician order.	A 053		

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A 053	Continued From page 19 The findings include: A request was made by the Surveyor to the Assistant Administrator #1, a Registered Nurse (RN) on at 12:40 PM for the facility incident report regarding Resident #1's incident that occurred on for review. The report was not completed and provided to the surveyor until . The facility didn't provide any additional information regarding the interal investigation. Review of the facility's incident/accident report dated revealed the following. Resident #1 was found on the floor on at 7:50AM and the resident was moaning, not responsive to verbal/ stimulation, sustained a on her , had 8 , and an saturation of 60%. Further review of this report indicated, the resident was transported to the hospital on at 1:20PM by Emergency Medical Services ( ) and the facility was to re-educate its staff in -preventions, resident monitoring and emergency procedures to prevent reoccurrence of a similar event. During an interview with the Assistant Administrator #1 (AA #1) on at 12:13 PM, she stated that Staff A called her on at around 7:50 AM and described that Resident #1 had a . Staff A did not describe that the resident . She stated that she told Staff A, that she would come to the facility and would assess the resident's . She stated, she received another call from Staff A on , sometime after 12:00 PM. Staff A told her that Resident #1 didn't look well. She stated, when she arrived to the facility on shortly thereafter; she found Resident #1 sitting in the reclining chair in the living room and noticed	A 053		

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A 053	Continued From page 20	A 053		

that the resident had slow breathing. She stated, the resident's saturation was at 60% at that time and this device read the resident's rate to be 206, which she felt was an erroneous reading. She stated that she called 911 after this, which was sometime after 12:00 PM. She stated, afterwards she administered Resident #1 supplemental from the concentrator that belonged to another resident at the facility, Resident #3. She stated, at this time, she also noticed that Resident #1 had a hematoma (a or of confined to an organ, tissue or space) above her right , which was black and blue, and a red scratch-like scar beneath her . She stated, on after the paramedics left the facility to transport Resident #1 to the hospital and the police officers were conducting their investigation that afternoon, she learned that Resident #1 had off her bed earlier that day. She stated, that Staff B described to her how Resident #1 was found lying on the floor, flat on her earlier on and how she did not consider how this event involving Resident #1 was one that she needed to looked at right away and with urgency.

During an interview with Staff A (unlicensed direct care staff) on at 11:30am, the following was revealed. She stated, on around 7:00am, she was alerted (yelled for) by Staff B that Resident #1 in her bedroom and she found the resident on the floor on the left side of the hospital bed. She stated, that she called AA #1 at around 7:50am to describe that Resident#1 had some to her lower extremities. She stated, AA #1 did not instruct her to do anything in and AA #1 told her she will be at the facility later in the day.

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A 053	Continued From page 21 She stated, she and Staff B picked the resident up from the floor and assisted the resident with a shower. She stated, she then assisted the resident to sit on the reclining chair in the living room and gave the resident some ginger tea, which the resident did not finish. She stated, on [illegible] at around 11:45am, she noticed that Resident #1 was pale and unresponsive, and she picked up the resident's arm and it was limp. She stated that she didn't check the resident's [illegible] or conduct any further assessment to determine if the resident was breathing. She stated, she notified AA #1 on [illegible] at approximately 11:50am of Resident#1's condition and AA #1 told her that she was on her way to the facility. She stated, on [illegible], sometime from 11:50am to 12:45pm, she administered a [illegible] treatment (a machine that provides a fine mist to assist with breathing) to the resident, and this did not improve the resident's unresponsive status. Staff A stated, the [illegible] machine belonged to a former [illegible] resident and that no physican ordered existed. She stated, AA #1 arrived onsite on [illegible] at approximately 12:45pm, at this time, AA #1 administered [illegible] to the resident and this did not improve the resident's status. Then, AA #1 called 911 and Emergency Medical Services ([illegible]) showed up shortly thereafter and they performed [illegible] on the resident and [illegible] then took the resident to the hospital. During an interview with AA #1 on [illegible] at 12:55pm she stated, resident #1 did not have a supplemental [illegible] order and that she used Resident #3's [illegible] concentrator machine on Resident #1 because she found Resident #1 being [illegible] and with a faint [illegible] when she arrived on [illegible] around 12:00pm. She	A 053		

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A 053	Continued From page 22 stated, she administered about 2 liters of to Resident #1 with Resident #3's mask and the police arrived on around 12:15pm and arrived shortly thereafter. Review of Resident #1's health assessment form (AHCA Form 1823) dated on indicated that the resident's diagnoses were listed as: and Legally . Review of this health assessment indicated that the resident had , Unsteady Gait and required assistance with Ambulation, Bathing, , Grooming, Toileting and Transfers. Further record review failed to indicate any physican orders for the use of treatment or treatment. Class III	A 053		
A 083 SS=D	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies	A 083		

