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
	AL11969665	A. BUILDING: _____ B. WING _____	08/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGRO	5901 LOXAHATCHEE ROAD PARKLAND, FL 33067

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CZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider	CZ830		

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CZ830	Continued From page 1 is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database	CZ830		

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CZ830	Continued From page 2 approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that its Comprehensive Emergency Management Plan (CEMP) was submitted for annual review and approval by the local emergency management agency. The facility also failed to include a detailed emergency environmental control plan (EECP) as a supplement to its CEMP to address the facility's alternate power source with the capability to maintain the facility designated area's air temperature at or below 81 degrees Fahrenheit in the event of the loss of primary electrical power. The findings are: In an interview with the maintenance director on at 4:00pm, he stated that the facility's most recent CEMP was approved by the local emergency management agency on and he did not know if the EECP was included with the CEMP for approval. He stated that he didn't know of a more recent CEMP that was submitted by the facility to the local emergency management agency. In an interview with the Executive Director (ED) on at 4:15pm, she stated that the facility's most recent CEMP was not presently approved by the local emergency management agency. Review of the facility's records revealed that its most recent CEMP was approved by the local emergency management agency on and it was valid until . Review of the approval	CZ830		

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CZ830	Continued From page 3 letter indicated that the facility needed to submit its updated CEMP on or by for review by the local emergency management agency. Further review of the facility records indicated that no EECP was attached to the facility's expired CEMP. (Photographic evidence was obtained.) Review of the local emergency management agency's website on . . . at https://www.broward.org/Emergency/Pages/HealthcareFacilityCEMP.aspx, it revealed that the facility's CEMP was last approved on and the EECP had no date of approval listed. (Photographic evidence was obtained.) Class III	CZ830		

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A 000	Initial Comments An unannounced Complaint survey (#2022011902) and a Generator Monitoring survey were conducted from to at Allegro. The facility had deficiencies related to the Complaint and Generator Monitoring surveys during this visit.	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 telephone number of the Florida Hotline,	A 030		

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A 030	Continued From page 1 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 capacity of 17 or more residents in which	A 030		

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A 030	Continued From page 2 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 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	A 030		

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A 030	Continued From page 3 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 provided to the resident or the resident's legal	A 030		

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A 030	Continued From page 4	A 030		

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 kept confidential pursuant to s. 400.0077 and that

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A 030	Continued From page 5 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 [illegible] Hotline operated by the Department of Children and Families, and [illegible], 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 [illegible], [illegible] or [illegible], [illegible] 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 interview, the facility failed to honor the rights of 1 out of 78 residents (Resident #1) who did not have a [illegible] ([illegible]) by withholding [illegible] ([illegible]) and the use of an automated external defibrillator ([illegible]) as an emergency life sustaining procedure. As	A 030		

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A 030	Continued From page 6	A 030		

evidenced of the facility staff failure to perform and to use the for Resident #1 when the resident was found unresponsive by the staff members on . Resident #1 was subsequently pronounced by emergency medical services ( ) personnel upon arrival to the facility on .

The findings included:

Review of the report dated on revealed that emergency medical personnel responded to the facility and found Resident #1 unresponsive and not breathing, with a primary impression of "obvious " and signs and symptoms of "dependent lividity." Review of this report indicated that the emergency call was received at 12:45pm and personnel arrived to the facility at 12:53pm. Review of this report indicated that the resident was found at 12:55pm, supine on her bed with her hanging off the edge of the bed and the resident "appeared to be lifeless" with lividity noted on the entire body. Review of the report indicated that the resident was pale and to the touch, with to all four extremities. Review of this report indicated that the resident was on scene without transportation and the scene was left with the police. Further review of this report indicated that the resident was " without efforts" and the facility staff refused to the resident.

