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
	AL11964388	A. BUILDING: _____ B. WING _____	01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALMETTO LANDING	1016 WILLA SPRINGS DRIVE WINTER SPRINGS, FL 32708

(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 Complaint Investigations #2023000869 and #2022017991 were conducted on [redacted] and [redacted]. Palmetto Landing had deficiencies at the time of the survey.	A 000		
A 030 SS=G	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 proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.	A 030		

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A 030	Continued From page 1 (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 telephone on each floor of each building where residents reside.	A 030		

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A 030	Continued From page 2 429.28 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 facility to provide safekeeping for funds as provided in s. 429.27.	A 030		

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A 030	Continued From page 3 (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 Ombudsman Program for assistance with relocation and must include the statewide toll-free	A 030		

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A 030	Continued From page 4	A 030		

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 exercising any other resident right. The facility must ensure a resident's access to a telephone to

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A 030	Continued From page 5 call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder [redacted] Hotline operated by the Department of Children and Families, and [redacted], 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 [redacted] or [redacted] 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 interview and record review, the facility failed to ensure residents were treated with consideration, respect, recognition of personal dignity, by allowing a caregiver to remain working at the facility when the caregiver was observed being rough with the resident and mocking the resident for 1 of 9 sampled residents (#2). Findings: Review of resident#2's health assessment it	A 030		

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A 030	Continued From page 6 revealed a medical history of Aphasia, [illegible] infraction, [illegible] and a history of falling. It also confirmed vision and hearing , and assistance with daily living to include ambulation, bathing, [illegible] eating, self-care, toileting, and transferring. Resident #2 is alert to person and can make her needs known. A review of a facility report dated revealed on [illegible] at 8:45 PM, Caregiver K stated she heard Caregiver A in Resident #2's room mocking her and heard the resident crying. Caregiver K stated she went to get Caregiver J to go to the room with her. When both caregivers reached the room, they heard resident #2 scream, so they opened the door and saw Caregiver B sitting on the chair next to the bed and the resident sitting on the toilet naked and crying. Caregiver A was with the resident in the bathroom. Resident #2 stated that Caregiver A was rough with her and was screaming and yelling at her. A review of a facility report dated revealed on at 8:45 PM, Caregiver J heard Caregiver A yell at Resident #2. Caregiver J entered the room and witnessed Caregiver A pulling the arm of the resident while changing the resident's shirt. Caregiver J asked Caregiver A to stop but Caregiver A continued to be rough with the resident while yelling at the resident and making fun of the way the resident talked. On [illegible] at 2:30 PM, Caregiver K stated she walked past Resident #2's room and heard a caregiver cursing and yelling at the resident. She stated she got Caregiver J, went to the	A 030		

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A 030	Continued From page 7 room, and saw the resident on the toilet while Caregiver A yelled and was rough with the resident. She stated she went in to help and Caregiver A began to curse at her to get out. She stated she went in anyway and saw Caregiver B on the bed and Caregiver A being rough with the resident while cursing at her. On ..... at 3:30 PM, the Administrator confirmed the incident took place based on the statements of the Caregivers K and J. She said Caregiver A was put on probation while the investigation took place and when it was completed, Caregiver A was terminated on ..... There was no documented evidence as to what actions were taken toward Caregiver B who saw Caregiver A be rough with the resident and did not intervene to protect the resident. Caregiver A was placed on probation but continued to work with residents in the facility until the investigation was completed, which put all residents at risk for verbal and , , . Caregiver A was terminated ten days later. There was no documentation that all residents were protected during the investigation. There was no documentation of in-service education after the incident on ...../neglect, activities of daily living, resident rights and any subject matter related to resident care. Photographic evidence was obtained. Class II	A 030		
A 076 SS=J	59A-36.009 FAC . . . . . ( )	A 076		

