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
	AL11967447	A. BUILDING: _____ B. WING _____	03/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIZCAYA BY THE SEA	1621 NORTH OCEAN BLVD POMPANO BEACH, FL 33062

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A 000	Initial Comments An unannounced Licensure Complaint survey (#2022004084) was commenced on [redacted] and concluded on [redacted] at Vizcaya By The Sea. The facility had a deficiency identified related to the Complaint (#2022004084) at the time of the survey.	A 000		
A 030	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; [redacted] Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- [redacted] or 1(800)962-2873. The telephone numbers must be posted in close	A 030		

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A 030	Continued From page 1	A 030		

proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and , ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and standard precautions;
8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical .
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible

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A 030	Continued From page 2 telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the	A 030		

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A 030	Continued From page 3 facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care ..., and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally ..., the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care	A 030		

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A 030	Continued From page 4 Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for	A 030		

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A 030	Continued From page 5 exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder . . . . . Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated . . . . , ... or . . , ... under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on interviews, record reviews and observations, it was determined that the facility failed to honor the rights of 1 of 64 sampled residents (Resident #1). As evidenced of the facility failure to perform , ... (.) when the resident was found unresponsive by the facility staff members on . . . . . and the resident did not have a . . . . . ( ) to withhold her	A 030		

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A 030	Continued From page 6 life sustaining treatment. The facility also failed to follow life sustaining policies established to ensure is provided to a resident without a . The facility currently has 5 of 65 residents with valid 's on file. (Residents #18, Resident #25, Resident #29, Resident #43 and Resident #54.The facility currently has 60 residents without a (Resident# , #19-24, #26-28, #30-42, #44-53, #55-61 and are at risk. The findings included: A review of the facility policy titled, - POLICY (undated) states the following: Policy: It is the policy of this facility to provide basic life support, including ( )- , , , when a resident requires such emergency care, prior to the arrival of emergency medical services, subject to physician order and resident choice indicated in the resident's directives. Nurse and other care staff are educated to initiate , as recommended by the American Association.(AHA) unless: A valid is in place The Objective of the policy is to provide basic life support based until emergency medical services arrives, consistent with the resident advance directives, in the absence of an advance directive or and if the resident does not show signs of clinical . Prompt initiation of is essential as begins four to six minutes following if is not initiated within that time.	A 030		

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A 030	Continued From page 7 A review of the facility policy titled, PROCEDURE FOR - {undated), states the following. PURPOSE: The facility shall provide basic life support, including to a resident who requires such emergency care prior to the arrival of emergency medical services, consistent with the resident's advance directive and physician orders. SUPPLIES: Backboard mask or Resuscitator Bag Automated External Defibrillator ( ) Crash Cart--- Basic airway equipment--- masks, --tubing, --suction machine and equipment PROCEDURE: 1) Employee to verify safety of the scene/environment 2) Check for resident response. Tap or shake of resident asking, "Are you okay" If no , begin , Place backboard under resident in bed or assist resident to a firm, flat surface if possible. 3) , assess the resident for breathing and for 10 seconds. -tilt/ -lift technique If a , or , injury is suspected, utilize the modified jaw-thrust maneuver. 4) Shout for nearby help or pull the call button for assistance. Activate emergency response system. Staff immediately instructed to retrieve and emergency equipment response system and retrieve (unless another staff member is able to retrieve device) before beginning . 5) Identify code status/advance directive preferences (Include facility process for identification Of code status/advance directive. If the resident has a valid advance directive, a	A 030		

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A 030	Continued From page 8 POLST (Physician Orders for Life-Sustaining Treatment Form that indicates that is not desired) or MOLST(specify State Specific documentation) or a " " ( ) (Also known as DNAR-Do Not Attempt) order,do not perform . 6) If no order/advance directive exists or if advance directive does not indicate " ", begin efforts: 7) If Resident does not exhibit normal breathing and has a , , begin rescue breathing, 1 Breath every seconds (per minute) using mask or Resuscitator Bag. If resident is presenting with agonal breaths, continue as if resident is not breathing. 8) Check , approximately every 2 minutes. 9) If no , begins (Please note: if is immediately available, use defibrillator as soon as possible when device is ready for use): Place backboard under resident in bed or assist resident to a firm, flat surface if possible 10) : Follow manufacture's recommendation (See Policy and Procedure): Check rhythm. If indicates yes, shockable, give 1 . Resume immediately for approximately 2 minutes until the prompts a rhythm check. Continue efforts until one of the following occurs: Resident presents with effective, spontaneous circulation Care is transferred to emergency responders to provide advanced life support Review of Pompano Beach Fire Rescue reported dated , revealed the following. A call was received on at 15:27 (3:27 PM), dispatched at 15:28 (3:28 PM) and they arrived on scene at 15:35 (3:35PM). Resident was found	A 030		