Review of the facility's policy and procedure titled "Automated External Defibrillators ( )" which was effective on , revealed the following: "The goal of an Automated External Defibrillator ( ) program is to increase the rate of survival of people who have sudden programs are designed to provide equipment and

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A 030	Continued From page 7 training as an important means for providing enhanced life safety response measures. AEDs make it possible for responders to administer prior to the arrival of Emergency Medical Services ( ). The company is committed to the health and safety of its residents, guests, and employees. This policy establishes an program for Company managed communities that will: - Implement enhanced life safety response measures; - Meet regulatory compliance; - Establish user training requirements; and - Provide continuity and consistency in installation, maintenance and use." "In a secured area near each , a bag with the following items which may be necessary for successful utilization of the should be made easily accessible: simplified directions for , , ( ) and use of the ." "The Resident Services Director ( ) is responsible for ensuring that there is at least one person trained in and use on the premises at all times." "The Business Office Manager (BOM) is responsible for ensuring that all designated staff receives initial / training within thirty (30) days of employment. The BOM will track each designated staff member's / training to ensure that it is renewed every two years or as required by the training organization." "All staff members designated as responders are required to present written documentation from a class instructor demonstrating they have	A 030		

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A 030	Continued From page 8 satisfactorily completed training in and use from the American Association or the American Red Cross or an equivalent nationally recognized course in and use." "Designated responders include all department heads, all care staff, anyone who has Manage on Duty responsibilities and any other staff so designated by the ED." "The may be used on anyone who has been determined to be: - ; - Not breathing; - Has no , and/or shows no signs of circulation; - Is not known to have signed a " " order. The first person on the scene will: - Call for assistance; - Assess the victim for the above, using universal precautions; and - If necessary and if trained, perform until the arrives; - The second person on the scene will ensure 911 has been called, the is brought to the location and initiate if not already in progress." Review of the facility's policy and procedure titled "Job Description - Executive Director" which was effective on , revealed the following: "The primary responsibility of the Executive Director (ED) is the overall success of the Community. This includes all phases of operation, general administration, resident care." "Supervision of the Community must be in strict accordance with Company policies and	A 030		

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A 030	Continued From page 9 procedures and regulatory requirements." "Responsible for the quality, care, resident satisfaction, associate satisfaction, maintaining compliance with regulatory requirements and Company policies and procedures." "Manage, educate, and develop all associates under direct and indirect supervision." "Be proactive in promoting a safe environment for all residents, visitors and associates of the Community regarding control, life safety and emergency procedures." Review of the facility's policy and procedure titled "Job Description - Resident Services Director" which was effective on 11- , revealed the following: "The Resident Services Director ( ) is responsible for oversight of the day to day activities in the Assisted Living (AL), including resident services, associate management, general administration and physical maintenance." "Support a safe environment for all residents, their visitors and the associates of the AL Department regarding control and life safety." "Special requirements/certifications: / certification is required." (Photographic evidence was obtained.) Review of the facility's Adverse Incident Report completed by the dated , revealed that on at 10:30 am, Resident #2 asked the Receptionist to please check on Resident #1	A 030		

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A 030	Continued From page 10 since the resident attempted calling Resident #1 several times and the resident did not answer. This report indicated that the Receptionist was not able to follow up on Resident #2's request since she was really busy at that time. This report indicated that Resident #2 went to Resident #1's room and knocked on the door several times at approximately 12:30 pm and then Resident #2 immediately went to the facility reception area to ask the Receptionist to check on Resident #1 since the resident did not answer the door. This report indicated that the Receptionist contacted the maintenance technician to unlock and open Resident #1's room door at approximately 12:40 pm and the Receptionist found Resident #1 fully dressed and unresponsive on her bed. This report indicated that the Receptionist noticed that Resident #1 was " . . . to touch and hard" and without a , . . . This report indicated that the Executive Director (ED) notified the Resident Services Director ( ) of this emergency at approximately 12:42 pm and told the Receptionist to call 911 at approximately 12:43 pm. This report indicated that the police and . . . personnel arrived at the facility at approximately 12:50 pm and personnel pronounced Resident #1 . . . . . at approximately 12:55 pm. Review of the facility's incident report completed by . . on . . . . . , revealed the following. On at approximately at 12:15 PM, Resident #2 went to Resident #1's room and knocked on the door several times and there was no answer. Resident #2 went to the front desk at 12:30 PM, to ask the Receptionist to check on Resident #1 in her room as she was not answering the door. Receptionist notified Maintenance Technician to open Resident #1's room. The Receptionist, the Maintenance	A 030		

