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
	AL11969059	A. BUILDING: _____ B. WING _____	10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE COCONUT POINT	8460 MURANO DEL LAGO DR BONITA SPRINGS, FL 34135

(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 complaint survey for #2023014868 was conducted on /233 through at American House Coconut Point, an assisted living Facility in Bonita Springs, Florida. Complaint #2023014868 was substantiated at A 0030 and A 0076 at Class I. The following is description of the deficiencies.	A 000		
A 030 SS=J	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	A 030		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 030	Continued From page 1 1(888)419-3456, and the statewide toll-free 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	A 030		

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A 030	Continued From page 2 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. 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.	A 030		

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A 030	Continued From page 3 (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. (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	A 030		

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A 030	Continued From page 4 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 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	A 030		

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A 030	Continued From page 5 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 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 interview, the facility failed to provide health care services which are consistent with established and recognized standards within the community including the right for personal independent decisions to be	A 030		

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A 030	Continued From page 6	A 030		

honored for 2 (Resident's #1 and #2) of 3 resident reviewed for Advanced Directives. Failure to honor a resident's decision to have or not have performed creates the likelihood of serious harm to the residents of the facility.

The findings included:

1. A review of Resident #1's record revealed an admission date of . Diagnoses included , , , , and Sarcopenia (loss of tissue). The record review revealed Resident #1's code status was documented as Full Code (Administer in the event of or).

Review of the progress note dated at 4:20 p.m., revealed Licensed Practical Nurse (LPN) Staff C documented, " Phone call from (Resident Assistant) on first floor stating private aide came to work as usual this a.m., to find resident not breathing, no noted. 911 was called as stayed in the room with resident. Noted resident was full code and ( ) was started. EMT (Emergency Medical Technician) notified MD (Physician) for order to stop code . . ."

Review of the Emergency Medical Services ( ) patient care record dated noted at 8:26 a.m., Resident #1 was unresponsive. The clinical impression included , and . The form noted staff gave the sheet of the resident that stated the resident was a full code. When the family arrived, they stated that the resident was a ( ) and they wished to honor the resident's wishes, despite no physical copy of the

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A 030	Continued From page 7 available. Review of the facility's investigation of the resident's conducted on noted that on at 8:00 a.m., the private duty aide hired by the resident's family arrived in the resident's room. On at 8:05 a.m., the private duty informed the Housekeeping Director. On at 8:06 a.m., the House keeping Director arrived in the resident's room. On at 8:09 a.m., the Medication Technician called 911, then the nurse confirms Resident #1's full code status via walkie talkie. On at 8:15 a.m., arrived on site. On at 8:30 a.m., Resident #1 was pronounced . The facility investigation noted in the narrative of facts, was started by , not by the community staff. On at 9:35 a.m., the facility Administrator stated the code status can be found on the computer system and in the resident's chart. She said nothing is kept in the residents' rooms to identify code status. She said, "We were told by corporate to start until we know they are a . If the resident does not want , then we can stop." On at 10:23 a.m., the Housekeeping Director said she was covering the front desk at 8:00 a.m., when Resident #1's private duty aide approached her and requested assistance in the resident's room. She radioed LPN Staff C STAT (immediately). She informed Staff C assistance was needed for Resident #1. They all went to the resident's room. LPN Staff C and Med Tech (Medication Technician) Staff D were right behind her. When they walked into the room, Resident	A 030		

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A	Continued From page 8	A 030		

#1 was lying in bed. LPN Staff C said he was "gone", call 911. The Director said, "It was clear, you could tell he had passed."

On [redacted] at 10:28 a.m., in a telephone interview, Med Tech Staff D said on [redacted] the Housekeeping Director called over the walkie talkie. She said assistance was needed in Resident #1's room, on the first floor. She arrived to the room at the same time as LPN Staff C who told her to call 911. LPN Staff C left the room and went to the third floor to check Resident #1's code status. It took about five minutes before LPN Staff C called [redacted] and said Resident #1 was a full code. By the time she radioed [redacted] the code status, 911 was already here, and started [redacted]. The resident's daughter arrived and was yelling he was a [redacted] and was screaming for them to stop [redacted] got on the phone with a physician and received the final ok to stop [redacted]. She verified the facility staff did not start [redacted] and said she did not know why the nurse did not start [redacted].

On [redacted] at 11:10 a.m., the private duty aide said he arrived at the facility on [redacted] between 7:30 a.m., and 7:35 a.m. When he entered Resident #1's room, and called his name, he didn't move. He said, "I touched him, his skin was cool, but his color was normal. I went to the front office to look for someone in charge. I couldn't find anyone for approximately 25 minutes until the Housekeeping Director came in. When the staff came to the room, they called the paramedics."