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A 030	Continued From page 9 un-responsive by Assisted Living Facility (ALF) staff. The last time seen normal was 45 min to 1 hour prior per staff. Resident had an unknown medical history and poor historians on scene. Upon arrival station #11 (Fire Rescue) found resident un-responsive pulseless, Apneic, with fixed and dilated pupils, . . . to touch. Resident had obvious rigor, secondary assess showed no significant injuries. Resident was found on floor after staff placed her there. Disposition resident . . . . on scene no . . . . . attempted without transport. Review of incident report completed by Assistant Administrator on . . . . . at 5:00 PM, regarding Resident #1 revealed the following. Staff A (Direct Care Staff) reported that while during rounds resident was found lying in bed unresponsive, 911 was called staff-initiated . until Paramedics arrived. Witness noted as Staff B (Nursing Assistant/CNA) and Staff D (Nursing Assistant/CNA). Further review of the report failed to indicate Staff A was the first responding staff. Review of adverse incident report submitted to AHCA and completed by the Administrator on . . . . . at 4:35PM, the report revealed the following. Staff A(CNA) found the resident (Resident #1) lying in bed un-responsive and she called Staff B, Staff C and Staff D. Staff B checked resident , . . . and resident had no , . Staff C immediately call 911, the Paramedics and Broward Sheriff arrived at the facility pronounced resident at approximately 3:20PM, as per Paramedics resident was . . . approximately 30 minutes prior to Paramedics arrival. At 3:30PM, the next of kin and PCP (Primary Care Provider) was made aware. was not performed due to the fact resident had no , . , and no on file.	A 030		

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A 030	Continued From page 10 Per Primary Care Provider resident . . . of natural causes. During an interview with the Assistant Administrator on . . . . . at 9:30 AM, she was questioned regarding the of Resident #1. She stated she nor the Administator were present at the facility during the time of the incident but was called via phone by Staff B (Nursing Assistant/CNA). She stated Resident #1 was found in her room by Staff A (Direct Care Staff), unresponsive. She stated other staff responded also to assist Staff A in Resident #1's room. She stated they all started on the resident. She stated, the facility had not further investigated the incident to ensure all staff had responded appropriately and according to protocol (policies and procedures). She stated she assumed staff performed accordingly and performed . timely based on her conversation with them on . . . . . around 4:00PM during her interviews while on site. She stated that she completed the incident report and the Administrator had completed the Adverse incident report and submitted to the Agency. However, she stated the facility had no further documentation regarding interviews conducted and/or further investigation. Review of Resident #1's facility charting notes dated documented by Assistant Administrator at 4:36 PM revealed the following. Staff reported that at 2:50PM went to Resident Room to assist resident (Resident#1) with a shower but resident refused and jokingly stated to staff that she doesn't have a million dollars to give for bath and wanted to just rest for Now prior to dinner. A second entry noted at 3:10PM ( ) under the notes, revealed the following. Staff reported that while during rounds resident observed lying in bed . . .	A 030		

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A 030	Continued From page 11 and immediately called for help. 911 called by staff. As per (Staff B) CNA/Medtech was initiated with no success. Paramedics and Broward Sheriff officers arrived and stated resident expired. Resident next of kin/brother and made doctor aware. Resident #1 was admitted to the facility on . Resident #1's Health Assessment dated on , shows the following diagnosis; with behavioral disturbances, , Mild and Resident #1's physical or sensory limitations noted as ambulates with a walker. or Behavioral status noted as alert and oriented, but forgetful. Further review of the form documents the resident requires assistance with bathing, independent with eathing, self-care(grooming), toileting, and requires supervise with ambulation (uses a walker) and . During interviews conducted with Staff (Staff A-F) present on the day of the incident ( ), multiple concerns and discrepancies were identified regarding Resident #1 being found unresponsive, the following was noted. 1) The time and actions taken by Staff (A -F) regarding Resident #1 when she was found unresponsive. 2) The actual time when was actually started and stopped, and whom was the first person to initiate it. 3) Submission of the Adverse incident report (the details/occurrence) to the Agency by the facility versus the staff interviews regarding the actual events.	A 030		

