STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910386	05/27/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
City Walk Active Living	534 Datura Street West Palm Beach, FL 33401	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0000 - - Initial Comments
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= J
St - A - 0077 - 58a-5.019(1) Fac - Staffing Standards - Administrators S-S= J

Specific Tag Findings:

0000-Initial Comments

An unannounced licensure complaint survey , CCR # 2014004259, was conducted on . . thru . . . . City Walk Active Living had deficiencies found at the time of the visit.

Class I (Immediate Jeopardy) identified at A 030 and A 0077 at the time of this visit.

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

Based on observation, interview and record review, the assisted living facility failed to honor the rights of 1 of 4 sampled residents (Resident #4) to adequate and appropriate health care during an emergency. Specifically, the assisted living facility failed to initiate on an unresponsive resident (Resident #4) when no was located in the resident ' s record in the facility. The failure of facility staff to perform in the absence of a places all residents of the facility at immediate risk of harm.

Findings Include:

During an interview with the Assistant Administrator on at 11:00 AM, she stated Staff B told her that Staff B found Resident # 4 lying on the floor in his to his bed on at 6:30 AM. The Assistant Administrator stated Staff B said she was unable to get a pulse on the resident and that's when 911 was called.

When Staff B was interviewed on at 2:43 PM via telephone, Staff B stated she entered Resident # 4's 6:30 AM on Staff B further stated Resident #4 was lying on the floor next to his bed, unresponsive. Staff B stated she did not start because she "assumed Resident # 4 was Staff B stated she was not able to get a pulse and further stated she called for help and for Staff A to call 911.

Staff A was interviewed on at 2:10 PM via telephone and stated she conducts rounds every two hours and stated resident #4 was in bed sleeping when she conducted rounds at 4:30AM on Staff A further stated Staff B came and got her between 6:20AM and 6:30AM and Staff B said Resident #4 was on the floor. Staff A stated she entered Resident #4 ' s Staff B and called out the resident ' s name and he did not respond. Staff A stated she did not start and went to the nurse ' s station and called 911. Staff A stated

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" no one was in charge at the time of the incident" .

During an interview in the facility ' s medication ..... Staff F on ..... at 1:45 PM, Staff F stated each unit has a list of residents that have a ..... Staff F further stated Resident # 4 was not on the list. Observations on ..... at 1:50 PM of the second floor and third floor revealed no list of residents with a ..... posted on the units.

A record review of the facility ' s ..... and Advance Directives Policy and Procedure on ..... indicated that the policy stated " Start First AID/C.P.R. immediately if the resident does not have a living will or a "No Code" order. Call 911 for assistance. Continue C.P.R. until paramedics arrive. "

Record review of Staff A and B personnel file on ..... revealed both staff members were certified nursing assistant (CNA), unlicensed staff members. Further record review revealed both staff members had current training in ..... and in the facility's ..... policy .

A review of Resident # 4 ' s closed record on ..... revealed that according to the facility ' s documentation, Staff B observed the "resident lying on his right side on the floor in his ..... his bed and night stand". Resident # 4 was "unresponsive with no pulse". A review of the record revealed no ..... in the file and the ..... box was not checked in the advanced directives section on the face sheet. Resident # 4's health assessment (AHCA Form 1823) completed and signed ..... documents the resident's medical diagnoses as ..... Insufficiency and ..... During an interview on ..... at 2:45 PM, the daughter of Resident #4 was asked if her father had a ..... on file, she stated Resident #4 did not have one on file.

Review of the facility's adverse incident report (1 day report) regarding Resident #4 submitted to the agency on ..... revealed the following. Time of the incident noted as 6:00. Resident observed lying on the floor on his right side by staff (Staff B) between the bed and nightstand, unresponsive with no pulse. ..... was not initiated due to skin being ..... to touch. 911(Paramedics) notified. He was pronounced expired by local Fire Rescue personnel. Resident was observed at 4 AM by staff (Staff A) during rounds to be sleeping on his bed. Review of the facility's adverse incident report (15 day report) regarding Resident #4 submitted on ..... revealed the following. Time of the incident noted as 6:00. Resident observed lying on the floor on his right side by staff between the bed and nightstand, unresponsive with no pulse. ..... was not initiated due to skin being ..... to touch. 911(Paramedics) notified. He was pronounced expired by local Fire Rescue personnel. Resident was observed at 4 AM by staff (Staff A) during rounds to be sleeping on his bed. Correction Action noted as all staff are having an in-service on ..... and ..... on ..... and .....

A review of West Palm Beach Fire Rescue report dated ..... conducted on ..... revealed the call came in at 6:44 AM on ..... The unit was dispatched and in route to the facility at 6:44 AM and arrived

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at the facility 6:51 AM. The report' s general comments stated " Upon arrival R4 (rescue # 4) noted a (year old male) pulseless and apneic in the right lateral position. R4 attached the patient to the monitor which showed . The patient was cool to touch with fixed and dilated pupils. The patient ' s downtime was unknown. R4 and E4 (fire engine #4) declared a Code 7 " (Resident pronounced

During a confidential interview (#1) on at 11:45 AM, it was revealed that upon arrival to the facility no staff members were observed performing on Resident #4. It was revealed that staff were observed standing outside the

Class I

0077-Staffing Standards - Administrators 58A-5.019(1) FAC

Based on observation, interview and record review, the facility administrator failed to provide adequate oversight and appropriate care to 1 of 4 sampled residents (Resident #4). Specifically, the administrator failed to ensure that facility staff performed (C.P.R.) on an unresponsive resident (Resident #4) when no for the resident was located at the facility. The administrator ' s failure to ensure that proper C.P.R. and emergency procedures were followed and that necessary documentation of was in place put the residents of the facility at immediate risk of harm.

