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
	AL11910710	A. BUILDING: _____ B. WING _____	12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRIMENT ASSISTED LIVING RESIDENCE	1835 WILSON STREET HOLLYWOOD, FL 33020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced licensure Complaint (#2022003869 and #2022017906) and Generator Monitoring survey was commenced on ..... and concluded on ..... at Merriment Assisted Living Residence. The facility had a deficiency identified related to Complaint #2022003869 and #2022017906 at the time of the survey.	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or ..... or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal	A 025		

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A 025	Continued From page 1 supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review, video review and interview the facility failed to ensure adequate supervision during meal service for 1 of 1 residents reviewed receiving a therapeutic diet, Resident #1. As evidenced by Resident #1 gaining access to and ingesting food prohibited on his diet, resulting in the resident choking and subsequently expiring due to the choking incident. The findings included:	A 025		

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A 025	Continued From page 2 Review of the undated Policy & Procedures titled - Emergency Situation states in part: Staff in charge of the facility at any given time will perform the following in the order listed below: "When a resident has a Medical Emergency the first thing to do is dial 911 and report the situation to them. If needed, perform or assist with first aid. Do not give any medication to the resident." Review of Resident #1's Resident Health Assessment AHCA form 1823 dated documented his diagnoses to include (difficulty swallowing), and . Under Special Precautions documented - Mechanical Soft Prep Missing . Review of the diet order documented under Special Diet Instructions - Mechanical Soft. Further, the resident's was documented as 5 with a . In an interview conducted with the Administrator on at 1:14 PM, she stated Resident #2 came into the office and told Medication Technician Staff C that Resident #1 was sitting outside and was not looking too good. Resident #1 was unassisted by staff at the time. She stated Medication Technician Staff B went outside, tried to arouse Resident #1, wake him up, rubbing his trying to get a response. She stated the facility's ARNP (Advanced Registered Nurse Practitioner) was at the facility, and she went outside, and Resident #1 was not looking good. She restated that Medication Technician Staff B was at his side, rubbing his , calling his name, and that his was open. She stated there was some food on his and he was unresponsive.	A 025		

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A 025	Continued From page 3 Further during the interview conducted with the Administrator on at 1:14 PM, she stated Medication Technician Staff C checked Resident #1's by and his -pressure was checked using the cuff that goes around the area. She stated they took Resident #1's level and . She stated the resident was sitting in an upright position during this time. She stated because of Resident #1's and they were not able to perform the Heimlich procedure, so they laid him down and she did a swipe. She stated she could not find any food in his when she did the swipe, and nothing was cleared out of his . She also stated that she did not see anything in the area, just some saliva and food like substance indicating he was eating something. She stated ( ) was started by the ARNP, 911 was called, the (Automated External Defibrillator) machine was placed on him, which she stated instructed them to continue but never instructed them to him. She stated they continued but did not blow air into his as they did not want to blow anything further down his . So, they continued to do until the paramedics came to the facility. A review of the binder log on revealed the machine was checked monthly and dated - . Observation of the machine revealed it was tested and found to be operable and functioning. Further observation revealed the was used during the incident with Resident #1 on . A review of the report from the local Fire Rescue documented "RS was dispatched to a . Upon arrival of (Emergency Medical	A 025		

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A 025	Continued From page 4 Services), the male patient was found laying on ground with nursing home staff performing , where patient was unresponsive, and not breathing. Nursing staff stated that the patient was last seen approximately 1 minute prior to calling and starting . The nursing home staff stated that the patient was possibly choking on food. During treatment, an airway obstruction in the form of food was found in the patient and was removed to improve BVM (bag valve mask) compliance. The patient remained unresponsive and (no rhythm) on monitor throughout and transport to hospital." A review of the hospital report documented Resident #1 arrived at the hospital by ambulance on at 4:51 PM with a diagnosis of , totally obstructed airway. It further documented that Resident #1 was found not able to breath as a result of a hot dog blocking his airway. was unaware of what time the choking started. Patient had been in (no rhythm) since arrival, the nursing home staff was performing upon their arrival. Patient received 3 times prior to arrival most recently a 4:45 PM. Patient was intubated (inserted) en route to the ED (Emergency Department). The patient arrived with Lucas device (automated machine) performing ." It also documented "Patient arrived via FR (Fire Rescue), in progress, by BVM (bag valve mask). Rescue call was 4:24 PM for a chocking patient, upon arrival staff was doing ." In an interview conducted with Dietary Staff A on at 11:08 AM, she stated the resident came to breakfast that morning and she gave him	A 025		

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A 025	Continued From page 5 his breakfast and he was okay. She stated he came to lunch, and she provided his lunch, he ate everything and was normal. She stated that at dinner she told Resident #1 that she was going to make his special meal and to sit and wait. She stated she was busy, so she did not see where he was sitting. She stated he did not get dinner because at that time she had to puree his dinner, and that she told Medication Technician Staff C who came in to help her, not to give him a hotdog because he could not eat it. She stated she informed Resident #1 that she had to fix his meal and to go outside and wait. She stated she was waiving her (in a go outside motion) because he is very quick and will start packing stuff, and because her was turned while she sent him outside, he would grab anything. Dietary Staff A further stated in the interview that she saw part of a video of the incident and saw Resident #1 take the hotdog from another resident's plate (Resident #2). She stated she did not see Resident #1 again until she saw something going on outside and she saw the doctor (facility's ARNP) pumping his . . . . She further stated in the interview that Resident #1 loved hotdogs, but he was not supposed to have it. She stated she had been caring for him for 3 and a half years and always makes sure he does not eat hotdogs. She stated Resident #1 was very quick and will grab things and you will not know it. In an interview conducted with the Administrator on at 3:29 PM she stated that where Resident #1 was siting that day was not his assigned seat, and that he is usually seated by the door so they can see him. She stated he was informed that his food was not ready yet and to have a seat because they were preparing his food. He was not instructed where to sit as we do	A 025		