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A 030	Continued From page 12 On . . . . . at 10:03AM, a . . . -to- . . . interview was conducted with Staff C(CNA/Cook), the following was revealed. Staff C was asked who found Resident #1 un-responsive? Staff C stated, it was Staff A(Direct Care Staff), B(Nursing Assistant/CNA) & D(Nursing Assistant/CNA). Staff C stated, she was in the kitchen, and she heard a staff yelling, so she went to see what was going on. She went to Resident #1's room and saw Resident #1 on the floor. I called 911 around 3:20PM. I ran and got the ( ) Automated External Defibrillator machine from the office. I don't know if anyone was doing , . Other staff was present during the 911 call, they (911) told me to remove her from the bed and remove her clothes. 911 said to use the machine and put the pads on her; and give her a . I don't remember who pressed the button and shocked Resident #1. The Paramedics came approximately 8 minutes later. The paramedics arrived, I stepped while the Paramedics started working on her. Staff B was doing paperwork. Staff B was in charge that day. We (Staff A, C and D) stayed with the Paramedics and Police while they worked on Resident #1 for around 30 minutes. Staff C stated that day, she worked as a CNA to cover a co-worker Staff F(Nursing Assistant/CNA) shift because she had car trouble. An interview with conducted with the Administrator on . . . . . at 10:30AM, she stated the following. The Administrator stated, she received a call on Sunday (. . . . .) at approximately 3:00PM from Staff B(Nursing Assistant/CNA), stating Resident #1 was found in bed un-responsive. Administrator stated, I asked if they had called 911? Staff B said "yes". I asked if anyone was doing ? She responded, "yes".	A 030		

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(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 030	Continued From page 13 She also stated that Staff B(Nursing Assistant/CNA) and Staff D (Nursing Assistant/CNA) were in Resident #1's room with her. She stated Resident #1 had no . She stated she also spoke to the paramedics upon their arrival, exact time could not be provided. She stated, the paramedics informed her that "Resident #1 was gone". Further interview with the Administrator on ., at approximately 10:50AM, she stated the Paramedics informed her that the resident had been for about 20 to 30 minutes. I asked if it was a ? The paramedics said yes. We were all shocked! Staff B was in charged. Staff B is a senior CNA/Med Tech, on Sundays. Staff B & C (Cook/CNA) are usually in charge. She further stated, Staff B, called the Assistant Administrator, she came into the facility due to the emergency. She stated, that the staff are trained. She stated, "The facility protocol is even if you have a , we do until the paramedics arrive". On at 11:35AM, an interview with Staff B (Nursing Assistant/CNA) was conducted, she revealed the following. During the interview, she reported her work schedule and hours are Tuesday-Friday 7:00PM-5:30PM and Sundays 7:00 AM-3:00PM. Staff B (Nursing Assistant/CNA) stated I was at work at 7:00AM. I spoke to Resident#1 around 7:15AM, in her room. Resident #1 went to breakfast; I gave her morning medication at approximately 8:15AM. Resident #1 was joking with me, and she returned to bed in her room. Staff B stated, she did a 2 hour check on the resident; she brought her toilet tissue to her room as she always does during the week. Staff B reported no problems. Later, Resident #1 went to lunch in the dining	A 030		

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A 030	Continued From page 14	A 030		

room around 12:00 PM. Resident #1 ate all her lunch and Staff B gave her lunch medications around 12:15PM. Staff B stated Staff E (Direct Care) offered Resident #1 a shower. Resident #1 was lying down and she refused a shower. At 3:00PM, the next shift came on. Staff A(Direct Care Staff) was doing her rounds and went into Resident#1 room; stood by the door called out to Resident #1 and she didn't respond. Staff A called her name several times no response so Staff A ran to the nurse's station to get me. Staff B stated she immediately went with her to Resident #1's room. Staff B stated I shook her , called her name no response, I checked her , , and it was poor, so I started doing . I stopped for 30 seconds went to the door and yelled for Staff C (Cook/CNA) and D to come help me. They came within a few seconds and Staff C called 911. Staff A &D were present they went and got the machine from the nurse's station. We did as 911 told us to do, we put her on the floor and did , . We turned the machine on and followed the directions. Staff B stated, "I pressed the button". Staff B stated 3 paramedics and 2 Police Officers arrived at approximately 3:30PM I gave them space to do their job. Staff D assisted me with the . I am trained in . Later I went to prepare the paperwork I left the other staff with the Paramedics. Staff B gave the Paramedics sheet, 1823 Doctor's information. Staff B stated the Paramedics and the Officers both spoke to the Administrator. Staff B stated the Administrator called the family. Staff B stated she was in charged on .

