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 |
|---|---|---|---|
| | AL11969061 | A. BUILDING: _____ B. WING _____ | 11/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SILVER CREEK OF ST | 165 SILVER LN SAINT , FL 32084 |

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| A 000 | Initial Comments<br><br>A Complaint Survey (Complaint# 2021015360, Complaint# 2021011623, and Complaint# 2021013590) was conducted on , 2021 at Silver Creek of St. . Deficient practice was identified at the time of the survey, including a Class I deficiency identified at A 0078, Staffing Standards. | A 000 | | |
| A 078 SS=J | 59A-36.010(2) FAC Staffing Standards - Staff<br><br>(2) STAFF.<br>(a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership.<br>1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of .<br>2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not | A 078 | | |

AHCA Form 3020-0001

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

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| A 078 | Continued From page 1<br>constitute a risk of transmitting a communicable<br><br>(b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter.<br>(c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C.<br>(d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents.<br>(e) For facilities with a licensed capacity of 17 or more residents, the facility must:<br>1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and,<br>2. Maintain time sheets for all staff.<br>(f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on interviews and record reviews, facility staff failed to exercise their responsibilities to provide ( ) for an unresponsive resident who did not have an | A 078 | | |

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| A 078 | Continued From page 2<br><br>executed a ( ). Staff's lack of ability to carry out the procedures they had been trained for placed 52 of 73 residents who have executed a at risk should they be found unresponsive.<br><br>The findings include:<br><br>Review of the medical record for Resident #1 revealed an admission date of . Resident #1 required daily oversight with observations of wellbeing, whereabouts, and reminders for important tasks. Resident #1's electronic record contained a facility specific assessment form which checked off her code status as . It was signed by the resident on . Photographic evidence obtained.<br><br>During an interview with Employee A, Resident Service Aide, on at 12:18 p.m., she explained that Resident #1 had not come out for lunch on so she went to check on her. She found the resident unresponsive in bed and she was not breathing. Employee A stepped out of the room and notified Employee B, LPN, by -held radio. After Employee B arrived to the room, Employee A stood outside of the room. Employee A explained that she stepped into the room briefly and saw Employee B perform a sternal rub and check for a , but she did not see Employee B performing .<br><br>Review of the nursing progress notes revealed an entry dated 16:39 by Employee B, Licensed Practical Nurse (LPN) which detailed that she was asked to go to Resident #1's room. Upon entry, Resident #1 was seen in bed, , . The note documented Resident #1 was without vital signs or a , , and that she was and was not aroused with painful | A 078 | | |

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| A 078 | Continued From page 3 | A 078 | | |

stimuli. The note did not indicate a code status was checked or that was initiated. Photographic evidence obtained.

An initial interview with the Administrator on at 12:05 p.m., revealed that during the facility's investigation, Employee B stated she did perform when the resident was found unresponsive. A follow up interview was conducted with the Administrator on 11/8/2021 at 2:38 p.m. where she was again asked about Resident #1's code status, and she stated the resident was a full code. She acknowledged that full code meant that was to be provided if the resident was found without a , or . She explained that an incident report submitted by Employee B after the event indicated that was initiated. The referenced incident report was reviewed with the Administrator on her laptop. The incident report did not indicate that was initiated. The Administrator then stated she, the Health and Wellness Director (HWD), and the Corporate nurse had spoken to Employee B and that Employee B confirmed she had provided . The Administrator stated the information in Resident #1's chart indicating she had a was incorrect since there was never a yellow form executed. She was considered full code.

On at 2:56 p.m., during a telephone interview with the HWD, she explained that she had just heard from the Administrator for the first time that Employee B stated she had initiated . The HWD explained that she responded to the facility on when she heard that police were present. She explained that she interviewed Employee B that day and that what she "got from the conversation" was that the

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| A 078 | Continued From page 4<br><br>resident was and gray so Employee B did not initiate . When asked whether she specifically asked the nurse if had been initiated, the HWD stated, "she told me she did not." The HWD confirmed that the resident was a full code and that her expectation was that would have been initiated.<br><br>During an interview on at 9:45 a.m. with Employee B, she explained that Employee A came to her at about 1:00 p.m. on and said the resident was unresponsive. Employee B explained that she entered the room and found the resident unresponsive in her bed without vital signs. She stated 911 was called by Employee C, Resident Service Aide, and 911 responded about 15 minutes later. Employee B confirmed that she did not initiate . When asked why she didn't initiate , or use the facility's machine, the nurse stated, "Because she was and I didn't think she would benefit from it. Employee B then stated Employee A told her Resident #1 had a .<br><br>Employee B's personnel file revealed she was an LPN hired on . Her certification was completed on , 9 days prior to the incident with Resident #1. She received one hour of training in the facility's . policy on .<br><br>On at 10:02 a.m., a second interview was conducted with Employee A. When asked whether she checked the code status of Resident #1 in response to the resident being found unresponsive, she stated, "No. I did not do that. I wasn't asked to do that. In fact, the nurse (Employee B) was the one that told me she was a ." When asked whether she had received any training on , Emergency Care, and | A 078 | | |

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| A 078 | Continued From page 5<br>(AEDs).<br>Employee A stated, "No. I've been bounced around from Memory Care to the Cove. They didn't train me on that. I never look at the charts. I never told the nurse she was a because I don't look at the charts."<br><br>Personnel file review for Employee A showed she received training in . She had training in the facility's Advanced Directive Policy on .<br><br>The facility's policy (undated) stated they would obtain the resident's code status at admission and copies of the executed would be placed in the Resident Emergency Information (911) binder. Photographic evidence obtained.<br><br>On at 11:01 a.m., the Administrator was interviewed about statements made by Employee B, which included that she did but also that Employee A told her Resident #1 had a . She explained that Employee B was telling different versions of her story to different people and that the facility had just terminated Employee B and escorted her out of the facility. The Administrator added that on the staff had called her to find out where they could locate a resident's code status. She told Employee C and the Maintenance Director to check the resident's chart. Once the employees confirmed that the resident did not have a in her record, Employee C notified Employee B over the handheld radio but Employee B failed to initiate .<br><br>Employee C explained in an interview on at 11:08 a.m. that Employee A had approached her in the hallway and had asked her | A 078 | | |

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| A 078 | Continued From page 6<br><br>for help in finding out whether Resident #1 was a . Employee C explained that she and the Maintenance Director checked the resident's chart and did not find a . She then announced to everyone over the handheld radio that the resident was a full code. Employee C stated she didn't have any further involvement after this point.<br><br>On at 2:35 p.m., a follow up interview was conducted with the Administrator. She confirmed once again that Resident #1 was a full code and confirmed that was not initiated.<br><br>Records of trainings were obtained which showed in-services were conducted following the facility's investigation into Resident #1's . As of the date of the survey, 13 direct care staff members have been educated or re-educated since . Thirty-three direct care staff members (whose hire dates precede the event with Resident #1) have not yet attended the re-education. Employee B was not on the list of staff who had gone through re-education. Photographic evidence obtained.<br><br>Employee E, an LPN, was listed as receiving the in-service on about . The education materials explained that the was used to identify people who did not want during , , or . Photographic evidence obtained.<br><br>Employee E was interviewed on at 1:49pm. When asked to explain the procedures, she explained that if she found an unresponsive resident, she would initiate then check the code status. If the resident had a , she would then stop that had been initiated. | A 078 | | |

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| A 078 | Continued From page 7<br><br>According to the American Association, is an emergency lifesaving procedure performed when the stops beating. Immediate can double or triple chances of survival after .<br><br>Class I | A 078 | | |