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
	AL11912132	A. BUILDING: _____ B. WING _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM AT BOCA RATON (THE)	1080 NORTHWEST 15TH STREET BOCA RATON, FL 33486

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced licensure complaint survey, #2025000144, was commenced on and concluded on at The Atrium At Boca Raton. The facility had deficiencies related to the complaint 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	A 030		

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A 030	Continued From page 1	A 030		

and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and , ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and standard precautions;
8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical .
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where

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A 030	Continued From page 2 residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as	A 030		

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A 030	Continued From page 3 provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with	A 030		

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A 030	Continued From page 4 relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility	A 030		

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A 030	Continued From page 5 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 reviews, interviews and observation, the facility failed to honor the rights of 1 of 4 sampled residents, Resident #1 by withholding ( ) and the use of an Automated External Defibrillator ( ), as an emergency life sustaining procedure, when the resident was found unresponsive by staff members (Staff B, C, D, E and F). Resident #1 did not have a ( ) and was	A 030		

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A 030	Continued From page 6 subsequently pronounced by Emergency Medical Services ( ) upon arrival at the facility. All 100 out 121 facility residents, who don't have a , are at risk of not receiving if its needed. The findings included: Review of the facility's policy and procedures (undated) titled, , , ( ) revealed the following: Policy: If a resident is found without a , and/or is not breathing, staff will respond to the emergency following established procedures and comply with state regulations. Process: 1. Assess Situation Determine if the resident is (e.g., gently shake, call name, check for , /breathing). If there is no response, call or help. Verify the resident's status. 2. Summon Assistance If the resident has a " " status (status may be indicated by a green dot, " ", or "Yes". It is usually located in several different places: on the outside edge of the Resident Binder, in a visible place in the resident's apartment or on the Resident Information and Contact Sheet. Follow the system that is currently in place in your community, as per state guidelines and state-specific policy and procedure): -Call 911 or the fire department immediately -Initiate and continue the until emergency personnel arrive. If the resident has a "No " status or " "	A 030		

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A 030	Continued From page 7 (No status may be indicated by a "red dot", "No ", or "No". -Call -1 immediately unless the resident is on hospice services. Call the hospice agency if the resident is receiving hospice services and has a order or form. -Await help; do not leave the resident or person alone unless assistance arrives. Review of the facility's policy and procedures titled, ( )-FL updated on revealed the following: Policy Overview: It is the policy of [....] Senior Living (management company of the facility) to honor any executed by a resident. In the event that a is not executed, [....] Senior Living will assume that the resident or their Responsible Party has consented to , , unless there is a documented in the resident's medical record. Review of the local Law Enforcement investigation report dated documented the following: "On at 0616 (6:16 AM) local law enforcement responded to the facility in reference to an unattended . [Staff B, Care Associate] stated during her rounds at 5 AM discovered Resident #1 unresponsive and not breathing with , and opened. Officer met with [Staff B] who advised at approximately 5:00 AM, she was conducting her morning rounds. When [Staff B] entered Resident #1's bedroom, she observed the resident unresponsive and not breathing, with his , and opened. At approximately 5:03 AM,	A 030		

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A 030	Continued From page 8 [Staff B] notified Lead Nursing Assistant [Staff E, Care Associate] for assistance since [Staff B] mentioned she was new to the facility. At approximately 5:04 AM, [Staff E] notified Medical Technician, [Staff F, Care Associate]. [Staff F] stated she got stuck in the elevator as she was heading towards Resident #1's room. [Staff E] then called 911 and the local Fire Department, who arrived on scene and pronounced Resident #1 at 6:27 AM. [Staff E and Staff B] both mentioned that they last saw Resident #1 alive at approximately 3:00 AM as they were conducting their rounds. The resident's medical history consisted of , , , Micro- , limited mobility, body aches and fatigue. The resident was observed by law enforcement lying in his bed with his , and opened." Review of the Emergency Medical Services Report (run report) documented that a call was received from the facility on at 6:14 AM. "The chief complaint noted as a , (Resident #1), not , not breathing and obvious . Emergency Services arrived at the facility at 6:22 AM, actions taken by was documented as provide Advanced Life Support ( )." A review of the facility's investigation report completed by the Administrator dated documented that on , Resident #1 who resided in the Memory Care Unit was found in bed, unresponsive, at approximately 5:20 AM while the Care Associates were conducting	A 030		