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A 076	Continued From page 8 (1) POLICIES AND PROCEDURES. (a) Each assisted living facility must have written policies and procedures that explain its implementation of state laws and rules relative to [illegible] ([illegible]). An assisted living facility may not require execution of a [illegible] as a condition of admission or treatment. The assisted living facility must provide the following to each resident, or resident's representative, at the time of admission: 1. Form SCHS- [illegible], "Health Care Advance Directives - The Patient's Right to Decide," [illegible], or with a copy of some other substantially similar document, which incorporates information regarding advance directives included in chapter 765, F.S. Form SCHS- [illegible] is available from the Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 34, Tallahassee, FL 32308 or the agency's website at: http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/HC_Advance_Directives/docs/adv_dir.pdf; and, 2. DH Form 1896, Florida [illegible] Form, [illegible], 2004, which is hereby incorporated by reference. This form may be obtained by calling the Department of Health's toll free number 1(800)226-1911, extension 2780 or online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04005. (b) There must be documentation in the resident's record indicating whether a DH Form 1896 has been executed. If a DH Form 1896 has been executed, a yellow copy of that document must be made a part of the resident's record. If the assisted living facility does not receive a copy of a resident's executed DH Form 1896, the assisted living facility must document in the	A 076		

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A 076	Continued From page 9	A 076		

resident's record that it has requested a copy.
(c) The executed DH Form 1896 must be readily available to medical staff in the event of an emergency.
(2) LICENSE REVOCATION. An assisted living facility's license is subject to revocation pursuant to section 408.815, F.S., if, as a condition of treatment or admission, the facility requires an individual to execute or waive DH Form 1896.
(3) PROCEDURES. Pursuant to section 429.255, F.S., an assisted living facility must honor a properly executed DH Form 1896 as follows:
(a) In the event a resident experiences or , staff trained in , , ( ) or a health care provider present in the facility, may withhold , , (and).
(b) In the event a resident is receiving hospice services and experiences or , , facility staff must immediately contact hospice staff. The hospice procedures take precedence over those of the assisted living facility.

This Statute or Rule is not met as evidenced by:
Based on the facility's documentation, record review and interview, the facility failed to follow ( ) policies and procedures for 1 of 1 sampled resident who did not have a (#1), and failed to explain the facility's implementation of Florida's state laws and rules completely on the policy to honor a properly executed , and to address occurrences in which residents do not have a .

Findings:

Agency for Health Care Administration

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A 076	Continued From page 10 Resident #1's record review revealed she was admitted on [redacted] and did not have a [redacted]. The 1823 Health Assessment dated [redacted] listed her medical history as [redacted], Severe [redacted], Fluid on [redacted], and [redacted]. She could stand and pivot but with assistance. She had short-term memory loss. [redacted] risk and needs assistance with all transfers. The resident required assistance with ambulation, bathing, [redacted], toileting and transferring. The resident required supervision with grooming, was independent with eating, and required assistance with self-administration of medications. Documentation from the County Fire and Rescue first responder reflected that on [redacted] at 7:03 PM, they were dispatched to the facility because staff reported Resident #1 became [redacted]. Upon arrival to the scene, they found Resident #1 slumped over in her wheelchair with Caregiver B and Medication Technician (Med Tech) E standing next to her. The first responder's report reflected that Med Tech E was on the phone and Caregiver B was holding the resident from falling out of the wheelchair. The first responder checked for a [redacted] for Resident #1, and nothing found. The first responder lifted Resident #1 to the stretcher, placed her in supine position, and observed her [redacted] and [redacted] were blue in color. The first responder then started manual [redacted] ([redacted]) and the stretcher was wheeled out to the rescue truck. The first responder completed vital signs; after 2 minutes of [redacted], the first responder checked Resident #1's [redacted] again and found nothing. Photographic evidence was obtained.	A 076		

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A 076	Continued From page 11 Resident #1 did not have a , therefore should have been performed immediately until the emergency first responder arrived. On at 2:48 PM, Med Tech E stated that she was giving medication to another resident across from Resident #1's when she saw Resident #1 on at approximately 7 PM wheel herself out of her room into the hallway saying that she was out of breath, and she was about to pass out. Med Tech E wheeled her into her room and handed her the . Resident #1 went to grab the but then slumped over and did not respond or move. Med Tech E called 911 and radioed Caregiver B to come assist. Med Tech E confirmed that she did not begin on the resident she said the first thing to do was to call 911. Med Tech E also stated that she called the Administrator and family member after the first responders arrived two minutes later. Med Tech E was the only staff with First Aid/ certification in the facility on for the PM shift. Caregiver B did not have First Aid/ certification. Med Tech E and Caregiver B did not begin . Med Tech E confirmed she did not begin because she panicked, and her first response was to call 911. Caregiver B did not have training certification. Caregiver B resigned from his position on . There was no documented evidence that was initiated and administered to resident #1, which resulted in Resident #1 dying. There was no documented evidence that Med Tech E and Caregiver B followed the facility's incomplete policies and procedures.	A 076		

