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
	AL11969122	A. BUILDING: _____ B. WING _____	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT DANIA BEACH	150 STIRLING RD DANIA BEACH, FL 33004

(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 Complaint (#2021011948) survey and Generator Monitoring survey was conducted on through at The Residence at Dania Beach. The facility had deficiencies identified related to the Complaint (#2021011948) at the time of the survey.	A 000		
A 025	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 or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . 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 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 services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal	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 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 ensure adequate supervision and monitoring for 1 of 8 sampled residents, Resident #1, as evidenced by facility staff failing to identify in a timely manner, Resident #1 had sustaining injury and requiring hospitalization. The findings included: Review of the facility's "Resident Supervision"	A 025		

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A 025	Continued From page 2	A 025		

policy and procedures dated , revealed that the facility "must provide care and services appropriate to the needs of residents" and "must offer personal supervision as appropriate for each resident" which included observation by the staff "of the activities of the resident" and "awareness of the general health, safety, and physical and emotional well-being of the resident." Further review of this document revealed that the facility implemented daily observations by the staff of the resident activities "that includes an hourly check of all residents" and every caregiver "must sign the sheet and state where the resident is located and what the resident is doing. Any change in resident's condition must be reported to the nurse and administrator".

Review of the facility's "Resident's Medical Concerns" policy and procedures dated , revealed that the facility staff "will notify the nurse verbally and in communication log of any medical concerns that were brought to their attention by the residents immediately. Also, any other concerns observed or reported by the staff will be documented in resident's file." Further review of this document revealed that the "administrator will conduct a meeting with the resident and discuss his/her concerns in details within 24 hours and document it in the resident's file" and "every progress of the resident's medical concern will show in the resident's file the ongoing monitoring and physical assessments that have been completed to address the medical concerns and status".

Review of the facility's undated "Physical Assessment/Care Plan" policy and procedures, revealed that the facility will complete a Physical Assessment/Care Plan and Behavior Symptoms Checklist for all residents upon admission to the

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A 025	Continued From page 3 facility and "upon any readmission to the facility from a hospital" so "to determine appropriate services to be provided to the resident." Further review of this document revealed that the facility will complete a "Quarterly/Change in Condition Assessment for each resident quarterly" and "all completed Physical Assessment/Care Plans, Behavior Symptoms Checklists and Quarterly/Change in Condition Assessment will be filed in the medical record". Review of the facility's undated " Prevention Program" policy and procedures revealed that the facility will "ensure that every effort is made to provide every resident adequate supervision and assistive devices to protect the resident from and injury. The staff is to assess residents that may be at risk for and make concerted efforts to prevent ." Review of this document revealed that the "administrator will assess every new admission for the potential of using the Risk Assessment form"; "a resident identified at risk for will have approaches developed by the resident care coordinator and administrator and implemented by the staff to prevent the residents from " and "a Risk Assessment will be completed quarterly by the resident care coordinator after admission and on an as needed basis when a resident experiences a change in condition." Further review of this document revealed that " assessments should be completed on all residents within the first 3 hours of admission, with any change of condition and after a ", "once a resident has been identified as 'at risk for falling', there should be documented evidence in the medical record of nursing interventions to prevent a from occurring" and the resident "should be monitored closely." Review of the facility's undated "Resident/Visitor	A 025		

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A 025	Continued From page 4 Incident Report" policy and procedures revealed that "all incidents are to be documented and reported to the administrator" and the procedures included that "the incident form is to be completed by the staff and or witness to incident immediately after occurrence" and the "report should include whether or not any visible injury is noted (ex: , , behavior reaction)". Review of the facility's accident investigation documentation dated at 6:00 PM, revealed Resident #1 was found on the floor inside his bedroom by an unidentified staff member. Review of this documentation revealed the resident lost his balance and with no , the facility called 911 and transferred the resident to the hospital. Further review of this documentation revealed the facility did not document an investigation, identify environmental factors or conduct follow-up/interventions involving the resident's . Review of Resident #1's Health Assessment Form 1823 dated , revealed diagnoses to include , , left , memory loss and , . Review of this assessment revealed the resident had a limp and refused to use a cane, had decreased cognition and was placed on and universal precautions. Review of this assessment revealed the resident's activities of daily living (ADLs) status was: he needed supervision with his ambulation, bathing and grooming, and he was independent with all other ADLs. Review of Resident #1's record notes dated at 5:56 PM, revealed the resident was found on the floor and the resident was transported to the hospital. On at 1:11 PM, the resident returned from the hospital. On	A 025		

