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
	AL11965368	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AT OCOEE	80 NORTH CLARK RD OCOEE, FL 34761

(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 A complaint investigation (#2024011875) was conducted at Madison at Ocoee on . . . . & . The facility had deficiencies at the time of the survey.	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, 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.	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	A 030		

(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

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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 [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] or [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 observations, record reviews and interviews, the facility failed to conduct a thorough investigation when 2 of 2 sampled resident's drug screen at a hospital tested positive for [illegible] (#4 & #5.) Findings: 1. A review of resident #4's record revealed a facility admission date of [illegible]. The resident's medical history included [illegible]. The resident	A 030		

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A 030	Continued From page 6 needed assistance with self-administration of medications. On at 10:44 am the resident was in bed and unresponsive to all stimuli. 911 was called and the resident was transported to a hospital. A hospital history and physical indicated the resident was sent to the hospital secondary to being unresponsive at the facility. A hospital drug screen was positive for . On at 4:02 pm the resident returned to the facility. A and drug screenings collected at the facility were both negative. On at 4:04 pm, the resident's family member said he was told by hospital staff that the resident's change in condition was caused by . The family member said the facility's administrator said an investigation found no in the facility. The family member said a facility doctor believed the result of the was a false positive. On at 2:15 pm, the administrator said an investigation was conducted in response to the drug screening results by way of conducting a medication cart audit which found no on site. On at 3:06 pm, the director of nursing (DON) said she learned of the positive result from the resident's family member after the resident's return to the facility. On at 12:33 pm, the DON said she	A 030		

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A 030	Continued From page 7 checked every medication cart and verified there was no , in the facility. 2. A review of resident #5's record revealed a facility admission date of . The resident's medical history included , and . The resident needed assistance with self-administration of medications. On at 1:11 pm the resident was alert to self, lying in bed breathing through his , had , no distress. His saturation level was 88% on room air, was , were 24. The resident was unable to verbalize his needs or discomfort. The resident was seen in the facility by Advanced Practice Registered Nurse (APRN) E, who suggested the resident be sent to the emergency room. An hospital history and physical indicated the resident presented to the emergency department for x2 days. An drug screen performed at the hospital was positive for . An hospital discharge summary indicated the resident was discharged to a hospice inpatient unit. On at 9:02 pm the facility learned from the resident's family member that the resident . A review of the health care provider orders in the resident's facility chart revealed was not prescribed. On at 10:05 am, the facility administrator	A 030		

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A 030	Continued From page 8 said an investigation was conducted upon learning the resident tested positive for , in the hospital. The administrator said the investigation consisted of doing a washing in-service, memory care cart audit and memory care apartment searches for medications. She said no , was found. She said none of the investigation was documented. She said the resident's medications were saved and the corporate office was working with the facility's pharmacy to test them. On at 11:08 am, unlicensed caregiver A said she did not know residents #4 and #5 tested positive for . She said she was never interviewed as part of the investigation. On at 12:22 pm, APRN E said she saw resident #5 on and ordered a because the resident's family member was concerned the resident was not eating and had no energy. The APRN said the resident was having periods of , and jerking movements, which was a change. She said during her exam of the resident she performed sternal rubs on him. The APRN said that when she was in the facility on the facility's nurse reported the resident's was elevated so the APRN said send him to the hospital. The APRN said the last time she saw him before the 19th was on . She said he was alert and sitting in the dining room. She said he would asleep, but in a normal way for him. The APRN said she was aware of resident #4's positive drug screen for . The APRN said she discussed with the DON performing drug screening on other residents, but the APRN was not sure if families had to be informed. On at 1:35 pm, the administrator said that	A 030		