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A 030	Continued From page 11 Technician and Resident #2 went to Resident #1's room around 12:40 PM. Resident #1's room was opened by the Maintenance Technician, at this time, the Receptionist called out for Resident #1 but there was no answer. The Receptionist proceeded to Resident #1's bedroom while the Maintenance Technician and Resident #2 waited outside of the room. The Receptionist noticed the resident was fully dressed laying across the bed and appeared unresponsive. 911 was called. Vital signs for Resident #1 were not documented in this incident report. Review of Resident #1's record revealed the resident was admitted to the facility on [redacted] and received a medical examination (AHCA Form 1823) on [redacted]. Review of this medical examination revealed that she was diagnosed with [redacted], and [redacted]. Review of this medical examination revealed that the resident was independent with all of her activities of daily living, and she self-administered her medications. Review of the facility "functional needs evaluation" dated on [redacted] revealed that the resident needed standby assist with bathing and transfer/mobility. Further review of the resident's record indicated that the resident was determined full code, without any [redacted] in place. (Photographic evidence was obtained.) In an interview with the Receptionist on [redacted] at 10:40 am, she stated that she worked in the facility on [redacted] and sometime from 10:30 am to 11:30 am, Resident #2 called her while she was in the reception area to ask for a wellness check on Resident #1 since the resident attempted calling Resident #1 several times and the resident did not answer. She stated that she	A 030		

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A 030	Continued From page 12	A 030		

was very busy at the time, and she didn't remember whether she called any direct care staff member on the radio to respond to this request. She stated that at approximately 12:30 pm, Resident #2 met her in the reception area to report that she went to Resident #1's room (located on 1st floor), and no one responded to her knocks on the door and asked to check inside Resident #1's room. She stated that she proceeded to call for assist on the radio and the Maintenance Technician answered and offered to unlock Resident #1's room door for access into the room. She stated that since she only performed checks on residents in the independent living side and not in the Assisted Living side of the facility, she did not have key access to the assisted living residents' rooms. She stated that the Maintenance Technician and her went to Resident #1's room, she entered the room at approximately 12:40 pm and she saw Resident #1 fully dressed and unresponsive lying on her bed. She stated that Resident #1 was . . . to the touch, hard and without a , ... She stated that she left the resident, and immediately went to the reception area (located on the 1st floor), where the ED's office was located, and informed the ED of this event. She stated that, the ED and I went to Resident #1's room, she called 911 while walking towards the resident's room and the ED saw the resident lying on her bed when they arrived at the room. She stated that neither of them initiated or used the machine on Resident #1 after finding the resident unresponsive on . She stated that personnel arrived at the facility at approximately 12:55 pm and they left the facility not too long after this without the resident.

In an interview with the Maintenance Technician on at 11:30 am, he stated that on

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A 030	Continued From page 13 . . . . . at approximately 12:30 pm, he received notification from the Receptionist to do a resident room check for Resident #1. He stated that the Receptionist and I went to Resident #1's room, and he unlocked the door so the Receptionist may check on the resident at approximately 12:45 pm. He stated that he saw the Receptionist leave the room a couple minutes after this while he stayed at the front door of the resident's room, and the Receptionist returned to the resident's room along with the ED a couple minutes after that. He stated that the ED stated that the resident had no , . . . and then he saw that . . personnel arrived at approximately 12:55 pm. He stated that he heard that the personnel declared Resident #1 . . He stated that he didn't know if . . was administered for the resident since he stayed by the front door of the room and he did not see the resident. In an interview with Resident #1's physician on at 12:30 pm, he stated that based on Resident #1's diagnoses and medical history, the cause of was likely from atherosclerotic . . . . . He stated that he was not aware if anyone had requested an autopsy be performed on the resident's body. In an interview with the ED on . . at 2:35 pm, she stated that on , she arrived at the facility at approximately 8:30 am and began her day as usual. She stated that she was notified that Resident #1 was found unresponsive by the Receptionist on at approximately 12:40 pm while she was in her office. She stated that she was initially shocked by this, and she and the Receptionist immediately walked towards the resident's room. At this time, she asked the Receptionist to call 911. She stated that she immediately notified the of this event by	A 030		