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A 083	Continued From page 23 this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to ensure one staff member with a current , , ( ) certification was present in the facility at all times, for 3 of 4 sampled staff members (Assistant Administrator #1, Staff A and B) as required, thus placing Residents at risk of not receiving life-saving interventions. The findings include: A review of the facility's undated Policy & Procedure titled: "Responding to the Unresponsive Resident" indicated the following: Purpose: To provide the best opportunity to prevent by following accepted standards for in accordance with the American Red Cross and American Association. In the absence of a signed activated Form, and/or Hospice, the staff is to perform the following steps: Procedure: 1) If a resident is found unresponsive the staff member will attempt to physically stimulate the resident by calling their name and gently shaking them by the . If unresponsive, look, listen and feel for , and , the staff member is to call for help and dial 911. 2) Return to the resident and begin to follow protocol. 3) is to continue until the EMT/Paramedics take over. On at 10:49 AM a review of the	A 083		

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A 083	Continued From page 24 National . Foundation's website at www.nationalcprfoundation.com was conducted. Review indicated " . stands for , , , , and it is a series of techniques that are designed to restore a heartbeat to those who have drowned, experienced a . . . . or . . . . . , or had a ." Through a combination of . . . . . and . . . -to- . . . . . , those administering . hope to restore a , and regular breath to those who have . . . It further stated: " certification is simply the document that attests to you being trained and allows you to perform on those in need. Since these life-or- . . . situations require fast action, having an in-depth understanding of the techniques is essential." On . . . . at 10:54 AM, a review of the American Red Cross website at www.redcross.org was conducted. Review of the website indicated "According to the American Red Cross Scientific Advisory Council, . skill retention declines within a few months of initial training - and continues to decline as time goes by. In addition, the council found that less than half of course participants can pass a skills test one year after training. This means that just one year into your two-year . certification, you may not remember how to help when you're needed most." Review of Staff 's A personnel file, revealed a hire date of as a Direct Care Staff member. Review of Staff A's . . . . . ( ) certification on file revealed it expired . . . . . Further review of the file revealed that Staff A did not obtain her current certification of . . . . . - . . . . . until . Staff A works alone on the 7:00 PM -	A 083		

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A 083	Continued From page 25 7:00 AM shift on Sunday, Monday, Wednesday, Thursday and Friday's as indicated by the Staff Schedule provided by Assistant Administrator #2 (AA #2). Review of Staff B's personnel file revealed she was hired on as a Direct Care Staff Member. Review of Staff B's ( ) certification in file revealed it expired . Further review of the file revealed that Staff B obtained her current recertification of - on . Staff B works the 7:00 AM - 7:00 PM shift alone on Sunday - Thursday as indicated by the Staff Schedule presented by Assistant Administrator 2. During the review of Assistant Administrator #1 (AA #1) facility file revealed, she was hired on , and is a Registered Nurse (her nurse license expires). Review of the file also revealed the presence of a ( ) certificate with a certification of - . Further review revealed Assistant Administrator #1 obtained her current certification of - on . In an interview with Staff A on at 11:45AM, she stated that she was not sure when she was last certified in . She stated that she felt like she should have called 911 for Resident #1 on at 7:00AM, when she identified that the resident sustained injuries after having from her bed. She stated that she was trained to initiate first aid and without having to receive specific orders from the Administrator or Assistant Administrator. In an interview with Staff B on at 2:06 PM, she stated that on around 7:00	A 083		

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A 083	Continued From page 26 AM when Resident #1 was discovered on the floor and the resident was likely to have been injured, she or Staff A should have immediately called 911. In an interview with the Administrator on [redacted] at 3:45 PM, she stated she was aware that the First Aid/ certifications for Assistant Administrator #1, Staff A and B were expired on . In an interview with Assistant Administrator #2 on [redacted] at 2:23 PM, he stated that the facility's policy regarding a Resident emergency is for staff to assess the resident, perform if there is no Do Not Resuscutate ( ) order, call 911 and contact Assistant Administrator #1. Review of facility records to include policies and procedures, resident records and interviews conducted on [redacted] through [redacted] with the Administrator, Assistant Administrator #1 and #2, Staff A and B, the following was revealed, Resident #1 was found on the floor on [redacted] at 7:50AM and the resident was moaning, not responsive to verbal/ stimulation, sustained a [redacted] on her [redacted], had 8 [redacted] per minute and an [redacted] saturation of 60%. The resident's condition worsened from the time of the incident until sometime after 12:00PM. Emergency Medical Services ( ) was contacted by Assistant Administrator #1 on [redacted] at 12:31PM. Upon arrival of at 12:35PM on to the facility, the resident was noted to be unresponsive. The resident was transported to the hospital on [redacted] at around 12:54PM by Emergency Medical Services ( ). Resident #1 arriving condition to the hospital was documented as , injuries noted to the resident.	A 083		

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A 083	Continued From page 27 Resident #1 , [redacted], shortly after being transported to the hospital around 1:12 PM on [redacted]. At the time of the Incident of Resident #1, all responding facility staff (Staff A, B and the Assistant Administrator #1) was noted to have expired and First Aid certification. Class III	A 083		
A 165 SS=D	429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident ' s condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her	A 165		