On at 3:30PM, an interview was conducted with Staff D (Nursing Assistant/CNA), the following was revealed. Staff D stated she works as a CNA from 3:00 -11:00PM (Saturday,

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A 030	Continued From page 15 Sunday and Thursday). On , my shift started at 3:00PM and I did my rounds. I checked on my assigned residents, including Resident #1. She stated, Staff A(Direct Care Staff) told her she noticed Resident #1 was in her roommate's bed in # . Staff D stated Resident #1 was never in her roommate's bed before. Staff A(Direct Care Staff) called Staff B (Nursing Assistant/CNA) stated she noticed Resident #1 was going up and down slowly and a low , . . . Staff A started calling everyone for help. Staff C (Cook/CNA) called 911 and Staff B&D started doing on Resident#1 in bed. Staff D stated she abruptly left the room to go get the machine from the medication room and return helping Staff B with . Further interview, at this time, with Staff D (Nursing Assistant/CNA) revealed 911 instructed us to put Resident #1 on the floor in her room and we did and continued with until the paramedics arrived. 911(over the phone) told us where to put the . . . . . Staff B (Nursing Assistant/CNA) placed the cord on Resident #1's . . . . Only one (1) , . . was placed on Resident #1 by Staff B then the paramedics arrived. Staff D stated the Paramedics upon arrival, took over and put something on her (Resident#1) and 2 minutes later the Paramedics told us she is no longer with us. Staff D stated Resident #1 wasn't when we started . Resident #1 , and was open. On at 4:00PM, an interview conducted with Staff A(Direct Care Staff) revealed the following. She stated she works the 3PM to 11 PM shift on (Saturday, Sunday and Thursday). She stated she was working the 3PM to 11 PM shift on . . . . . She stated, she entered Resident #1's room (alone) at 3:00PM doing her	A 030		

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A 030	Continued From page 16 rounds, she stood by the door calling Resident #1's name several times no answer from the resident. Staff A stated she didn't do an assessment of the resident, I didn't touch her. I left the resident's room, no other staff present and ran for approximately 1 minute to the nurse's station (on the other side of the building) got Staff B (Nursing Assistant/CNA) and we returned to Resident #1 room. Staff B did an assessment of the resident. Staff B shook the resident , she was un-responsive, checked her , . . . and it was very weak. Staff B started . . . on the bed. Staff B stopped . . . rushed to Resident #1 door and yelled for Staff C (Cook/CNA) & D (Nursing Assistant/CNA). Both came to the room in about 1 minute. Staff A stated, that she did not assist with . . . She stated Staff D assisted Staff B with , . Staff A stated it took 4 people to ease Resident #1 to the floor. Staff A stated she never assisted with because she was . . . and forth. During a further interview, at approximately 4:30 PM on , Staff A (Direct Care Staff) was asked how did she identify Resident #1 was unresponsive and not breathing. She stated, I knew she was unresponvie and not breathing because she didn't answer me. She further stated, she didn't check the resident physically to determine if the resident was just sleeping or unable to hear her. She stated, she knew something was wrong when she stood at the door of the room and saw resident in the bed and unresponsive response. She was asked from the door , could she see Resident #1 in her bed, she stated "yes". However, she was unable to state that she was able to observe whether Resident #1 was observed in distress simply by looking at her from the doorway of Resident #1's room.	A 030		

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A 030	Continued From page 17 Observations of Resident #1's room, revealed the bed is located approximately 5 to 7 from the door. The bed is located on the right-side of the room near the window. The room is an open floor layout, with two beds located. Further observations of the surveyor standing at the door in the position described by Staff A, revealed you would be unable to determine the physical condition of the resident laying in the bed (specifically Resident #1's bed). On at 4:30PM during a telephone interview with Staff E(Direct Care Staff) the following was revealed. She stated she works the 7:00-3:00PM shift (works Saturday, Sunday and Tues-Thursday). She stated she was working on . . . . . at the facility. She stated, she checked on Resident #1 at the start of her shift around 7:00AM and she was fine, we had a conservation. Later, Resident #1 went to breakfast, she had her morning medications and returned to her room. Staff E stated, shed checked on Resident #1 every 2 hours during her shift. Resident #1 went to the dining room around Noon for lunch, she ate all her lunch took her noon medications and returned to her room. Staff E said Resident #1 refused a shower after lunch, she was joking with me asking do I have to pay for a shower.? Staff E stated, I told her no you don't have to pay. Staff E stated before she left work at 3:00PM on . . . . . , she checked on Resident # . Resident#1 was lying in bed and stated she was doing fine. No complaints. Staff E stated she left work at 3:00PM. She stated she received a call after getting home that Resident#1 . Staff E stated I don't remember who called me. On at 10:40AM during a follow up telephone interview with Staff F(Nursing	A 030		