On [redacted] at 1:35 p.m., in a telephone interview LPN Staff C said on [redacted] when she entered Resident #1's room, it was obvious he had ceased to breathe. She said she ran upstairs to get the chart, and called down to tell them the

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A 030	Continued From page 9	A 030		

resident was a full code. arrived as she was coming down the elevator. He had no , he had obviously expired. There was no rate, no carotid , he was cool. She said, "I wouldn't say he was , and I can't say (rigidity) had set in. placed him on the floor and did . She verified the facility staff did not attempt and did not use the ( ) when Resident #1 was found without a or as required per his code status. She said, "We found out he was a full code, but everyone just froze at that moment." LPN Staff C verified the facility staff should have initiated when the resident was found without a or .

On at 4:12 p.m., in a telephone interview, the Vice President of Resident Care said everyone should follow the Emergency Care Policy. Each resident's code status is located in the electronic health record, on tablets the staff have access to, as well as laptops located throughout the facility. She said there was a need for more clarity. The community needed to know what the code status is. The decision was made to start and stop once the was confirmed.

On at 11:12 a.m., the Director of the Memory Care Units stated staff do not carry the tablets with them while working. The Director said if the tablets are not charging in the laundry area, they are either on or in the medication cart. There are two tablets and one laptop available in memory care. The Resident Care Coordinator updates the charts as new information comes in. Upon admission the code status should be reviewed with the family. When staff are checking for code status, they should open the

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A 030	Continued From page 10 chart and confirm on the sheet and yellow form. 2. Record review of Resident #2's chart revealed the sheet indicated his code status was (- Do not administer in the event of or). Chart also contained a Hospice Plan of Care with a start of care date of , a separate Hospice form identifying the resident as a Hospice resident with status, and an executed Florida Form which had been signed . On at 10:40 a.m., Resident Aide Staff A said she went in to do rounds on around 2:25 a.m., and saw the cord leading into the bathroom, where she found Resident #2 on the floor unresponsive. She said she called out to Med Tech Staff B and immediately started and Staff B called 911. Staff A said when Emergency Medical Services ( ) arrived, they took over. Staff A said at this time she took the stairs running up to the third floor to verify the code status. She said she just grabbed the binder, ripped out the Order and sheet and ran down to the first floor. She explained it is 3 flights of stairs and the elevator takes time. She said the is either on the third floor in the chart or can be found on the tablet, but the tablets are normally kept on the 3rd floor charging. Staff A said they should be left on the med cart, but they are upstairs in the nursing office, so either way you go to 3rd floor. She said the previous day, , she went through a refresher in-service with the Assistant Wellness Director (AWD) where it was reinforced the status is not kept in the room and we are trained if you don't know the status, then start and	A 030		

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A 030	Continued From page 11 have a second person call 911, get the documents together, and the machine. On 10:35 a.m., Staff B (med tech) said Resident #2 about 2 o'clock in the morning. She said Staff A found him on the floor and called her. She said Staff A started and she (Staff B) called 911 who was directing them over the phone counting the with them. Staff B said she didn't have time to see if he was a . Staff B said arrived about 5 minutes later and took over . At this time Staff A ran upstairs to check Resident #2's status. When she came downstairs, She showed the EMTs the paper and that's when they stopped , . Staff B said he was unresponsive, they looked for a , , didn't feel one and they didn't have time to check if he was , they were just trying to save him. Staff B said some residents have the posted on the of the door, but Resident #2 did not and she wasn't sure why. She explained Resident #2 was on the first floor, and it took about 5 minutes to check his status, as you had to run down the hall, past kitchen and dining room to the elevator and the nurse station is 3 floors up. Staff B said that's what they are told to start if the resident is unresponsive. On at 9:38 a.m., the Executive Director (ED) explained the procedure to be followed when a resident was found unresponsive, was to start - , ( ) until status could be confirmed. She said they would stop once they had the . She said all staff were trained to start immediately until they could access the residents' chart for status. The ED said she confirmed with corporate after the event with Resident #2 that starting immediately without confirming	A 030		

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A 030	Continued From page 12 status was the policy they wanted to stick with. ED said she had done no investigation into this incident as she felt corporate policy had been followed. On at 11:14 a.m., the Assistant Wellness Director (AWD) verified she provided the code drill training. She said staff are taught to check , and breathing, and if not found to yell for help and immediately start , then when help arrives, send them to check status and get the automated electric defibrillator. AWD said when the second person returns and tells them the resident is , will stop. AWD said no matter what, they are starting until status is verified. Review of facility Policy number: WEL-37 - Emergency Care, Revision Date indicated the following: 4. Determine status of resident: a. YES - if orders are present, DO NOT start . Return to resident and assist resident to a comfortable position. Provide emergency medical response with the orders on their arrival. b. NO - if orders are not present - begin . On at 1:15 p.m., the ED said she verified with corporate there was no other official policy. She said the Emergency Care Policy is what they would use as policy. She said the decision to initiate prior to verifying status had come from corporate compliance and referred surveyor to Regional Health and Wellness Director. On at 2:58 p.m., the Regional Health and Wellness Director said the policy would be	A 030		