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A 030	Continued From page 9 rounds. 911 was called and they were able to pronounce the resident. Resident #1 documented as being alert and oriented x1(resident can respond to their surroundings but may struggle with recalling specific details). Additional documentation noted on the investigation report by the Administrator dated documented that the resident was last rounded on at 3 AM. The resident was sleeping and confirmed breathing. When he was checked on again at 5 AM, his was open, and were open. The resident was not a was not provided at the time as it was apparent he had passed. Record review of Resident #1's record revealed an admission date to the facility on . Further review revealed Resident #1's Health Assessment (AHCA Form 1823) dated , documented the resident's medical diagnoses as with behaviors, , ( ), History (Hx) of , , ( ), and History . Retention. The resident's physical limitations was documented as ambulated with assistance. The resident's status was documented as poor judgment. The nursing service requirements was listed as care to lower extremities. Special precautions was noted as . Activities of Daily Living (ADL) was documented as independent for eating and transferring; supervision for ambulation and grooming; and assistance with bathing, and toileting. During a tour of the facility conducted with the Administrator and the Director of Wellness on at 9:30 AM, it was observed that the facility is a five-story (1st through 5th floor)	A 030		

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A 030	Continued From page 10 building. The 1st floor is the location of the common areas, lobby, main dining room, bistro, activity room, administrative offices etc.,). The 2nd floor is the location of the Memory Care Unit. The 3rd floor is the location of the AL residents, Nurses Station, and the Automated External Defibrillator ( ) inside the nurse's station and AL residents. Lastly, the 4th and 5th floors house are for AL residents. During an interview on at 11:56 AM, the Administrator stated Resident #1 of natural causes and she understands the facility did not follow their protocol by not performing . She stated she was not present at the facility the day of the incident on . Further interview, at this time, with the Administrator revealed 5 staff members (Staff B thru F) were on duty (10 PM to 6 AM shift). She stated, each shift has a Staff member designated as the Lead Staff in charge of the facility (including staff and residents). On the day of the incident Staff F was in charge as the Lead Staff. The Administrator stated the resident was pronounced [ ] by the paramedics. Review of the facility's daily assignment sheet and staffing schedule for and provided by the Administrator revealed Staff B, C, D, E and F were assigned the 10 PM to 6 AM shift. Further review revealed Staff B and E were assigned to work in the Memory Care unit (MCU) and Staff C and D were assigned to the Assisted Living Unit (AL). Staff F was assigned as the Lead Shift Staff (person in charge for designated shift) and Medication Technician for the entire facility. During a further interview with the Administrator on at 11:56 AM, she stated that on	A 030		

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A 030	Continued From page 11 at approximately 6:08 AM, she received a call from Staff C (Care Associate). She stated during the call, Staff C was translating what Staff B (Care Associate) was communicating to her (in her native language). Staff B told Staff C that she found Resident #1 on his bed with his , and open and she had asked other staff for help to confirm Resident #1 was . The Administrator stated she asked staff if they had performed and staff answered "no". She asked if 911 was activated and staff stated, no. The Administrator stated she told the staff (Staff C) to call 911. The Administrator stated an investigation was conducted by the facility regarding Resident #1's and staff failure to perform . At the time of the incident, Staff G (Wellness Director) was on vacation, upon her return on she also participated in the investigation. At this time, a request was made for the documentation and information regarding the facility's investigation and steps implemented to prevent occurrence. The facility provided no documentation in reference to this investigation. During an interview on at 12:32 PM with Staff B (Care Associate), it was revealed that she is a new hire to the facility as of and worked the night shift from 10:00 PM to 6:00 AM. She further stated she found Resident #1 on with his , and open in his room during her rounds at approximately 5:00 AM. Staff B stated on the day of the incident she called two other staff members (exact time unknown); Staff E (Care Associate), who at the time was in the next-door room and Staff D (Care Associate) was called for help from her personal phone. Staff B was asked if she assessed the resident and performed before calling staff	A 030		

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A 030	Continued From page 12	A 030		

for assistance, and she stated "no". She was asked again if was performed after the arrival of the other two staff members, and she stated, no. She was asked if she received training on and the facility's policy for , and she stated, no. Staff B stated on the day of the incident, she was in . . and was not able to perform .

