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
	AL11969144	A. BUILDING: _____ B. WING _____	06/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALM VIEW AT GULF COAST VILLAGE	1433 SANTA BARBARA BLVD CAPE CORAL, FL 33991

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A 000	Initial Comments An unannounced complaint survey for complaint #2022007941 was conducted on . . . . . at Palm View at Gulf Coast Village, an assisted living facility in Cape Coral, Florida. Complaint #2022007941 was substantiated at A0030. The following is description of the deficiency.	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; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free	A 030		

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A 030	Continued From page 1 telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close 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	A 030		

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A 030	Continued From page 2 capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible 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 [redacted] 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	A 030		

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A 030	Continued From page 3 resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the 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	A 030		

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A 030	Continued From page 4 provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care 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	A 030		

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A 030	Continued From page 5 kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for 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 record review, and staff interviews, the facility neglected to assess the unresponsive resident; failed to provide , , , ( ) in a timely manner to 1 (Resident #1) of 3 resident's reviewed. The failure to provide emergency treatment and	A 030		

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A 030	Continued From page 6 . timely to an unresponsive resident placed the resident and potentially all other residents as a direct threat and violated the resident's rights to timely life saving measures. The findings included: Review of the procedure titled: "Resident found unresponsive procedure" revealed the following: 1. Resident found unresponsive: 2. Staff to call for "Help" to nearby staff. This includes finding an associate or activating the emergency pull cord or pendant. 3. All clinical staff to respond to room. a. 1 Staff to retrieve Resident's Chart b. 1 Staff member to retrieve the [automated external defibrillator] from either of the 3 designated areas . . . c. 1 Staff to call 911 and notify . . 4) 2 Licensed or Certified individuals are to check for the presence of Valid . . . . . . 5) If there is a Valid . . . . . in place. . . will NOT be performed. 6) If there is NOT a Valid . . . . . in place. should be initiated immediately per protocol. 7). Procedure for : a. Ensure the area is free of hazards (wheelchairs, bedside tables, carts, etc) b. If Resident is not laying on hard surface place the resident onto the floor. c. The Automated External Defibrillator (. . .) will be used per manufacturer's guideline. d. Continue . procedure until . . arrival at facility and takes over . . 1. Record review found Resident #1 was admitted to the facility on . . . . . The Health Assessment Form 1823 completed on , included	A 030		

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A 030	Continued From page 7 diagnosis of , , , ( ), hyperlipidimia (HLP), , , and muscular . The activities of daily living assessment (ADLs) indicated the resident needed supervision with ambulation, grooming, transferring, and assistance with bathing, , and toileting, and was independent with eating. The resident on . Review of the Functional Evaluation and Service Plan revealed: Assistive device, if present, is used independently Minimal assistance with difficult transfers Requires one person on assist for bathing Requires assistance/cueing of staff for management Requires one person assist for , and grooming Selects food and feeds self independently Oriented to time, place and person Administration of medications Requires no routine licensed nurse interventions Wears glasses, needs daily general oversight. Sleeps through the night. ADL care for bathing, showers, oral care routine. A nurse's note created by licensed practical nurse (LPN) Staff C, dated at 9:27 a.m. documented, "This nurse entered resident's room at 08:30 [8:30 a.m.] & resident was lying in bed unresponsive, to touch, & not breathing. Supervisor immediately notified, calling 911 while this nurse obtained . With assistance from CNA's, resident was placed on the floor & was initiated. arrived & took over , working on resident till TOD [time of] of 0927 [9:27 a.m.]. Physician and family notified during this time. Police arrived to facility for chain of custody. Son arrived, spoke with staff and law	A 030		

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A 030	Continued From page 8 enforcement at this time. Family was very grateful of the care taken. Police remained with resident until selected funeral home arrived. Resident was p/u [picked up] by funeral home at 11:15am this shift." Further record review found no previous incidents where Resident #1 was found unresponsive by staff. 2. Interview on at 9:57 a.m., the Executive Director (ED) said when she came in that morning she got an excellent report of what happened that day. It was later on when she found out what really happened. The housekeeping supervisor (HS) called her and told her that one of his housekeepers, Staff B was very upset because of what happened to Resident #1. He said that Staff B told him that she went to LPN Staff C and told her that the resident looked , but the nurse did not go and check on him right away. Staff B, got very upset when she found out that Resident #1 had passed. The ED said Staff B told the HS that when she reported the issue to Staff C, Staff C told Staff B that Resident #1 was most probably sleeping in. The ED said she and the HS checked the camera and it supports Staff B's statement that she went and talked to the nurse around 8:00 a.m. When they talked to Staff C, Staff C said that Staff B just told her that she is going to clean another room. LPN Staff C was suspended. She is not coming . . . . We began in-servicing all staff relating to responding to residents. We immediately self reported the incident to the Agency and ensured all staff were re-educated. The ED said they notified the Department of Children and Families (DCF), but they did not take the report. The ED said the expectation is the nurse will go to the residents for help right	A 030		