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A 030	Continued From page 14 cellphone while walking to the resident's room. She stated that when she arrived and entered the resident's room, she walked to the resident's bedroom (adjacent to the living room); she saw Resident #1 alone, lying on the bed (entire body), unresponsive and without signs of visible injury. She stated that upon looking and touching the resident, that she knew the resident was . . . . . She stated that, the resident's . . . were dark colored, her was white/gray pale, no , . . . and skin was . . . to the touch. The ED was asked if she was qualified to pronounce any individual . . . . . She stated that no staff member, including herself, was qualified to determine if an individual was . . . . . She stated that the arrived at the resident's room shortly thereafter, and then the personnel arrived at approximately 12:55 pm and declared the resident . . . . . She stated that neither her, the . . , or any other staff member initiated . . or used the . . on Resident #1 after finding the resident unresponsive on . She stated that she never thought of needing to perform or use the on Resident #1 because the resident looked lifeless to her. In an interview with the . . on at 3:15 pm, she stated that on at approximately 12:40 pm, she received notification from the ED that Resident #1 was found unresponsive in her room. She stated that when she arrived at the resident's room at approximately 12:45 pm, she tended to Resident #2 whom was outside the room doorway and was distraught to learn of Resident #1 being found unresponsive. She stated that she was aware that the ED and the Receptionist were inside the resident's room next to the resident, so she didn't feel the need to go inside the resident's bedroom at that time. She stated that she and the staff were aware that	A 030		

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A 030	Continued From page 15 Resident #1 was a full code and did not have a . She stated that she was also aware that no staff member initiated or sought to use the when the resident was found unresponsive. She stated that the personnel arrived onsite at approximately 12:55 pm and declared the resident . She stated that she did not presently have a certification and there were 2 other direct care staff members in the facility at the time of this event who had active certifications. She stated that neither of these staff members were alerted or notified to respond to Resident #1 on so to initiate and use the on this unresponsive resident. In an interview with Caregiver Staff B on at 4:25 pm, she stated that she was aware that personnel responded to the facility and declared Resident #1 on after the fact. She stated that she knew this resident well and that the resident was physically independent and had no recent changes in overall condition. She stated that she last saw Resident #1 on (the day of the incident) at approximately 8:49 am, when she went inside her room to perform a wellness check. She stated that she greeted the resident and the resident greeted to her. She further stated that she saw the resident lying supine on her bed with her raised on pillows and the resident did not present to be in distress at all, she then left the room. She stated she didn't remember when she recently took a certification course, but in case of an emergency, if she found a resident who was unresponsive, she'd immediately notify the or ED to initiate and use. She stated that she resigned from her position at the facility on because she was continually being asked about this event	A 030		

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A 030	Continued From page 16 involving the resident's and she was tired of being questioned by the facility administration. In an interview with Resident #1's family member on at 8:55 am, he stated that since he was also related to Resident #2, he was aware that Resident #1 was last seen by Resident #2 on at approximately 7:00 pm. He stated that Resident #1 was physically independent, managed her own medications and she had a condition. He stated that Resident #1 likely had a , but he didn't know exactly when this could have happened. He stated that he has not yet spoken with Resident #1's physician to discuss the resident's cause of . In an interview with Resident #2 on at 9:40 am, she stated that she knew Resident #1 very well and she last saw the resident on at approximately 7:00 pm. She stated there was nothing unusual with Resident #1 at that time and that on at approximately 10:30 am, she called Resident #1 on the telephone several times and received no answer. She stated that since this was unusual, she asked, the Receptionist to ask to check on Resident #1. She stated that at approximately 12:15 pm, she went to Resident #1's room, and she knocked on the door but received no answer. She stated that she then went to the receptionist to ask for a wellness check on Resident #1 because she was concerned, and the Receptionist went to the resident's room shortly thereafter and found the resident to be . Review of the American Association's (AHA) website on at https://www. .org/en/news/2018/05/01/new-resuscitation-guidelines-update- , - -pushes	A 030		

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A 030	Continued From page 17	A 030		

revealed that "The AHA recommends that anyone who sees an adult suddenly collapse should call 911 and push hard and fast on the center of the , a technique known as -Only ", " is used to treat people who suffer , the abrupt loss of an effective heartbeat" and "Guidelines recommend that be given immediately after someone collapses and continue until a defibrillator is ready to use, emergency medical services take over or a victim starts moving." Further review of this website documented that "To be in is the most critically ill human condition" and "Every able-bodied person should be able to respond to by at least recognizing it, calling 911 and doing , ."