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A 030	Continued From page 9 on ..... she, along with the DON, spoke with resident #5's hospital doctor, who informed them of the positive ... ... Despite both residents #4 and #5 testing positive for ... , the administrator she did not question the doctor further. The administrator said law enforcement was not contacted after the second positive case, and she did not discuss the findings with the pharmacy. The administrator said she did not ask any of the facility's doctors about performing drug screenings on additional residents. On ..... at 1:51 pm, caregiver F said she saw resident #5 on ... at approximately 7:30 am. She said the resident's ... were hanging over his bed, his ... was wide open, and he was breathing funny. The caregiver said she informed nurse I. The caregiver said resident #5 did not get out of bed that day and did not eat breakfast or lunch. The caregiver said the resident did drink a cup of water. The caregiver said she cleaned the resident's ... with a sponge then changed and repositioned him in the bed. She said the resident's ... were open and he screamed when his ... were moved, she believed because they had been hanging over the bed. The caregiver said it was the first time she'd ever seen him that way. She said she did not know about the positive ... ... tests and was not interviewed about it. On ... at 2 pm, caregiver B said that on ..... resident #5 did not get out of bed for breakfast. She said the resident did get up for lunch but did not eat. The caregiver said that on ... the resident was not alert. The caregiver said that on ..... the resident was left in bed and was given an Ensure drink for breakfast but did not want it. The caregiver said she noticed a decline in the resident approximately one week	A 030		

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A 030	Continued From page 10	A 030		

prior and told nurse D. The caregiver said that on she told nurse H. The caregiver did not know residents #4 and #5 tested positive for . The caregiver said no meeting was held with staff and she was not interviewed by administration.

On at 2:10 pm, nurse D said resident #5 did not like taking his medications so they were given in his food. She said for 2 to 3 weeks prior to the resident slept a lot but was easy to wake up. The nurse said she told the caregivers in passing on to make sure the resident was seen by the health care provider on . The nurse said she learned the resident tested positive for today and that administration did not interview her about it.

On at 2:23 pm, the DON said that when she spoke with the hospital doctor regarding resident #5 on she did not discuss the fact that resident #4 also tested positive for . The DON said she did not notify law enforcement and did not discuss the cases with the pharmacy. The DON said she spoke with resident #5's health care provider about it and was not given new orders. The DON said she searched all the memory care apartments for something odd. She conducted an audit of all medication carts. She did not interview staff because the administrator was going to do it.

On at 2:40 pm, caregiver G said resident #5 was sleepy and hard to wake up on & . The caregiver said the resident was in and out of bed. He had a poor appetite, was agitated and did not want to be touched.

On at 10:05 am, nurse I said she checked on resident #5, she was unsure of the

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time and did not like the way he looked. His was open, and he was breathing through it. His looked kind of purplish. Nurse, I said she did not know the resident well enough to know if that was his baseline. She recalled the specimen for the ordered on was contaminated with and could not be used for testing. The nurse said she suggested to APRN E that the resident be sent to a hospital. The nurse said the resident took his 8 am medications on but he was breathing through his . She said the resident's at that time were really red. She said the resident's family member texted her on at 9:48 am asking for a bed wedge to be used to prevent the resident from rolling over. The family also said the resident had sleep and asked to have a pillow to help him breathe better.

On at 2:05 pm, caregiver K said she could not recall resident #5's condition during the 2 pm-10 pm shift on . She said when the resident slept it was like he was trying to catch his breath, and he moved around a lot. She was unaware of the positive results and said she was never interviewed by administration.

On at 2:19 pm, caregiver L said resident #5 was sleepy on during the 6 am-2 pm shift. His was open, and he was snoring. It was hard to get him up at times. He was out of bed that shift. His gait was unsteady. The caregiver said she told nurse D. The caregiver said she heard about the positive only yesterday from a co-worker and said she was not interviewed by administration.

On at 3 pm, the administrator said she did not know law enforcement should have been notified when the two residents tested positive for

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A 030	Continued From page 12 . . . . . She said staff were not interviewed about resident #5. She then said she spoke with nurses H and L and asked them how the resident was doing. She said no other staff were interviewed and she did not tell any staff about the positive . . . . . results because the staff talked a lot. On . . . . . at 9:45 am, nurse H said that on . . . . . resident #5 was really sleepy. He dozed off easily and was snoring. She said his family member previously said he had sleep . . . . . but refused to wear the machine at home. The nurse said the administrator did tell her of resident #5's positive . . . . . and asked the nurse if she knew anything about it or if anyone was taking . . . . . The nurse said the memory care medication cart and apartments were checked for . . . . . . Class III	A 030		
A 077 SS=D	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52	A 077		

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A 077	Continued From page 13 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to [illegible], are not required to take the competency test unless specified elsewhere in this rule; and,	A 077		

