STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953306	05/06/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Inn At Freedom Village (the)	6410 21st Avenue, W. Bradenton, FL 34209	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= J

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

A complaint survey CCR# 2014004191, was conducted from , 2014, through , 2014.

The Inn at Freedom Village, assisted living facility, had a deficiency at the time of the visit.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS

Based on interview and record review the assisted living facility failed to honor resident rights by providing adequate and appropriate health care to 1 of 3 (#1) sampled residents. Specifically, the assisted living facility failed to initiate ( ) on an unresponsive resident (#1) when a ( ) was not located. The assisted living facility also failed to call 911 in a timely manner by waiting thirty-five (35) minutes after being aware of the resident ' s condition, which resulted in the a of a resident.

Findings include:

Record review of the facility's progress notes located in the chart revealed that Staff A was called to Resident #1 ' s 9:00 AM. At 9:10 AM Staff A called Staff E to confirm vitals on Resident #1. At 9:15 AM Staff A contacted the assisted living facility health and wellness director " to inform of resident ' s " and at 9:18 AM the progress note noted " call placed to administrator to inform of resident ' s " . " At 9:30 AM Staff A noted " call place to resident ' s son to notify of " . Finally at 9:20 AM resident ' s primary care doctor ' s office was contacted and 9:35 AM " call placed to 911 " . At 10:02 AM " pronounced resident ' s time of ." .

Record review of Resident #1 ' s chart revealed no evidence that Resident #1 had a . A neon yellow advanced directive sticker revealed no check mark by the advanced directive (Photo obtained) and no document was located in the section designated for advanced directives.

Record review of Resident #1 ' s health assessment (AHCA Form 1823) dated revealed Resident #1 ' s medical diagnoses as ( ), ( ), (A-Fib) and high , ( ).

A review of the assisted living facility protocol dated noted, " in the event a resident goes into and/or , associates should immediately call 911 and is initiated by a properly

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trained associate unless the resident has a " " ( ) order in place.

A review of the assisted living facility employee orientation training guide dated 2013 noted, " When a resident expires, FIRST check the back of the for a yellow . If present, proceed to call 911 and Police Department. If the is not present, continue emergency protocol. "

On , 2014 at 10:27 AM an interview was conducted with the assisted living facility administrator. The administrator stated the normal procedure for the assisted living facility is to put the on the in the residents ' . The administrator stated when the staff went to look for Resident #1 ' s ; there was no on the back of the door. The administrator stated the staff could not find a for Resident #1. The administrator stated it is the assisted living facility ' s policy to follow normal protocol when a resident ' s is not located. The administrator stated both nurses involved " were both wrong, they should have done ." The administrator stated, " when it happened I knew should have been done. "

On , , 2014 at 11:37 AM an interview was conducted with Staff B. Staff B stated she observed Staff A checking Resident #1 and Staff A said Resident #1 did not have a pulse. Staff B stated she did not locate a in Resident #1 ' s I asked Staff A if she was going to perform . Staff B stated was not performed while she was in the . Staff B stated she heard the emergency medical technician (EMT) telling Staff A that he had to perform if the facility did not have a for Resident #1.

On , , 2014 at 11:47AM an interview was conducted with Staff D. Staff D stated she observed Staff A checking Resident #1 to see if the resident had a pulse. Staff A stated she felt Resident #1 ' s legs and Resident #1 was still warm. Staff D stated Staff A said Resident #1 . Staff D stated while she was in Resident #1 ' s B said that Resident #1 was a " full code " because they did not see a . Staff D stated she did not witness the facility staff perform on Resident #1. Staff D stated when emergency medical services ( ) arrived, the emergency medical technician (EMT) performed because the resident was still warm and there was no .

On , , 2014 at 12:04 PM an interview was conducted with Staff A. Staff A stated she was notified at 9:00 AM that Resident #1 was found unresponsive. Staff A stated when she went to Resident #1 ' s checked Resident #1 ' s vital signs and there was no signs of life. Staff A stated she, " never thought to look for the yellow paper and it was not posted on the . " Staff A stated she did not perform on Resident #1 because Resident #1 did not have any vital signs and " I knew she was a because she informed me of it every day that I worked with her. " Staff A stated " I always knew she had a based on what she said frequently " . Staff A stated that she has been a nurse for 42 years and stated that she has seen many bodies. Staff A stated she went to get another nurse from the 3rd floor of the assisted living facility to check to see what to do when a resident . Staff A stated Staff G checked Resident #1 ' s vital signs again and neither Staff A nor Staff G performed . Staff A stated when came, " there was a mix up in the paperwork and we did not have the yellow copy of the so they started . "

On , 2014 at 1:01 PM an interview was conducted with Staff C. Staff C stated she found Resident #1 unresponsive in her . Stated she called Staff A and Staff A checked Resident #1 ' s pulse and breathing and