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A 030	Continued From page 13 the Emergency Care Policy. In explaining the conflict between what staff describes as policy and the written policy, she said she would guess in her situation, if she came across someone with no , . . , she would start . herself. She said it was imperative to start . She said if she saw the she wouldn't, but until she saw it, she absolutely would start . When asked about following a residents/representatives expressed written wishes for versus Full Code, the Regional Health and Wellness Director said the Emergency Care Policy is the policy and should be followed. She said it would be corporate compliance who could say otherwise and referred surveyor to the Vice President of Resident Care. On at 4:12 p.m., the Vice President of Resident Care said the Policy says they should determine status, but she could understand their response would be to administer . . She said the American Association says if you don't know, then start . , but the community should know the code status of the residents. The Vice President said they had decided the policy was to start and stop once was confirmed. She agreed there needed to be more clarity and the community does need to know what the code status is. She said they may need to re-look at their policy. Class I	A 030		
A 076 SS=J	59A-36.009 FAC (. .) (1) POLICIES AND PROCEDURES. (a) Each assisted living facility must have written policies and procedures that explain its	A 076		

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A 076	Continued From page 14 implementation of state laws and rules relative to ( ). An assisted living facility may not require execution of a 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- , "Health Care Advance Directives - The Patient's Right to Decide," , , or with a copy of some other substantially similar document, which incorporates information regarding advance directives included in chapter 765, F.S. Form SCHS- 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 Form, , 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 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	A 076		

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A 076	Continued From page 15 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 record review and interview, the facility failed to ensure the written policies and procedures explaining the implementation of state laws and rules relative to ( ) were adhered to for 2 (Residents #1 and #2) of 3 residents reviewed for Advanced directives. The facility failed to ensure a properly executed DH Form 1896; Florida Form was honored for 1 (Resident #2) of 3 residents reviewed for Advanced directives. The facility failed to ensure the Code Status information and a copy of the DH Form 1896 was readily available to facility staff during an emergency event for 2 (Residents #1 and #2) of 3 residents reviewed for	A 076		

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A 076	Continued From page 16 Advanced directives. This has the potential for serious harm to all facility residents, , , 49 residents with properly executed Florida . . The findings included: American House Senior Living Communities Policy and Procedure Manual Title: Emergency Care Policy Number: WEL-37-Emergency Care Effective Date: Revision Date: Policy: It is the American House policy that residents will receive appropriate emergency care. Purpose: To ensure health and safety Procedure: 1. Staff trained in first aid, , and the Heimlich maneuver will be available at the community per state regulation. 2. When in doubt, summon Emergency Medical Services. See "Summoning Emergency Medical Services" policy. If resident is on Hospice, in the case of , , or failure, call hospice before summoning emergency medical services. 3. Determine if resident is unresponsive. Summon a co-worker for help. Ask co-worker to determine status of resident. 4. Determine status of resident: a. YES - if orders are present, DO NOT start . - Return to resident and assist resident to a comfortable position. Provide emergency response with the orders on their arrival. b. NO - if orders not present - begin . 1. A review of the Incident Report dated revealed, Resident #1. residing on the first floor, was designated as Full Code (- ,	A 076		

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A 076	Continued From page 17 [ ] to be administered in the event of). The resident's private duty aide arrived in the room at 8:00 a.m. to find the resident unresponsive. The private duty aide went to front desk and notified the Housekeeping Director (manager on duty) who called over the walkie talkie for assistance to the resident's room. Med Tech Staff D, Licensed Practical Nurse (LPN) Staff C and Housekeeping Director went to the resident's room. Staff C instructed Staff D to call 911. was not started by any staff member at the facility. Staff C went to the third floor to determine if the resident was a full code or . By the time they determined code status as full code, and the resident's family had arrived. started and continued until stop order was obtained from physician. The resident was pronounced at 8:30 a.m. On at 10:23 a.m., the Housekeeping Director said she and the private duty aide entered the room and found the resident unresponsive. She said no one checked the resident's , and no one checked to see if he was breathing. The Director said the nurse and med tech entered the room and the LPN said he was gone, call 911. The Director said the nurse left the room to go to the office on the third floor to check the resident's code status. She said she then discussed with the med Tech why they can't post the behind the doors in the resident rooms. The Director's understanding was Corporate said it can be maintained more accurately if it is in one place. On at 10:28 a.m., Med Tech Staff D said she and LPN Staff C arrived at Resident #1's room at the same time. Staff D said the nurse told her to call 911 and the nurse went upstairs to the nursing office on the third floor to check the Code	A 076		