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A 165	Continued From page 28 consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency ' s online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility ' s investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency ' s online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility ' s investigation into the adverse incident. (6) . . , neglect, or . , ... must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which	A 165		

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A 165	Continued From page 29 case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. 59A-36.016 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1), above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting.	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965079	A. BUILDING: _____ B. WING _____	12/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 165	Continued From page 30 This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to submit an Adverse Incident Report as required for any condition that requires the transfer of the resident from the facility to a unit providing more acute care within one (1) day of the incident, and a full report within fifteen (15) days following the incident. The findings include: A review of facility's undated Policy/Procedure, Incident Reporting section documents the following: Purpose: To assure proper documentation of all incidents for reporting purposes, including investigation, analysis, and quality improvement or preventative actions; to be administered by the Risk Manager. Policy: An Incident Report shall be completed on any happening which is not consistent with the routine operation of the facility or routine care of a resident/patient, this includes employees and visitors. Incidents are defined as accidents or untoward events that may eventuate in undesirable outcome. Further review of the Policy/Procedure states: NOTE: If the incident is one with serious injury, or of an otherwise significant nature, immediately contact the Executive Director or Assistant Executive Director during business hours or on weekends or holidays, and they will notify the Risk Manager. If appropriate a 1 Day and 15 Day Adverse Incident Report is to be completed. In an interview with Staff B on . . . . . at 9:36 AM, she stated that on , she arrived at the facility at 7:00 AM and she saw Staff A, who worked the 7:00 PM - 7:00 AM shift, in the	A 165		

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A 165	Continued From page 31 laundry area of the facility. She stated that at this time, she heard someone falling in Resident #1's bedroom and she immediately alerted Staff A that Resident #1 had . She stated that upon opening the resident's bedroom door and entering the bedroom, Resident #1 was lying down on the floor between the bed and the wall. She stated that she and Staff A rolled Resident #1 over and Staff B retrieved the (lift) and they placed Resident #1 in the lift to take the resident to the bathroom so they could shower the resident. She stated that after showering Resident #1, she and Staff B took Resident #1 to her bed to dry and dress the resident. She stated that after this, they took Resident #1 to the living room area to sit down in the reclining chair around 8:00am. She stated that the resident remained in the reclining chair until around 11:30am and she observed the resident being okay and breathing. In an interview with the Assistant Administrator #1 (AA1) on at 12:13 PM, she stated that Staff A called her on around 7:50 AM and described that Resident #1 had a and Staff A did not describe that the resident had . She stated, she told Staff A that she would come to the facility and would assess the resident's . She stated that Resident #1 began to exhibit behavioral issues and would not perform her activities of daily living about 2 months ago. She stated that she received another call from Staff A on sometime after 12:00 PM, and Staff A told her that Resident #1 didn't look well. She stated that when she arrived at the facility on shortly thereafter, she found Resident #1 sitting on the reclining chair in the living room and noticed that the resident had slow breathing. She stated that the resident's saturation was at 60% at that time and this device read the	A 165		

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A 165	Continued From page 32	A 165		

resident's rate to be 206, which she felt was an erroneous reading. She stated that she called 911 after this, which was sometime after 12:00 PM. She stated, afterwards, she administered resident #1 supplemental from the concentrator that belonged to another resident, resident #3 and she also noticed that resident #1 had a hematoma above her right , which was black and blue, and a red scratch-like scar beneath her . She stated that on after the paramedics left the facility to transport resident #1 to the hospital and the police officers were conducting their investigation that afternoon, she learned that resident #1 had off her bed earlier that day. She stated, Staff B described to her how resident #1 was found lying on the floor, flat on her earlier on and how she did not consider how this event involving resident #1 was one that she needed to look at right away and with urgency.

In an interview with Assistant Administrator #1(AA #1) on at 1:31 PM she stated, she attempted to log into the Adverse Incident Reporting System (AIRS) to submit the one (1) day report, but it would not allow her to. She stated she received an error message. AA #1 stated they did not have documentation of the error messages received during the stated attempts to submit the report.

In an interview with Assistant Administrator #2 (AA# 2) on at 1:52 PM, he stated he tried to submit the AIRS the same day of the incident on but the system would not allow him to and that he got an error message when attempting to submit the report. He further stated, he called the Agency for Health Care Administration's (AHCA) and was told to refresh the page as there must be something wrong with

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A 165	Continued From page 33 the server. AA #2 stated he could not remember who he spoke with on the telephone call but that it was the same day of the incident when he called. He further stated, he did not take photo of the screen. AA #2 scrolled through entries on his cellular phone to find the call but stated the call log only went . . . to Wednesday. On .... at 12:01 PM a review of the AIRS by the Local Field Office revealed an entry by the facility for an incident on . . . . . with a report submission date of . No other entries were observed. The facility failed to submit the Initial Adverse Incident Report required within one (1) day of the incident and the Full Adverse Incident Report within fifteen (15) days of the incident occurring on . . . . . . Class III	A 165		