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A 025	Continued From page 6 not have assigned seating; we do not dictate where they should sit, but he usually sits up front. She stated he walked into the . . . of the room the day of the incident. A review of the facility's camera footage on . . . . revealed Resident #1 entering the dining room during the dinner dining on . . . . at 4:17 PM. The resident was observed to have walked to the of the dining room, spoke to a female resident, sat down at a table with two female residents (Resident #3 had her plate with a hotdog on it). Resident #1 appears to ask Resident #3 for the hotdog (no audio of the conversation), reaches onto the plate of Resident #3 and takes the hotdog. At 4:20 PM, Resident #1 proceeds to get up from the table. Resident #1 then walks to the preparation kitchen area of the room and speaks to Dietary Staff A who appears to instruct him to go outside, which he does. The Administrator stated they have no footage of the outside area where Resident #1 began to experience distress. There was no staff observed monitoring Resident#1 or the dining room on the video during the dining observation. (Video evidence obtained). On at 4:14 PM, Medication Technician Staff B stated in an interview she occasionally helps Dietary Staff A in the kitchen. She stated that on . . . . at approximately 4:00 PM she was helping Dietary Staff A by serving the food to the residents in the dining room. She stated she was assisting in guiding residents to the tables, and that Resident #1 arrived later than usual. She stated she saw him wash his . . . . and sat at the . . . of the dining room area because he arrived late. She stated Resident #1 usually sits at the front of the dining room. She stated Resident #1 was at a table with	A 025		

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A 025	Continued From page 7 two female residents as he was awaiting a mechanical soft meal from Dietary Staff A. Medication Technician Staff B further stated in the interview that she was focused on serving the other residents in the dining room, then about 4:30 PM she noticed the lights from a Fire Rescue vehicle. She stated she went outside to see what was going on and noticed Resident #1 on the floor outside of the dining area with the Administrator performing on him and the ARNP besides her. When the Paramedics arrived on the scene, they took over doing the . Medication Technician Staff B said that the Administrator asked her if Resident #1 had eaten anything in the dining room. Medication Technician Staff B said that she told the Administrator that she did not see Resident #1 eat anything and that he was awaiting his specially prepared meal. Medication Technician Staff B stated that she was focused on serving the other residents in the dining room. She stated that about 4:30 PM she noticed the lights from a Fire Rescue vehicle and went outside to see what was going on. She noticed Resident #1 on the floor outside of the dining area with the Administrator performing on him and the ARNP besides her. When the Paramedics arrived on the scene, they took over doing the . Medication Technician Staff B stated that the Administrator asked her if Resident #1 had eaten anything in the dining room. Medication Technician Staff B stated she told the Administrator that she did not see Resident #1 eat anything. On at 4:30 PM, Medication Technician Staff C stated in an interview that she was preparing to begin the 5:00 PM medication	A 025		

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A 025	Continued From page 8 passes on . She stated that sometime after 4:00 PM, Resident #2 came to her and told her that Resident #1 did not look well. She went to Resident #1 and saw him sitting on a chair outside the dining room area. She stated she called out the name of Resident #1, but he did not respond. Medication Technician Staff C stated she tried to feel for the , of Resident #1 and did not feel a , . She then requested that Resident #2, who reported the incident to her, go get the Administrator. She stated the Administrator arrived quickly accompanied by the ARNP and the Administrator started on Resident #1. She stated front desk receptionist Staff D called 911 and the paramedics arrived and took over performing . She stated at about 4:45 PM the paramedics took Resident #1 to the hospital. On at 4:48 PM, an interview was conducted with the ARNP who stated she was in the facility on the day of the incident. She stated she was in the medication room assessing a resident when Resident #2 came into the office around 4:00 PM and stated Resident #1 was not looking good and was sitting in a chair across from the dining room. She stated that she and the Administrator immediately went out to the resident. She stated their observation revealed that Resident #1 was in a sitting position, he looked , (blue in color), with his open. She stated that she immediately aroused him, and he let out a burp. She stated she felt his left for a , but it was faint, so she put on the , cuff on his , but it gave no reading. She stated she, the Administrator and front desk receptionist Staff D lowered him to the ground, and she started as the Administrator went to get the and front desk receptionist Staff D called 911. She stated she and the	A 025		

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A 025	Continued From page 9 Administrator switched after 2 minutes with the Administrator performing . She stated Fire Rescue arrived and took over. She stated Fire Rescue used their own machine to do . In an interview conducted with the Administrator on at 1:35 PM, she stated Resident #1 was not supposed to eat hotdogs. She stated they puree his food as he has no so he cannot chew his food. She stated he was and would go and get snacks and candy, soda, and other things from the other residents. She restated that no one was monitoring the dining room the day of the incident on when Resident #1 retrieved and ate a hot dog he took from another resident's plate. No staff observed the resident take the hotdog and as a result, Resident #1 subsequently from choking on the hot dog. On at 4:58 PM, this surveyor conducted a telephonic exit conference with the Administrator. She was informed of and acknowledged the findings of the survey. Class III	A 025		