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Staff A said Resident #1 was . Staff C stated there was not a on Resident #1 ' s door or closet. Staff C stated she checked Resident #1 ' s MOR (medication observation record) and the MOR did not say that Resident #1 had a . Staff C stated she told Staff A that Resident #1 ' s medication observation records (MOR) did not say that Resident #1 had a . Staff C stated Staff B told Staff A that if " we don ' t see a we are supposed to do " but Staff A said Resident #1 was already . Staff C stated " Staff A asked us to move her on a bed and I heard an exhale and saw her twitch and Staff A said it was her last breath and said it was her nerves and that she was and there was no reason for us to do because she was already . "

On , 2014 at 1:48 PM an interview was conducted with Staff E. Staff E stated she was informed by Staff A that Resident #1 was found unresponsive. Staff E stated, " I could not find the paper " for Resident #1. Staff E stated she " attempted to do Resident #1 ' s and pulse but she was obviously expired. " Staff E stated she did not do because she remembered that Resident #1 had a a year ago when Staff E sent Resident #1 out to the hospital.

On , 2014 at 10:10 AM an interview was conducted with a Bradenton Emergency Medical Services Lead Paramedic. The Paramedic stated when his unit arrived on scene Resident #1 was still warm, her jaw was loose and there was no lividity in the resident ' s arms, back or legs. The Paramedic stated the facility nurse told him that they did not have a for the resident so was begun on Resident #1. The Paramedic stated the staff at " the facility did not do anything for the resident and the nurse was a little with her role. " The Paramedic stated the nurse did not want him to perform and when the paramedic informed the nurse that he had to do his job and perform the nurse began crying and responded that she has been doing her job as a nurse longer than he has been alive. The paramedic stated the nurse made the comment that she " should have taken a walk before she called 911. "

On , 2014 at 9:45 AM an interview was conducted with a medical technician from Resident ' s #1 ' s primary care physician ' s office. The medical technician stated that after looking through Resident ' s #1 medical chart she could not locate a for Resident #1. The medical technician stated the primary care doctor signed Resident #1 ' s certificate on and listed the cause of as unspecified, natural causes, old age.

On , 2014 at 10:10 AM an interview was conducted with Resident #1 ' s power of attorney (POA). The POA stated Resident #1 did not have a . The POA stated he never spoke to Resident #1 ' s doctor about getting a because he figured if something happened " they could at least try to save her " .

Class I

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

', 2014

Administrator
Inn at Freedom Village (The)
6410 21st Avenue, W.
Bradenton, FL 34209

Dear Administrator:

Re: **CCR# 2014004191**

This letter reports the findings of a complaint survey that was conducted from , 2014, through ', 2014, by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiency identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone (727) 552-2000; Fax (727) 552-1161

, 2014

ARC Bradenton HC, Inc. dba Inn at Freedom Village
6410 21st Avenue, W.
Bradenton, FL 34209
Attn: Donna C. Holden, Administrator

Dear Administrator,

This letter reports the findings of a complaint inspection survey (CCR# 2014004191) conducted from , 2014, through , 2014, by representatives of the Agency for Health Care Administration. Attached is the provider's copy of the State (3020) Form, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's request within **five (5) calendar days** of receipt of this report.

The inspection resulted in findings of non-compliance in the following areas:

1) A0030 – Resident Care – Rights & Facility Procedures - Class I
The Assisted Living Facility failed to honor resident rights by providing adequate and appropriate health care to 1 of 3 (#1) sampled residents per the guidelines as noted in 429.28, F.S. The facility failed to follow emergency procedures and administer ( ) to a resident. The non-compliance posed a direct threat to the resident and delayed necessary medical treatment. All current residents are at risk of harm or until this deficient practice has been corrected.

Your facility must comply with the following:

1) All employees in your facility must take or retake a valid course, offered by an accredited college, university or vocational school, a licensed hospital, the American Red Cross, American Association, or National Safety Council or a provider approved by the Department of Health, even if they are currently certified in . A staff member who holds a valid card documenting completion of an approved course must be in the facility at all times. This must be completed **5 calendar days** from the date of this letter.

2) Your facility must have a written policy on steps to take in emergency situations, including sudden illness of a resident. This policy must include a plan for making all resident records (including medical records and medication records) available to direct care staff and emergency personnel. This must be completed **5 calendar days** from the date of this letter.

3) All facility employees must be retrained on the facility's emergency, ( ) and policy and procedures. This must be completed **5 calendar days** from the date of this letter. A roster of these employees and written verification will be requested on the follow up visit.

4) Complete an audit of all resident records.

5) Documentation of the above training must be on file for each employee and available for review within **5 calendar days** of the date of this letter.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call Mr. **Paul Brown**, ALF Supervisor, at (727) 552-2000.

Sincerely,

Patricia Reid Caufman
Field Office Manager