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A 076	Continued From page 18 status of the resident. Staff D said by the time Staff C called to the resident's room with the resident's status as Full Code, had arrived and started . Staff D said it took about 5 minutes for the nurse to report the resident's Code status. Staff D said the resident's daughter arrived while was performing and became upset. The daughter demanded that they stop declaring that Resident #1 was a . Staff D said it was very stressful and the team called the resident's physician for instructions. Review of Resident #1's record found the resident had a Designation of Health Care Surrogate document prepared by the resident's lawyer. The surrogacy document references the resident's Living Will directive of No Code/ status. Resident #1 was admitted on . The initial Health Assessment Form 1823, signed by the physician on stated the resident was Full Code. All other documents in the chart from day one indicate full code. There are no notes in the resident's record of a discussion with the resident and/or family about the Living Will. There was no in the chart. The code status was not readily available to the staff at the outset of the event of Resident #1 being found unresponsive. On at 12:45 a.m., the Executive Director stated whenever the living will was provided to the facility, they should have met with the physician to have the conversation with the family and write the on the yellow form. 2. Record review of Resident #2's chart revealed the sheet indicated his code status was . Chart also contained a Hospice Plan of Care with a start of care date of , a	A 076		

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A 076	Continued From page 19 separate Hospice form identifying him as a Hospice resident with status, and an executed Florida Form which had been signed . On at 9:38 a.m., the Executive Director (ED) explained the procedure to be followed when a resident was found unresponsive, was to start - , ( ) until status could be confirmed. She said they would stop once they had the . She said all staff were trained to start immediately until they could access the resident's chart for status. The ED said in the early morning hours of , Resident #2 had been found unresponsive in the bathroom of his apartment on the first floor. Resident Aide Staff A immediately started and called for help. Med Tech Staff B responded, called 911 and began to alternate administering with Staff A. When Emergency Medical Services arrived and took over, Staff A ran to the nursing office on the third floor to verify whether the resident was status or full code. Staff A then ran down from the third floor and showed the properly executed form, at which time ceased , and Resident #2 was pronounced . The ED said the trip up and to the third floor would take approximately 5 minutes on the elevator. The ED said after the event, she confirmed with corporate compliance that starting immediately without confirming status was the policy they wanted to stick with. The ED said she had done no investigation into this incident as she felt corporate policy had been followed. On at 10:40 a.m., Staff A confirmed that when she found Resident #2 unresponsive, she immediately started without confirming	A 076		

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A 076	Continued From page 20 status. Staff A said this is how the facility trained them to respond and she had in fact just done a refresher with the Assistant Wellness Director reinforcing this practice the day prior. On 10:35 a.m., Staff B confirmed she responded to Staff A's call for assistance. She said she contacted 911 and began alternating with Staff A. Staff B said they did not have time to check status as was assisting them with counting over the phone. Staff B said that was what they're told to do: if unresponsive start . On at 11:14 a.m., the Assistant Wellness Director (AWD) verified she provided the code drill training. She said staff are taught to check and breathing, and if not found to yell for help and immediately start , then when help arrives, send them to check status and get the automated electric defibrillator. AWD said when the second person returns, they will tell them if they are and if so, will stop. AWD said no matter what, they are starting until status is verified. On at 1:15 p.m., the ED said she verified with corporate there was no other official policy. She said the Emergency Care Policy is what they would use as policy. She said the decision to initiate prior to verifying status had come from corporate compliance. On at 2:58 p.m., the Regional Health and Wellness Director said the policy would be the Emergency Care Policy. In explaining the conflict between what staff describes as policy and the written policy, she said: She would guess in her situation, if she came across someone with no , she would start herself. She said	A 076		

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A 076	Continued From page 21 it was imperative to start . She said if she saw the she wouldn't, but until she saw it, she absolutely would start . When asked about following a residents/representatives expressed written wishes for versus Full Code, the Regional Health and Wellness Director said the Emergency Care Policy is the policy and should be followed. She said it would be corporate compliance who could say otherwise. On at 4:12 p.m., the Vice President of Corporate Compliance said the Policy says they should determine status, but she could understand their response would be to administer . She said the American Association says if you don't know then start , but the community should know resident's code status. She said they had decided policy was to start and stop once was confirmed. She agreed there needed to be more clarity and the community does need to know what the code status is. She said they may need to re-look at their policy. Class I	A 076		