Review of the American Association's (AHA) website on at https://www. .org/-/media/Files/Health-Topics/Answers-by- /What-is-an- .pdf revealed that "An automated external defibrillator ( ) is a , portable device that delivers an electric through the to the . The can potentially stop an irregular heartbeat (,) and allow a normal rhythm to resume following sudden (SCA). SCA occurs when the and stops beating unexpectedly. If not treated within minutes, it quickly leads to " and "Most SCAs result from ( ). is a rapid and unsynchronized rhythm that originates in the 's lower chambers (the ventricles). The must be "defibrillated" quickly because a victim's chance of surviving drops by 7 to 10 percent for every minute a normal heartbeat isn't restored. AEDs make it possible for more people to respond to a medical emergency where is required. Because AEDs are portable, they can be used by

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A 030	Continued From page 18 nonmedical people (lay- rescuers). They can be made part of emergency response programs that also include rapid use of -1 and prompt delivery of , , ( ). All three of these activities are vital to improving survival from SCA". Review of the personnel files for the staff members that had direct contact and/or First Responding Person with the resident on , revealed the following: a) Review of the Receptionist's employee personnel record revealed she was hired on as a receptionist and she presently held this same position. Review of this employee personnel record revealed that there was no certificate to represent that she received and first aid training. Further review of this employee personnel record revealed that this staff member was not required to have an active /First Aid certification to fulfill this position. b) Review of Staff B's employee personnel record revealed she was hired on as a resident Caregiver/med tech and served in that position on . Review of this employee personnel record revealed that there was no certificate to represent that she received and first aid training. c) Review of the 's employee personnel record revealed she was hired on as a and she presently served in that position. Review of this employee personnel record revealed that she was a registered nurse and there was no certificate to represent that she received training. Further review of this employee job description revealed that it was required that this staff member had an active /First Aid certification to fulfill this position.	A 030		

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A 030	Continued From page 19 (Photographic evidence was obtained.) d) Review of the ED's employee personnel record revealed she was hired on as the ED and she presently served in that position. Review of this employee personnel record revealed that there was no certificate to represent that she received /First Aid training. During a tour of the facility on , observations revealed the facility has 2 machines. #1 is located on the 1st floor on the 100-level hallway and #2 is in the memory care unit located on 3rd floor. During an interview with the on at approximately 12PM, she stated that all staff members were aware of the location of the facilities 2 machines. She confirmed that the machine was not obtained during the incident regarding Resident#1 on . Further observations of the location of Resident #1's room and the location of #1 revealed it was in proximity to be accessed by the staff to respond to the resident's emergency (unresponsive condition). However, the staff didn't attempt to obtain the for usage for Resident #1. In an interview with the ED on at 1:30 pm, she stated that she was aware that not all the facility's direct care and management staff positions had current /First Aid training with certificates as required by the facility policies and procedures. She stated that she's recently had difficulty hiring and staffing the facility with personnel which met the /First Aid training requirements. At the request of the surveyor, the ED was able to produce a census count that shows 78 of 89 current residents who did not have a in place. She further stated that no	A 030		

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A 030	Continued From page 20 additional training or in-service was performed for the staff after the incident on to handle emergency situations involving an unresponsive resident and the usage of the machine and . . In an interview with the Business Office Manager on at 2:35 pm, he stated that he was not aware that his position was responsible to ensure all designated staff received initial . . / . . training within thirty (30) days of employment, according to facility policy and procedure. He stated that he has been in his position for about 1 year in the facility and he has not ensured all designated staff had this training and he did not track each designated staff member's . . / training to ensure that it was renewed to remain current. Class I	A 030		