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A 030	Continued From page 18 Assistant/CNA). Staff F stated she works Friday's 4:00PM -10:00PM and Sunday's 10:00AM-2:00PM. Staff F stated she worked on , the day of Resident #1's . I saw Resident#1 in the dining room eating lunch (I don't remember what she was eating or the exact time). Staff F stated Resident #1 is independent with personal care. Her shower was already completed when she came down for lunch on . I had a conversation with her in the dining room. Staff F stated the last time I saw Resident #1 was at 12:00PM in the dining room. I left work at 2:00PM on . I received a call at 4:00PM on from Staff B stating Resident #1 , . I asked Staff B, what happened to Resident #1. She stated, Staff B informed her "we don't know what happened maybe a ". I never received a call from Administrator or Assistant Administrator regarding Resident#1's on the date of the incident or after the incident. I was never interviewed by the Administrator or the Assistant Administrator regarding my interactions with Resident #1. On at 3:20PM, a confidential telephone interview was held with the local Fire Rescue Paramedic Department regarding Resident #1 incident on . It was revealed by the confidential individual that upon arrival of this Paramedic unit; no staff or persons at the facility were observed performing nor was machine in use for Resident #1. Resident was lying on the floor, staff were in the room. Review of the Record revealed the cause of was Natural with immediate cause noted as , , . Other significant conditions	A 030		

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contributing noted as [illegible], Time of noted as 1520 (3:20PM).

On [illegible] at 2:44PM, observations of the (Automated External Defibrillator) machine revealed the device does not reflect the last maintenance date: in addition, the pads were noted to be expired. The dates of the [illegible] sets were and . At this time, the Assistant Administrator confirmed the pads were expired and that she would order new ones for the facility. She stated she was not aware of the expiration unitl surveyor intervention. She was also unable to provide any documentation of maintenance of this machine to ensure that it was working properly and that all materials were current.

On at 3:30 PM, an interview conducted with Administrator, she reiterated that all staff are trained in . She also stated, the facility protocol is, "if you have a , we still do until the Paramedics arrives". I never came in on the day of the incident, my Assistant Administrator was communicating with me via telephone I overheard them saying they should have done and should not have left her. Administrator stated we have had no other deaths within the facility in the past.

On at 12:15PM, an interview was conducted with the Assistant Administrator; she revealed the facility has not evaluated and/or assessed the situation regarding Resident #1 being found un-responsive on , staff not following the policy and the policy to ensure with respect to the other employees working at the facility (20 employees/Staff A -T). All employees are crossed trained and works

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A 030	Continued From page 20 other shifts in addition to assigned routine shift. During an interview conducted with the Administrator and the Assistant Administrator on . . . . . at 2:20 PM, the facility was questioned again regarding their investigation regarding the events surrounding Resident #1's . They stated, they felt Resident #1 of natural causes and was not aware of any concerns/discrepancies regarding staff performance in this matter. They stated they had not recognized Staff A (Direct Care Staff) failed to perform after determining Resident #1 was un-responsive during her round check (shift from 3 to 11PM). They also stated they were not aware of Staff A leaving Resident #1 alone in the room to obtain assistance. At this time, they both stated Staff A never should have left Resident #1 alone. Neither had the Administrator and/or Assistant Administrator fully intereviewed all witnessess and person involved on . . . . . incident of Resident#1's , to determine if the staff had responded timely to Resident #1 and performed . On at 3 PM, it was revealed that the facility has cameras throughout the facility by the Assistant Administrator and the Administrator. However, they stated the camera(s) were not working properly and recording full images. She stated, the camera only showed the dining room, courtyard, and the Nursing Station. Review of the facility surveillance footage provided by the Administrator around 3:20PM on revealed the camera footage provided was pieces of the video (not continous stream footage) during the day of . . . . . from approximately 12PM to 1 PM. The Administrator stated, she is still working to determine if any other footage was available to provide full video. Both stated, they	A 030		