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A 025	Continued From page 5 . . . . . at 10:35 AM, the resident presented to be weak and was , and 911 was called to transport the resident to the hospital. In an interview conducted with the Administrator on at 10:30 AM, she stated Resident #1 was hospitalized on . . . . . for evaluation after being found on the floor in his room and he returned to the facility on . . . . . without any specific orders from the hospital. Further she stated the resident was found to be weak by the Director of Nursing (DON) Staff A, who was the director of resident care, on . . . . and the resident was subsequently transported to the hospital at this time. In an interview conducted with DON Staff A on at 10:50 AM, she stated she found Resident #1 on the floor on . . . . . and she called 911 to have him evaluated in the hospital. She stated on . . . at approximately 9:30 AM, she found Resident #1 in his room on his bed wet in his own . . . .-soaked clothes and he was uncharacteristically weak. She stated the resident walked, transferred and performed all of his other ADLs independently before , and she also realized that he became . . . . . at approximately 10:00 AM, so she called 911 to have the resident transported to the hospital. She stated that while she and Caregiver Staff B were changing the resident's clothing and bed linens, the Emergency Medical Services (. . .) personnel arrived onsite and began transportation of the resident to the hospital. She stated she observed the resident's skin to be intact while she was changing his clothing on . . . . . and she did not remember the exact timing on when the personnel arrived or when the resident left for the hospital on .	A 025		

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A 025	Continued From page 6 In an interview conducted with Caregiver Staff B on at 1:20 PM, she stated on at approximately 9:20 AM, she received a call from DON Staff A to assist her with Resident #1, who was found to be weak in his bed. She stated she arrived to the resident's bedroom shortly thereafter and assisted DON Staff A to reposition the resident in his bed and the resident presented to be in considerable , to his . She stated the resident walked, transferred and performed all of his other ADLs independently before . She stated the resident was extremely weak on and DON Staff A called 911. She stated the personnel arrived onsite on at approximately 9:35 AM to transport him to the hospital. She stated the resident was dry and had no offensive odors on . In an interview conducted with the Administrator on at 1:40 PM, she stated Resident #1 walked, transferred and performed all of his ADLs independently before , and she was aware that he was deemed to be a risk by his physician on his Health Assessment. She stated the facility did not assess the resident for his identified risk for and did not develop approaches to diminish this risk as per the facility's policy and procedures. She stated she felt the facility did not need to perform further actions after the resident's hospitalization on . In an interview conducted with Caregiver Staff C on at 10:15 AM, she stated she usually worked the 11 PM to 7 AM shift in the facility and she worked the evening of in the facility. She stated she was familiar with Resident #1, but she did not see him at all when she worked on the overnight shift on . She stated since	A 025		

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A 025	Continued From page 7	A 025		