During an interview on at 9:01 AM with Staff D (Care Associate) she revealed that she received a phone call from Staff B (Care Associate) asking for help. She stated she was assigned to work on the fifth floor the day of the incident on . She stated Staff B asked her to go into Resident #1's room with her. Staff D stated once inside the room she announced herself by saying hello, hello and no response. She stated at that point she realized Resident #1 was unresponsive and Staff E who was also present in the room, stated "he is ". Staff D was asked if she performed , and she stated "no". She stated she received a call from a resident's pendant and left the memory care unit and went to her duties assigned on the fifth floor.

During an interview on at 9:29 AM with Staff C (Care Associate), she stated she was assigned to work on the fourth floor on the day of the incident that took place on . She stated she received a call on her personal phone requesting for help from Staff F (Lead Staff / Medication Technician) (MT) and heard on the radio "med tech[Medication Technician], med tech come in" and no sense of urgency. She stated she arrived (the exact time unknown) in the Memory Care Unit on the second floor and three Care Associates were in the resident's room, which included Staff D (Care Associate AL), Staff

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A 030	Continued From page 13 E (Care Associate MC) and Staff B (Care Associate MC) and saw the Resident with his and , open. During the interview, Staff C was asked if she provided to the resident, and she stated "no", because she heard the caregivers saying the resident was not responsive. She stated she was in and did not think of it. She stated Staff F (Medication Technician) was on her way to the second floor to the nurse's station to check on Resident #1's chart and got stuck in the elevator. Staff C stated she tried calling Staff G (Wellness Director) four times and does not remember the last times she called. She stated Staff G did not answer her phone. She stated she called the Administrator and told her about the emergency and that Staff F was stuck in the elevator. She stated Staff E called 911. Staff C was asked if she was aware of the facility's Policy for / , and she stated, no. During an interview on at 9:52 AM Staff F (Med-Tech) she stated she was completing medication pass at the time of the incident on (does not remember the time). She stated twice she heard on the radio/walkie talkie "Med Tech come in". She stated she remembered going to the Memory Care Unit on the second floor and saw Resident #1 unresponsive. Staff F was asked how did you know Resident #1 was unresponsive. She stated, she heard one of the Care Associates shouting he is not responsive. She stated she told staff she was going to the third floor (nurse station) to check on the resident's chart for the or full code status. She stated she got stuck in the elevator for approximately 2 hours during the incident. She was asked if she called 911, and she stated, no. She stated instead she pressed the emergency button in the elevator.	A 030		

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	AL11912132	A. BUILDING: _____ B. WING _____	01/17/2025

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A 030	Continued From page 14 She stated she got out of the elevator at approximately 7:00 AM when the Fire Department arrived and got her out. She was asked if she was aware of the facility's Policy and Procedures for and , and she stated "no". During further interview, she stated at this time she had no additional information to add. During an interview on at 5:43 PM with Staff E (Care Associate), she stated that she does not remember the names of all the staff involved on the day of the incident that occurred on . She stated she was in the room next door (in the MCU) to Resident #1, when Staff B walked over and said come and look at the resident, come and look at the patient he is not getting up. Staff E stated she saw Resident #1 lying on his bed with his and , open. Staff E was asked if she performed , and she stated "no". Staff E was asked why, and she stated because she was not sure if the resident had a . She stated she called Staff F (Med Tech/lead staff in charge), and she told her to call 911. Staff E stated she then called 911 between 6:10 AM and 6:14 AM. She was asked why she called at that time, and she stated she needed to finish her tasks first. Review of the facility's records revealed, the facility's current census at the time of the survey was 121 residents, of which 28 residents reside in the MCU (Memory Care Unit) 10 as and 18 non- residents; and 93 residents resided in the AL (Assisted Living), 11 as residents and 82 non- residents. During an interview on at approximately 4:00 PM, the Administrator stated all residents residing in the MCU and AL that have a have a red sticker on the door	A 030		

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A 030	Continued From page 15 frame (room door entrance). However, all non- residents have a green dot sticker on their chart (sticker on the , of the binder). Resident charts are located on the third floor in the nurse's station. She stated Resident #1 chart had a green dot sticker, also confirmed during resident record review. During an interview on at approximately 4:00 PM with the Administrator and Director of Wellness, both were questioned regarding steps the facility had implemented since Resident#1's (lack of efforts by staff) to prevent reoccurrence. The Administrator stated staff (Staff B thru F) are still working at the facility without disciplinary action due to the ongoing internal investigation. She was also unable to provide documentation regarding further assessment of the circumstances regarding Resident #1 and staff not performing , recognizing status, identifying an unresponsive resident and failure to follow protocol resulting in the extended delay for request of emergency medical services. All 100 facility residents, who don't have a , are at risk for not receiving if its needed. Class I	A 030		
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before	A 078		