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A 030	Continued From page 21 had not reviewed this footage prior to this investigation of this complaint by the surveyors. Review of this footage shows Resident #1 in the dining room around 12:16 PM on , then it shows her in the courtyard, no time noted on the video only date of . They both confirmed the images were of Resident#1. During an interview with the Administrator and the Assistant Administrator on at 12:15 PM and on at 2:45PM, the Administrator and Assistant Administrator was questioned regarding steps to assess, correct, evaluate and implemented to prevent the reoccurrence of staff failure to follow protocol regarding the incident of Resident #1. The facility stated, no actions had been implemented. Further interview revealed the facility at the time of the survey, has not evaluated and/or assessed the situation regarding Resident #1 being found unresponsive, staff not following the facility's policy and the policy to ensure with respect to the other employees working at the facility (20 employees). All Employees are crossed trained and work addition shifts in addition to assigned routine shifts. Therefore, it was discussed and agreed by the both parties, that the incident was not to a shift and that all shifts were at risk in addition to the the 3PM to 11 PM shift (timeframe of the incident involving Resident #1). The Assistant Administrator acknowledged that the employees need more training including how to deal with the emotional aspect of finding an unresponsive person and still being able to perform emergency response duties including . She also stated based on review of the documentation with the surveyors that their are discrepancies between the staff statements and the actual emergencies duties performed for Resident #1 (including timely	A 030		

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During a further interview with the Administrator and Assistant Administrator at 3:15 PM on , the actual harm identified during the survey was discussed. It was also noted that the following harm elements were not identified until surveyor intervention.
a) Staff A (Direct Care Staff), the first responding staff member left Resident #1 unattended after being found un-responsive in her room in the bed to go seek help from Staff B (Nursing Assistant/CNA) located at the Nurse Station. The Nurse Station is located on first floor in the main building. Location of the Nurse Station does not allow a visual view of Resident #1's room. You have to go out the main entrance doors, walked through the outside courtyard to obtain access to Resident #1's room, located on the left side across from the courtyard. Resident #1 room located on the westside of the building.

b) Staff B (Nursing Assistant/CNA) started performing on the resident (Resident#1) in the bed. Instead of placing resident on a hard flat surface to ensure the procedure was implemented effectively. As noted in facility protocol. Review of website www.firstaidforfree.com/can-you-perform- , -on-a-bed on , titled Certification revealed the following. is unlikely to be effective if performed on a bed. First aider should attempt to move the victim to the floor in order to perform , . Staff B also halted in her process, when she stopped to yell for help from other staff present in the facility from the door of Resident #1's room. Staff A still didn't assist with , she was the only other employee present in the room at this time.

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A 030	Continued From page 23 c) . and use of the machine were halted before Paramedics entered the room, based on interview with Staff A -E during the investigation. It was also confirmed during interview with the Paramedic. The exact time the staff ceased services is unknown. However, upon arrival of the Paradmedics, was not actively being performed by staff present in the room. Discrepancies noted with the actual events per staff interviews and documentation completed and submitted to the Agency. d) Staff (A- E) were involved in the incident regarding Resident #1. Staff (A-E) that worked the 3:00PM -11:00PM shift on . . . . . , are still currently employed and have not received any additional training and/or steps to prevent reoccurrence since the occurrence of the incident. Review of the staff personnel files(Staff A-E, and the reminder of the staff files (20 employees total) revealed none of the employees had received any training or in-service(s) since the . . . . of Resident #1 on . . . . . . e) According to the Administrator, the facility staff are trained by an outside source or already have the training prior to being hired. The facility does not have a specific policy titled . Staff are aware to perform the policies. However, the Assistant Administrator stated, she will ensure everyone has the same training, the policies will be reviewed to ensure it provides specific instructions to the staff regarding responding to an unresponsive person, initiation of and . . f) The situation could happen again for the sixty (60) residents who do not have a and require ; if found unresponsive. The identified 60 residents without (R# ,	A 030		

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A	Continued From page 24 #19-24, #26-28, #30-42, #44-53, #55-61). According to the Administrator the staff would have to review the files to determine who doesn't have a and that the files are located in the nursing station office (main building), location is not in close proximity of resident rooms (quarters). Facility has no system to help staff identify in a more timely effective and efficient manner. According to the Administrator, she is looking into a new method to safely identify the residents's status to relay to the staff. During the exit conference, the Administrator and Assistant Administrator stated the facility has good employees, they believe the responding employee just froze up when it came to Resident #1 being found unresponsive. She further stated that she believe all the staff involved froze up , because all staff know the complete protocol to follow. Class I	A 030		