she worked alone in the facility's 100, 200, 300 and 400 wings that evening and there were over 100 residents present in these wings, she did not have time to check up on Resident #1 and many other residents during her shift. She stated she remembered seeing Resident #1 on Sunday [redacted], and he was lying flat on his [redacted] on the bed and he said he was watching television as he looked towards the ceiling. She stated that this was strange because there was no television turned on in the bedroom. She stated she could not assist this resident because he was a very large man who [redacted] close to [redacted] and there usually was no other staff member who could assist her. She stated she did not document or notify anyone because she was too busy that day and it slipped her mind. She stated the resident had not been the same since he returned from the hospital on [redacted] and knew something was off with him. She stated she felt it was not safe for her to work alone during the overnight shifts, for herself and for the residents. She stated she worked alone last night on [redacted], and the receptionist who usually worked this shift, was designated to the reception area and not able to assist on the wings. She stated there was a [redacted] staff member who worked last night, but this staff member left the facility at approximately 2:30 AM. She stated the facility's Memory Care area (500 wing) was usually staffed with one caregiver during the overnight shifts and this staff member was also designated to this area which was a locked unit for the memory care residents. She stated she felt scared to walk the 100, 200, 300 and 400 wings of the facility during her overnight shift because the facility's hallways were so long, empty and since there was no security guard at night, anyone could break in from the outside into the facility without her knowing. She stated she

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A 025	Continued From page 8	A 025		

also felt like she could not assist all the residents during her shift because if she was assisting one resident on one side of the facility and another resident across the facility were to need assistance or have an emergency, it would take a very long time for her to respond to this resident.

Review of the facility floor plan revealed the facility's 100, 200, 300 and 400 wings had approximately 80 resident bedrooms with each bedroom accommodating a capacity of 2 residents. Further review of this floor plan revealed the facility occupied a full square city in area.

Review of the report dated revealed was dispatched to the facility on at 10:49 AM and personnel reached Resident #1 at 10:56 AM, who found the resident lying up on the floor inside his room, with the resident and the whole floor wet in his own and the resident said he out of his bed but could not say how this happened. Review of this report revealed the resident stated no staff member tried to assist him off of the floor, he denied and the resident presented to have extreme to his with movement. Review of this report revealed the resident's bed was also wet with and it was uncertain how long the resident was lying on the floor. Review of this report revealed the resident's skin on his had signs of deterioration, was red in color and due to being in contact with his for a prolonged period of time. Further review of this report revealed the resident had an open on his along with a possible second open to his coccygeal area and the resident was transported to the hospital and was suspected to have been neglected of care in the facility due to the

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A 025	Continued From page 9 condition he was found in. Review of 2 photographs taken by the staff on revealed the resident was on the floor and turned on his right side, which exposed a view of an open on his upper by the left region, a taped bandage on his left side by his lower and defined reddened areas on his region which was partially covered with the resident's clothing garment. Review of a third photograph taken by staff on revealed the resident's bed had partially removed linens which were completely stained with a brown colored substance and there was a towel on the floor which was also stained with a brown colored substance. Review of Resident #1's hospital record revealed the resident presented to the emergency room on at 11:26 AM with a chief complaint of falling out of his bed last night and being on the floor "for hours prior to being found by the ALF nursing staff." Review of this record revealed the resident was found to be in "unkempt appearance" and determined to have an emergency medical condition. Review of the resident's Internal Medicine consultation dated at 8:10 AM, revealed the chief complaint was he "can't get up" and he was assessed to have . Review of the resident's Plastic Surgery consultation dated at 2:16 PM, revealed the resident was "bedridden and does not get frequent movement or diaper changes, presents with of the skin and some partial-thickness loss in the region." Further review of this consultation revealed the resident's / had " , probable between and possible of the inner region". It was assessed to be an	A 025		

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A 025	Continued From page 10 " of the region" and it was recommended that "the patient needs to be frequently moved". In an interview conducted with Resident #1's representative on at 3:15 PM, he stated he found out about Resident #1 being in the hospital on by receiving a phone call from the hospital staff and not by the facility staff to inform him of what had happened to the resident. He stated the hospital staff contacted him on or about to ask him for consent to transfer the resident to a nursing home whenever the resident was to be discharged from the hospital and he provided this consent to the hospital. He stated the hospital contacted him on or about to inform him that the resident was in process of being discharged to the nursing home. He stated he was disappointed the facility did not contact him on or to inform him of the resident's status which led to the resident's hospitalizations. Review of the facility's list which described 34 residents in total who needed to receive assistance and/or supervision with their ADLs and who were at risk for , also revealed that Resident #1 was identified to need supervision with his ambulation and was at risk for with precautions. In an interview conducted with Caregiver Staff E on at 10:52 AM, she stated she usually worked the 3 PM to 11 PM shift in the facility and she worked the afternoon/evening of in the facility. She stated she was familiar with Resident #1 and she saw him on inside his room at approximately 9:00 PM lying on his bed without distress but he couldn't move. She stated the resident asked her for a cola and she	A 025		