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A 078	Continued From page 16 submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that	A 078		

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A 078	Continued From page 17 individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 5 out of 5 sampled (Staff B, C, D, E and F) staff were qualified to perform assigned duties as a Care Associate and capable of implementing the facility's policy and procedure regarding , , ( ) and ( ). The facility's failure to ensure staff were appropriately trained in and capable of performing , placed the residents who were full codes/non- (100 out of 121 residents) at risk for serious harm and/or should there be a need to initiate life-saving procedures. As evidence of Resident #1 being found unresponsive on by Care Associates (Staff B, C, D, E and F) . The findings included: Review of the facility's policy and procedures titled, (updated	A 078		

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A 078	Continued From page 18	A 078		

) stated the facility will honor any executed by a resident. Review of the facility's policy and procedure titled, , , ( ) stated that if a resident is determined to be by Staff and doesn't have a status (No), staff are to initiate and continue the until emergency personnel arrives.

Record review of the facility's investigation report, the Police report, and Emergency Services report revealed Resident #1 was found unresponsive during the round checks by Staff B (Care Associate) on at approximately 5:00 AM. Further review of these documents revealed 3 other Care Associates (Staff C, D, E) and a Lead Staff/Medication Technician (Staff F) were summoned for assistance by Staff B, all arrived at Resident#1's room and failed to perform (on a resident who did not have a). Further review revealed staff delayed contacting emergency services (911 emergency services) for over 1 hour (call made at 6:14 AM) after discovering Resident #1 unresponsive.

During an interview on at 11:56 AM, the Administrator stated Resident #1 of natural causes and she understands the facility did not follow their protocol by not performing . She stated 5 Staff members (Staff B, C, D, E, F) were on duty (10 PM to 6 AM shift). She stated each shift has a Staff member designated as the Lead Staff in charge of the facility/building (including staff and residents). On the day of the incident Staff F was in charge as the Lead Staff. The Administrator stated the resident was pronounced [ ] by the paramedics.

Review of the facility's daily assignment sheet and staffing schedule for and

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A 078	Continued From page 19 (the shift started on at 10 PM and ended on at 6 AM) provided by the Administrator revealed Staff B, C, D, E and F were assigned the 10 PM to 6 AM shift. Further review revealed Staff B and E were assigned to work in the Memory Care Unit (MCU) and Staff C and D were assigned to the Assisted Living Unit (AL). Staff F was assigned as the Lead Shift Staff (person in charge of designated shift) and Medication Technician for the entire facility. During an interview on at 12:32 PM with Staff B (Care Associate), it was revealed that she is a new hire to the facility as of and worked the night shift from 10:00 PM to 6:00 AM. She further stated she found Resident #1 on with his , and open in his room during her rounds at approximately 5:00 AM. Staff B stated on the day of the incident she called two other staff members (exact time unknown); Staff E (Care Associate), who at the time was in the room next door and Staff D (Care Associate) was called for help from her personal phone. Staff B was asked if she assessed the resident and performed before calling staff for assistance, and she stated "no". She was asked again if was performed after the arrival of the other two staff members, and she stated, no. She was asked if she received training on and the facility's policy for , and she stated, no. Staff B stated on the day of the incident, she was in and was not able to perform . During an interview on at 9:01 AM with Staff D (Care Associate) she revealed that she received a phone call from Staff B (Care Associate) asking for help. She stated she was assigned to work on the fifth floor the day of the incident on . She stated Staff B asked	A 078		