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A 030	Continued From page 9 away. What happened is unacceptable. The ED said they notified the family right away. Cape Coral police were here and the medical examiner did not ask for an autopsy. The son was notified and he came right away. 3. Interview on . . . . . at 10:49 a.m., the Housekeeping Supervisor (HS) said, Staff B had called him and she was very upset. She said that one of the residents, she went to clean the apartment and he looked . . . . . He did not get up for breakfast as usual, so she went to the nurse on that wing to let her know, and the nurse told her he was just sleeping in it's the holiday weekend. Staff B told the HS that was odd because the resident gets up the same time every day. The housekeeping supervisor said he wasn't here that day. It was his day off. He wasn't there so he went right away to the ED the next morning and told her what happened. When he talked to the ED, they then pulled up the camera footage and watched together. They saw that Staff B went to the apartment around 8:00 a.m. and she left right away and went to the nurse. It was 8:45 a.m., when they saw LPN Staff C going in Resident #1's room. It looked like she went to do her regular med pass and it was at 8:45, outside of the residents room. It is clear she did not go before. 4. Telephone interview on . . . . . at 2:51 p.m., Housekeeper Staff B said it was the long weekend. She said she started her day early. She knew Resident #1 liked to get up early in the morning to go for breakfast. By 7:00 a.m. he was up. Staff B said when she went by his room his door was closed so she though that was strange. He usually got up early and left the door open for her to clean while he was having breakfast. She said she told Staff C. Staff C said maybe he is	A 030		

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A 030	Continued From page 10	A 030		

asleep. It's the long weekend. Staff B then knocked on the door, she has a pass key and opened the door. Staff B said when she saw him she was by the refrigerator. Staff B described that Resident #1 was half way out of the bed. He was on his . One of his was close to the floor and had he had a slack . . . She said she ran out and told Staff C. She said she told Staff C he looks . . . . . Staff C said he is probably asleep it's the long weekend.
Staff B said afterwards when she saw all the commotion and everything that happened, she got so upset. She called her boss and told him that she had told Staff C that the resident look . . . but she didn't go. Staff B said she was so upset. She couldn't believe Staff C didn't take her seriously. She said she knew her boss was off that day but the next morning he came in and told the ED. Staff C was suspended. Staff B hasn't seen Staff C since then. Staff B said it is horrible. She still couldn't believe she didn't act immediately.

5. Interview on at 10:15 a.m., certified nursing assistant (CNA) Staff A said, she didn't remember the exact times but, she was working on the hallway, it was close to 7:30 a.m., and she saw him sleeping." Then after 8:00, exact time unknown, LPN Staff C came and told her she needed help. Staff C told Staff A Resident #1 was . . . to the touch and did not have a , . . . , not breathing and looked stiff. Staff C had a restriction she could not lift the resident. Staff A said she could not lift the resident by herself to put him on the floor to begin . . . LPN Staff C said she called for another CNA and that is how Staff D came in and brought in the nurse supervisor Staff E and then Staff D did .
Staff A said it was the 3 of them. Staff A said since Staff C had hurt her , she could not

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A 030	Continued From page 11	A 030		

bend or do anything so Staff D was the one that did , everything happened within seconds. Staff A said they got him on the floor and Staff D did . And at the same time, Staff C brought in the . Staff A said to be honest everything happened so fast it was chaotic. Staff A said when she saw him earlier he was in bed on his and covered with his blanket; he was not on the floor or anything. Staff A thought it was 7:30 - 7:35 a.m. Staff A was not looking at a clock, but she knew he looked fine. It was happening so fast Staff E called 911 before she came in and called the resident's son. Staff C got the , started the and the machine was telling them not to do anything, nothing was necessary. The machine instructed that noting could be done that was weird, but we didn't stop. was there in less than 5 minutes, minutes. Everything happened so fast. Staff A said she knew if she finds anyone, she needs to call the nurse right away, not to wait.

6. Interview on at 11:25 a.m., Nurse Supervisor Staff E said she was filling in for the clinical manager. She was in the copy room and LPN Staff C approached her around 8:40 a.m. She thinks Staff C told her she though Resident #1 was . Staff E told her go to his room, while she checked his chart. He was a full code. They got him on the floor. Staff E called 911 and the family. She was calling 911 on the phone and walking down the hallway. She saw another CNA Staff D, they got him on the floor with Staff A and started . Staff C brought the and Staff D was doing and she was on the phone and then prepared the paperwork in case Resident #1 need to go to the hospital. Staff E said she talked to his son. The son said he lives 15 minutes away and he would come in right away. She said she knew Staff C could not lift more than .

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A 030	Continued From page 12 because of a [redacted] injury. Staff E didn't know why Staff C left the resident and came and told her. She said she knew she wouldn't have done that. She said she would have called someone to go and check the residents status and then began using the right away. She said she can't speak for Staff C. She didn't know what Staff C was thinking. 7. Interview on at 1:05 p.m., CNA Staff D he said he did not remember the exact time, but LPN Staff C sent out an emergency call and he responded right away. He went to [redacted]. There was Staff C, another CNA Staff A and the resident, in his bed on his [redacted]. Staff D said he placed the resident on the floor and began . Then Staff C began the [redacted] right away. He said came right away and they took over and then they said the resident was [redacted]. He knew that Staff C could not lift the resident, she had a restriction. 8. Record review found documentation of an interview on at 8:20 a.m. with Staff C. Staff C reported around 8:30 a.m. she was passing medications. She said the resident was looked like he was asleep and she though it was unusual since the resident usually got up on his own and went down to breakfast. She reportedly walked up to the resident and she could tell he had passed. She reported the resident was pale and cool to the touch. She said she went and got Staff A and then went to the Nurse Supervisor Staff E. Staff E reportedly called 911. Staff C reported they got the resident up and began and then came and took over. Per the documented statement the ED asked Staff C if anyone brought to her attention before 8:30 a.m., that Resident #1 was not well. Per the documented statement on record Staff C reportedly told the ED that	A 030		

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
	AL11969144	A. BUILDING: _____ B. WING _____	06/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 030	Continued From page 13 housekeeper Staff B told Staff C that the resident was asleep and she will go and clean other rooms. Staff C reportedly told the ED she though Resident #1 was sleeping in. It was nothing alarming and she knew Staff A was checking on the resident. Class II	A 030		