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told him that she could not get that for him because the kitchen was closed. She stated the resident's room always smelled of . . . and he would move his on the bed because after he returned from the hospital on . . . . . , he was really weak and could not perform any of his ADLs independently. She stated she would have to clean him in his bed because she could not assist him with transfers, ambulation and toileting by herself since he was a large, heavy man and there was no staff help in the facility.

In an interview conducted with DON Staff A on at 11:25 AM, she stated she saw Resident #1 lying on his bed on . . . . . and his condition had declined from before. She stated the resident's condition really changed on after he returned from the hospital, and she did not discuss this resident's decrease in ADL function or condition with other facility staff members. She stated she did not see the resident walk or transfer from to . . . . . , which was uncharacteristic for him, and she also did not notify the resident's Physician of any changes in his function or condition after . She stated she knew of 2 other times in which the resident soiled his clothing and bed linens with . . . during the period from . to . . . . .

In an interview conducted with the Administrator on at 11:45 AM, she stated she received no reports from the staff that Resident #1 had declined in condition after and she felt since the resident did not go through a significant change in condition during this time period, the facility did not have to investigate in detail what occurred on . She stated the facility did not take any steps to identify or assess the root cause of the resident's recent decline in

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A 025	Continued From page 12 function which culminated in his hospitalization and did not implement steps in order to prevent future occurrences like this to other residents. In an observation conducted of Resident #1's bedroom with the Administrator on at 12:00 PM, the room had an offensive and fecal matter-like odor and the room presented to be cluttered and unclean. During this observation, the resident's bed had partially removed linens which were mostly stained with a brown colored substance and there was a towel on the floor which was also stained with a brown colored substance. Further observation of the room's floor revealed there were brown-colored stains next to the bed. In an interview conducted with the Administrator on at 12:00 PM, she stated the facility did not yet "refresh" the resident's room and that the fecal matter stains on the sheets and towel were from when Resident #1 was there on , confirming Resident #1's room had not been touched since his transfer to the hospital 16 days prior. Class III	A 025		
A 079	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 6-15 212 16-25 253 26-35 294	A 079		

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36-45 335
46-55 375
56-65 416
66-75 457
76-85 498
86-95 539

For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week.
2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours.
3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.
4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night.
5. 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 of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement.
b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT DANIA BEACH	150 STIRLING RD DANIA BEACH, FL 33004

(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 079	Continued From page 14 certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least . . . . . must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work	A 079		

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A 079	Continued From page 15 schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no	A 079		

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A 079	Continued From page 16 longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure adequate staffing to meet resident care needs affecting 6 of 8 sampled residents reviewed, Resident #1, Resident #2, Resident #3, Resident #4, Resident #7 and Resident #8. The findings included: Review of the facility's "Resident Supervision" policy and procedures dated , revealed that the facility "must provide care and services appropriate to the needs of residents" and "must offer personal supervision as appropriate for each resident" which included observation by the staff "of the activities of the resident" and "awareness of the general health, safety, and physical and emotional well-being of the resident." Further review of this document revealed that the facility implemented daily observations by the staff of the resident activities "that includes an hourly check of all residents" and every caregiver "must sign the sheet and state where the resident is located and what the resident is doing. Any change in	A 079		