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A 078	Continued From page 20 to go into Resident #1's room with her. Staff D stated once inside the room she announced herself by saying hello, hello and no response. She stated at that point she realized Resident #1 was unresponsive and Staff E who was also present in the room, stated "he is ". Staff D was asked if she performed , and she stated "no". She stated she received a call from a resident's pendant and left the memory care unit and went to her duties assigned on the fifth floor. During an interview on at 9:29 AM with Staff C (Care Associate), she stated she was assigned to work on the fourth floor on the day of the incident that took place on . She stated, she received a call on her personal phone requesting help from Staff F (Lead Staff) and heard on the radio "med tech, med tech come in" and no sense of urgency. She stated she arrived (the exact time unknown) at the Memory Care Unit on the second floor and three Care Associates were in the resident's room, which included Staff D (Care Associate AL), Staff E (Care Associate MC) and Staff B (Care Associate MC) and saw the Resident with his and , open. During the interview, Staff C was asked if she provided to the resident, and she stated "no", because she heard the caregivers saying the resident was not responsive. She stated she was in and did not think of it. She stated Staff F (Lead Staff) was on her way to the second floor to the nurse's station to check on Resident #1's chart and got stuck in the elevator. Staff C stated she tried calling Staff G (Wellness Director) four times and does not remember the last times she called. She stated Staff G did not answer her phone. She stated she called the Administrator and told her about the emergency and that Staff F was stuck	A 078		

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A 078	Continued From page 21 in the elevator. She stated Staff E called 911. Staff C was asked if she was aware of the facility's Policy for / , and she stated, no. During an interview on at 9:52 AM Staff F (Lead Staff) she stated she was completing medication pass at the time of the incident on (does not remember the time). She stated twice she heard on the radio/walkie talkie "Med Tech come in". She stated she remembered going to the Memory Care Unit on the second floor and saw Resident #1 unresponsive. Staff F was asked how did you know Resident #1 was unresponsive. She stated, she heard one of the Care Associates shouting he is not responsive. She stated she told staff she was going to the third floor (nurse station) to check on the resident's chart for the or full code status. She stated she got stuck in the elevator for approximately 2 hours during the incident. She was asked if she called 911, and she stated, no. She stated instead she pressed the emergency button in the elevator. She stated she got out of the elevator at approximately 7:00 AM when the Fire Department arrived and got her out. She was asked if she was aware of the facility's Policy and Procedures for and , and she stated "no". During further interviews, she stated at this time she had no additional information to add. During an interview on at 5:43 PM with Staff E (Care Associate), she stated that she does not remember the names of all the staff involved on the day of the incident that occurred on . She stated she was in the room next door (in the MCU) to Resident #1, when Staff B walked over and said "come and look at the resident, come and look at the patient he is	A 078		

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A 078	Continued From page 22 not getting up". Staff E stated she saw Resident #1 lying on his bed with his and , open. Staff E was asked if she performed , and she stated "no". Staff E was asked why, and she stated because she was not sure if the resident had a . She stated she called Staff F (Lead Staff), and she told her to call 911. Staff E stated she called 911 between 6:10 AM and 6:14 AM. She was asked why she called at that time, and she stated she needed to finish her tasks first. Review of Staff personnel files revealed the following (curriculum of the American Association Basic Life Support (and) certification and training: 1) Staff B was hired on as a Care Associate. Staff B completed certification on and training on . 2) Staff C was hired on as a Care Associate. Staff C completed certification on and training on . 3) Staff D was hired on as a Care Associate. Staff D completed certification on and training on . 4) Staff E was hired on as a Care Associate. Staff E completed certification on and training on . 5) Staff F was hired on as a Care Associate. Staff F completed certification on and training on . Review of the American Association website assessed on reads, " - or , , - is an emergency lifesaving procedure performed when the stops beating. Immediate can double or triple the chances of survival after . Record review revealed the 5 Staff (Staff B, C, D,	A 078		

Agency for Health Care Administration

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A 078	Continued From page 23 E and F) on duty on and (the shift started on at 10 PM and ended on at 6 AM) had completed certification and training. However, the 5 Staff upon identifying Resident #1 was unresponsive on failed to activate/initiate their certification training and the training (the facility's policy regarding). Furthermore, the Staff also failed to immediately contact 911 (emergency services) upon identifying Resident #1 was unresponsive. During an interview on at approximately 4:00 PM with the Administrator and the Director of Wellness, they acknowledged that Staff B, C, D, E and F had current certification and training on the facility's policy and procedures on (date of the incident), however, staff did not follow the facility protocol regarding and . The Administrator was also informed that staff who found Resident #1 were asked during the interviews if they have received and training and they stated "no". The Administrator was unable to provide any further information regarding the staff's inability to demonstrate knowledge and competency in and . Class I	A 078		