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	AL11965368	A. BUILDING: _____ B. WING _____	09/04/2024

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A 077	Continued From page 14 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the . . . . of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile . . . . of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to	A 077		

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A 077	Continued From page 15 paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the administrator, who was responsible for the management of all staff and the provision of appropriate care to all residents, failed to ensure a thorough investigation was conducted when the facility learned 2 of 2 sampled resident's drug screen at a hospital tested positive for , (#4 & #5.) Findings: 1. A review of resident #4's record revealed a facility admission date of . The resident's medical history included . The resident needed assistance with self-administration of medications. On at 10:44 am the resident was in bed	A 077		

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A 077	Continued From page 16 and unresponsive to all stimuli. 911 was called and the resident was transported to a hospital. A hospital history and physical indicated the resident was sent to the hospital secondary to being unresponsive at the facility. A hospital drug screen was positive for . On at 4:02 pm the resident returned to the facility. A and drug screenings collected at the facility were both negative. On at 4:04 pm, the resident's family member said he was told by hospital staff that the resident's change in condition was caused by . The family member said the facility's administrator said an investigation found no in the facility. The family member said a facility doctor believed the result of the was a false positive. On at 2:15 pm, the administrator said an investigation was conducted in response to the drug screening results by way of conducting a medication cart audit which found no on site. On at 3:06 pm, the director of nursing (DON) said she learned of the positive result from the resident's family member after the resident's return to the facility. On at 12:33 pm, the DON said she checked every medication cart and verified there was no in the facility. 2. A review of resident #5's record revealed a	A 077		

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A 077	Continued From page 17 facility admission date of . The resident's medical history included , and , . The resident needed assistance with self-administration of medications. On at 1:11 pm the resident was alert to self, lying in bed breathing through his , had , no distress. His saturation level was 88% on room air, was , were 24. The resident was unable to verbalize his needs or discomfort. The resident was seen in the facility by Advanced Practice Registered Nurse (APRN) E, who suggested the resident be sent to the emergency room. An hospital history and physical indicated the resident presented to the emergency department for x2 days. An drug screen performed at the hospital was positive for . An hospital discharge summary indicated the resident was discharged to a hospice inpatient unit. On at 9:02 pm the facility learned from the resident's family member that the resident . A review of the health care provider orders in the resident's facility chart revealed , was not prescribed. On at 10:05 am, the facility administrator said an investigation was conducted upon learning the resident tested positive for in the hospital. The administrator said the investigation consisted of doing a washing	A 077		

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A 077	Continued From page 18 in-service, memory care cart audit and memory care apartment searches for medications. She said no [illegible] was found. She said none of the investigation was documented. She said the resident's medications were saved and the corporate office was working with the facility's pharmacy to test them. On [illegible] at 11:08 am, unlicensed caregiver A said she did not know residents #4 and #5 tested positive for [illegible]. She said she was never interviewed as part of the investigation. On [illegible] at 12:22 pm, APRN E said she saw resident #5 on [illegible] and ordered a [illegible] because the resident's family member was concerned the resident was not eating and had no energy. The APRN said the resident was having periods of [illegible] and jerking movements, which was a change. She said during her exam of the resident she performed sternal rubs on him. The APRN said that when she was in the facility on [illegible] the facility's nurse reported the resident's [illegible] was elevated so the APRN said send him to the hospital. The APRN said the last time she saw him before the 19th was on [illegible]. She said he was alert and sitting in the dining room. She said he would [illegible] asleep, but in a normal way for him. The APRN said she was aware of resident #4's positive [illegible] drug screen for [illegible]. The APRN said she discussed with the DON performing [illegible] drug screening on other residents, but the APRN was not sure if families had to be informed. On [illegible] at 1:35 pm, the administrator said that on [illegible] she, along with the DON, spoke with resident #5's hospital doctor, who informed them of the positive [illegible]. Despite both residents #4 and #5 testing positive for [illegible], the	A 077		

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A 077	Continued From page 19	A 077		

administrator she did not question the doctor further. The administrator said law enforcement was not contacted after the second positive case, and she did not discuss the findings with the pharmacy. The administrator said she did not ask any of the facility's doctors about performing drug screenings on additional residents.