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A 079	Continued From page 17 resident's condition must be reported to the nurse and administrator". Review of Resident #1's Resident Health Assessment Form 1823 dated revealed diagnoses to include , , , left , , memory loss and . Review of this assessment revealed that the resident had a limp and refused to use a cane, had decreased cognition and was placed on and universal precautions. Review of this assessment revealed the resident's activities of daily living (ADLs) status was: he needed supervision with his ambulation, bathing and grooming, and he was independent with all other ADLs. Review of Resident #1's record notes dated at 5:56 PM revealed that the resident was found on the floor and the resident was transported to the hospital. On at 1:11 PM the resident returned from the hospital. On at 10:35 AM the resident presented to be weak and was , and 911 was called to transport the resident to the hospital. Review of the (Emergency Medical System) report dated revealed that was dispatched to the facility and reached Resident #1 at 10:56 AM, who was found lying up on the floor inside his room. The resident said he out of his bed but could not say how this happened. Review of this report revealed the resident stated no staff member tried to assist him off of the floor. Further review of this report revealed the resident was assessed with having a with injury and the resident was transported to the hospital. In an interview with the Director of Nursing (DON) Staff A on at 10:50 AM, she stated she found Resident #1 on the floor on and	A 079		

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A 079	Continued From page 18 she called 911 to have him evaluated in the hospital. She stated on at approximately 9:30 AM, she found Resident #1 in his bed in his room and he was uncharacteristically weak. She stated she did not know if the resident was checked on by any staff member before she saw him on . Review of the facility resident hourly check forms revealed there was no hourly check form dated and the hourly checks dated for Resident #1 documented an unnamed staff member checked hourly on this resident from 11 PM to 6 AM. Review of the hourly checks dated for Resident #1 documented that there was no staff member who checked on this resident from 7 AM to 3 PM and an unnamed staff member checked hourly on this resident from 4 PM until 6 AM on . Further review of the hourly checks dated for Resident #1, documented a staff member checked hourly on this resident from 7 AM until 6 AM on , and on a staff member checked hourly on this resident from 7 AM until 6 AM on . Of note, Resident #1 was hospitalized on and was not present in the facility to have hourly checks conducted on , , and as was documented on the hourly check form. In an interview conducted with the Administrator on at 1:40 PM, who stated she was aware that whenever any resident needed assistance with their ADLs, the facility must ensure adequate staffing is available to offer the personal care as appropriate for each resident as per facility policy and procedure. She stated the facility staff was supposed to complete the resident hourly checks, but she could not confirm the accuracy of these checks because there was	A 079		

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A 079	Continued From page 19	A 079		

no method in place to verify if each staff member actually performed the documented resident checks. She stated she had no explanation on why the facility staff documented on , and that Resident #1 was checked on and observed, when the resident was actually in the hospital since the morning of .

In an interview conducted with Caregiver Staff C on at 10:15 AM, she stated she usually worked the 11 PM to 7 AM shift in the facility and that she worked the evening of in the facility. She stated she was familiar with Resident #1, but she did not see him at all when she worked on or . She stated since she worked alone in the facility's 100, 200, 300 and 400 wings that evening and there being over 100 residents in these wings, she did not have time to check up on Resident #1 and many other residents during her shift. She stated she felt it was not safe for her to work alone during her shift, for herself and for the residents. She stated she also worked alone last night on , and that the receptionist who usually worked this shift, was designated to the reception area and not able to assist on the wings. She stated there was a staff member who worked there last night, but this staff member left the facility at approximately 2:30 AM. She stated the facility's Memory Care area (500 wing) was usually staffed with one caregiver during her shift and this staff member was also designated to this area which was locked. She stated she felt scared to walk the 100, 200, 300 and 400 wings of the facility during her overnight shift because the facility's hallways were so long and empty and since there was no security guard at night, anyone could break in from the outside into the facility without her knowing. She stated she also