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A 076	Continued From page 12 The Corporate Regional Clinical Nurse G took a verbal statement over the phone from Caregiver B about Resident #1's incident on , but a documented statement was not written, signed and dated. Nurse G later documented in the facility notes on , a month later, per report by Med Tech E and the Administrator, that the resident wheeled herself into the hallway, complained of not feeling well. Med Tech E was in the hallway and escorted the resident to her room where she reached for to give the resident. The resident "slouched" and became unresponsive. Med Tech E called 911. Another Med Tech nearby came into the room, stayed with the resident while Med Tech E went to get paperwork, escort the emergency first responder into building and notified Executive Director. Resident #1 was unresponsive but breathing per report by the second Med Tech who stayed with her. Within 3 minutes, emergency medical services ( ) arrived and transferred the resident to the local hospital. Family was notified. Later, a family member called and informed the facility that the resident expired in the hospital. On at 2:30 PM, the Administrator confirmed that she did not complete a documented internal investigation and did not submit an adverse incident to the Agency for Health Care Administration for staff not performing on resident #1 on when found unresponsive. Class I	A 076		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other	A 152		

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A 152	Continued From page 13 (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation, facility documentation and	A 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964388	A. BUILDING: _____ B. WING _____	01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 152	Continued From page 14 interview, the facility failed to provide a clean and safe environment: pests (Memory Care dining room), and heavily stained carpet ( ). Findings: 1. On at 10 AM in the Memory Care dining room, 5 roaches crawled around on the sink, on the countertop and on the wall. Photographic evidence was obtained. The facility's pest control maintenance contract reflected that the last times pest control treatment and services was completed in the facility for bugs was on and . Review of the grievance log dated revealed the resident in submitted a complaint that there were bugs on her bed and on her dresser at night time. Pest control came out and treated for bed bugs on . 2. On at 10:45 AM in , the carpet by the resident's bed and recliner, in front of TV, and near the front door entrance of the room was soiled. The resident said in she filed a grievance for bugs on her bed and dresser. The pest control came out the same day and treated her room. Photographic evidence was obtained. On at 10:58 AM, the Administrator confirmed the findings and stated that the bugs in Memory Care was brought to her attention on yesterday by a staff member. On at 11 AM, the Maintenance Director confirmed the findings of the bugs in Memory Care. He stated he was not happy with the pest control company, and hired a new company for	A 152		

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A 152	Continued From page 15 pest control maintenance to come out next week. The Maintenance Director was not aware of the grievance complaint dated ... . was for bugs in . Class III	A 152		
CZ821	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010	CZ821		

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CZ821	Continued From page 16 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPo	CZ821		

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CZ821	Continued From page 17 rtal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15	CZ821		

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CZ821	Continued From page 18 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on facility documentation, record review and interview, the facility failed to submit a 1 business day and 15 calendar day adverse incident report to Agency for Health Care Administration (AHCA) after staff did not initiate . , ( ) for 1 of 1 sampled resident (#1). Findings: Documentation from the County Fire and Rescue first responder reflected that on at 7:03 PM, they were dispatched to the facility because staff reported Resident #1 went . . . . . Upon arrival to the scene, they found Resident #1 slumped over in her wheelchair with Caregiver B and Medication Technician (Med Tech) E standing next to her.	CZ821		

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CZ821	Continued From page 19 The first responder's report reflected that it was observed that Med Tech E was on the phone and Caregiver B was holding the resident from falling out of the wheelchair. The first responder checked for a , . . . for Resident #1 and nothing found. The first responder lifted Resident #1 to the stretcher and placed her in supine position, and her and were blue in color. The first responder then started manual . and the stretcher was wheeled out to rescue truck. The first responder completed vital signs; after 2 minutes of , the first responder checked Resident #1's , . . . again and found nothing. Photographic evidence was obtained. On at 2:30 PM, the Administrator confirmed that she did not complete an internal investigation and did not submit an adverse incident to AHCA regarding Resident #1, who did not have a ( ), not receiving . . on . . . . . when found unresponsive. Unclassified	CZ821		