On ..... at 1:51 pm, caregiver F said she saw resident #5 on at approximately 7:30 am. She said the resident's ... were hanging over his bed, his was wide open, and he was breathing funny. The caregiver said she informed nurse I. The caregiver said resident #5 did not get out of bed that day and did not eat breakfast or lunch. The caregiver said the resident did drink a cup of water. The caregiver said she cleaned the resident's with a sponge then changed and repositioned him in the bed. She said the resident's were open and he screamed when his were moved, she believed because they had been hanging over the bed. The caregiver said it was the first time she'd ever seen him that way. She said she did not know about the positive tests and was not interviewed about it.

On at 2 pm, caregiver B said that on ..... resident #5 did not get out of bed for breakfast. She said the resident did get up for lunch but did not eat. The caregiver said that on the resident was not alert. The caregiver said that on ..... the resident was left in bed and was given an Ensure drink for breakfast but did not want it. The caregiver said she noticed a decline in the resident approximately one week prior and told nurse D. The caregiver said that on she told nurse H. The caregiver did not know residents #4 and #5 tested positive for . The caregiver said no meeting was held

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A 077	Continued From page 20 with staff and she was not interviewed by administration. On at 2:10 pm, nurse D said resident #5 did not like taking his medications so they were given in his food. She said for 2 to 3 weeks prior to the resident slept a lot but was easy to wake up. The nurse said she told the caregivers in passing on to make sure the resident was seen by the health care provider on . The nurse said she learned the resident tested positive for , today and that administration did not interview her about it. On at 2:23 pm, the DON said that when she spoke with the hospital doctor regarding resident #5 on she did not discuss the fact that resident #4 also tested positive for , . The DON said she did not notify law enforcement and did not discuss the cases with the pharmacy. The DON said she spoke with resident #5's health care provider about it and was not given new orders. The DON said she searched all the memory care apartments for something odd. She conducted an audit of all medication carts. She did not interview staff because the administrator was going to do it. On at 2:40 pm, caregiver G said resident #5 was sleepy and hard to wake up on & . The caregiver said the resident was in and out of bed. He had a poor appetite, was agitated and did not want to be touched. On at 10:05 am, nurse I said she checked on resident #5, she was unsure of the time and did not like the way he looked. His was open, and he was breathing through it. His looked kind of purplish. Nurse, I said she did not know the resident well enough to	A 077		

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A 077	Continued From page 21 know if that was his baseline. She recalled the specimen for the , ordered on was contaminated with and could not be used for testing. The nurse said she suggested to APRN E that the resident be sent to a hospital. The nurse said the resident took his 8 am medications on but he was breathing through his . She said the resident's , at that time were really red. She said the resident's family member texted her on at 9:48 am asking for a bed wedge to be used to prevent the resident from rolling over. The family also said the resident had sleep , and asked to have a pillow to help him breathe better. On at 2:05 pm, caregiver K said she could not recall resident #5's condition during the 2 pm-10 pm shift on . She said when the resident slept it was like he was trying to catch his breath, and he moved around a lot. She was unaware of the positive , results and said she was never interviewed by administration. On at 2:19 pm, caregiver L said resident #5 was sleepy on during the 6 am-2 pm shift. His was open, and he was snoring. It was hard to get him up at times. He was out of bed that shift. His gait was unsteady. The caregiver said she told nurse D. The caregiver said she heard about the positive , only yesterday from a co-worker and said she was not interviewed by administration. On at 3 pm, the administrator said she did not know law enforcement should have been notified when the two residents tested positive for , . She said staff were not interviewed about resident #5. She then said she spoke with nurses H and L and asked them how the resident was doing. She said no other staff were	A 077		

Agency for Health Care Administration

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A 077	Continued From page 22 interviewed and she did not tell any staff about the positive , results because the staff talked a lot. On . . . . at 9:45 am, nurse H said that on . . resident #5 was really sleepy. He dozed off easily and was snoring. She said his family member previously said he had sleep , but refused to wear the machine at home. The nurse said the administrator did tell her of resident #5's positive . . , and asked the nurse if she knew anything about it or if anyone was taking . . , . The nurse said the memory care medication cart and apartments were checked for . . , . Class III	A 077		