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A 079	Continued From page 20 felt like she could not assist all the residents during her shift because if she was assisting one resident on one side of the facility and another resident across the facility were to need assistance or have an emergency, it would take a very long time for her to respond to this resident. Review of the facility floor plan revealed that the facility's 100, 200, 300 and 400 wings had approximately 80 resident bedrooms with each bedroom accommodating a capacity of 2 residents each. Further review of this floor plan revealed that the facility occupied a full square city in area. Review of the facility census forms from until revealed that on the facility had a total of 134 residents with 104 residents in the general assisted living wings of the facility (100, 200, 300 and 400 wings) and 30 residents in the Memory Care (500) wing of the facility. Review of the facility's fluctuation of daily resident occupancy for the month of revealed that there were no more or less than 2 residents' difference from the census, with the resident census in the 100, 200, 300 and 400 wings remaining at approximately 104 residents throughout the entire month of . Review of the facility staffing schedule for revealed there were 2 staff members scheduled to work the 11 PM to 7 AM shift, including Caregiver Staff C and a staff member who no longer worked in the facility. Review of the facility staffing schedule for documented that Caregiver Staff C was the only staff member scheduled to work the 11 PM to 7 AM shift.	A 079		

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A 079	Continued From page 21 Review of the facility's list which described the residents who needed to receive assistance and/or supervision with their ambulation, transfer, and toileting ADLs and who were at risk for , revealed that there was a total of 34 residents in the facility who required some level of this identified additional personal care. In an interview conducted with Caregiver Staff E on at 10:52 AM, she stated she usually worked the 3 PM to 11 PM shift in the facility and there were usually only caregivers working the 100, 200, 300 and 400 wings. She stated that this was a time when residents needed more -on care and supervision, which she felt she could not do. She stated the facility administration was aware of this and all the other residents who needed additional daily care could not receive this care due to staff shortage. In an interview conducted with the Administrator on at 11:45 AM, she stated she was not aware that Caregiver Staff C worked by herself during the overnight 11 PM to 7 AM shifts on and on . She stated the facility entered into agreements with 2 staffing agencies last week to provide contract caregivers for the 3 PM to 11 PM and 11 PM to 7 AM shifts, but she could not confirm if a contract caregiver worked in the facility on during the 11 PM to 7 AM shift. Review of the contract caregivers' sign-in and sign-out timesheets dated , revealed there was no contract caregiver who signed these timesheets for the 11 PM to 7 AM shift. In an interview conducted with Resident #2 on at 9:45 AM, he stated he has lived here for over a year and that the facility was short	A 079		

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A 079	Continued From page 22	A 079		

staffed. He stated it seems like most of the facility's direct care staff have quit and he is left by himself for hours. He stated he needed assistance to transfer in and out of his wheelchair and to eat, and the staff took hours to come to help him. He stated his food often went since he had to wait for staff to help him eat and he could not do this on his own.

In an interview conducted with Resident #3 on at 12:20 PM, he stated he has lived here for a while and it took the staff a while to help him go to the bathroom. He stated he could wheel himself in his wheelchair about the facility, but he needed assistance from staff to go to the bathroom and it often took too long to receive this help on a daily basis.

In an interview conducted with Resident #4 on at 2:55 PM, he stated he has lived here for a while and the facility was "short of help." He stated he often needed help with showering, and he hardly ever got any help for this. He stated this lack of help happened almost daily.

In an interview conducted with Resident #7 on at 2:40 PM, he stated he has lived here for years, and the facility was definitely short staffed. He stated he needed assistance with transfers and ambulating but stated there were probably other residents who needed more help than him.

In an interview conducted with Resident #8 on at 3:50 PM, he stated he has lived here for a couple of months and he last month inside his bathroom. He stated when he , he did not get any assistance from the staff for hours. He stated he needed assistance to go to the bathroom and he had to do it on his own. He

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A 079	Continued From page 23 stated he uses a wheelchair to ambulate, and he wheeled himself about the facility without any staff supervision. He also stated he felt the facility was short staffed, mostly in the evening and overnight shifts. In an observation conducted on [redacted] from 4:10 PM to 4:15 PM, Resident #8 transferred from his bed into his wheelchair and propelled himself in his wheelchair from his bedroom to the courtyard area of the facility. During this observation, there were no staff members supervising the resident with his ADLs. Class III	A 079		