Findings include:

During an interview with the Assistant Administrator on at 11:00 AM, she stated Staff B told her that Staff B found Resident # 4 lying on the floor in his to his bed on at 6:30 AM. The Assistant Administrator stated Staff B said she was unable to get a pulse on the resident and that's when 911 was called.

When Staff B was interviewed on at 2:43 PM via telephone, Staff B stated she entered Resident # 4's 6:30 AM on . Staff B further stated Resident #4 was lying on the floor next to his bed, unresponsive. Staff B stated she did not start because she "assumed Resident # 4 was . Staff B stated she was not able to get a pulse and further stated she called for help and for Staff A to call 911.

Staff A was interviewed on at 2:10 PM via telephone and stated she conducts rounds every two hours and stated resident #4 was in bed sleeping when she conducted rounds at 4:30AM on Staff A further stated Staff B came and got her between 6:20AM and 6:30AM and Staff B said Resident #4 was on the floor. Staff A stated she entered Resident #4 ' s staff B and called out the resident ' s name and he did not respond. Staff A stated she did not start and went to the nurse ' s station and called 911. When asked if there was a point person or staff in charge who was contacted about Resident #4, Staff A stated " no one was in

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charge at the time of the incident " .

During an interview in the facility ' s medication staff F on at 1:45 PM, Staff F stated each unit has a list of residents that have a Staff F further stated Resident # 4 was not on the list. Observations on at 1:50 PM of the second floor and third floor revealed no list of residents with a posted on the units.

An interview with Staff D, the facility ' s manager/designee was conducted on at 12:30PM. Staff D stated she was the manager on duty on She stated Resident # 4 was up in his wheel chair during the day and Staff D saw no signs of discomforts while she was on duty. She stated she left work at 5:00PM. A review of the facility ' s staffing schedule dated - revealed no staff marked as charge staff or manager/supervisor for the night of to the morning of

When interviewed on at 11:15 AM, the administrator was asked who was in charge and/or what manager was on duty at the time Resident #4 was found. The administrator stated the facility does not have a manager on duty at night and there was no staff in the facility designated to be in charge. The administrator also confirms that she oversees a total of three facilities, including one on the other side of the state in Tampa.

A review of the facility ' s license effective revealed that the facility has a specialty license for Limited Mental Health and Limited Nursing Services. The facility is licensed for 200 beds, with 50 beds designated for . A review of the facility ' s census at the start of the survey on revealed that the facility had 168 residents at the start of the survey.

A record review of the facility ' s and Advance Directives Policy and Procedure on indicated that the policy stated " Start First AID/C.P.R. immediately if the resident does not have a living will or a "No Code" order. Call 911 for assistance. Continue C.P.R. until paramedics arrive. "

A review of Resident # 4 ' s closed record on revealed that according to the facility ' s documentation, Staff B observed the "resident lying on his right side on the floor in his his bed and night stand". Resident # 4 was "unresponsive with no pulse". A review of the record revealed no in the file and the box was not checked in the advanced directives section on the face sheet. Resident # 4's health assessment (AHCA Form 1823) completed and signed and medical diagnoses listed were Insufficiency, and . During an interview on at 2:45 PM, the daughter of Resident #4 was asked if her father had a on file, she stated Resident #4 did not have one on file.

A review of West Palm Beach Fire Rescue report dated conducted on revealed the call

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came in at 6:44AM on . The unit was dispatched and en route to the facility at 6:44AM and arrived at the facility 6:51 AM. The report ' s general comments stated " Upon arrival R4 (rescue # 4) noted a . . . . . (year old male) pulseless and apneic in the right lateral position. R4 attached the patient to the . . . . . monitor which showed . The patient was cool to touch with fixed and dilated pupils. The patient ' s downtime was unknown. R4 and E4 (fire engine #4) declared a Code 7 " . (Resident pronounced .

Class I

AHCA

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

Akangoor
ANGELA CHANGOOR
05/30/14 @1:55pm.
Will deliver to administrator Ricki Kaneti.

Administrator
City Walk Active Living
534 Datura Street
West Palm Beach, FL 33401

Dear Kaneti:

This letter reports the findings of a complaint inspection survey (CCR# 2014004259) conducted from by representatives of the Agency for Health Care Administration. Attached is the provider's copy of the AHCA Form 5000-3547 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 and 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.

2) A0077 – Staffing Standards – Administrators- Class I
The Assisted Living Facility's administrator failed to provide adequate oversight of the facility and facility staff by failing to ensure staff performed on a resident and failing to ensure staff had access to necessary documentation of

Your facility must comply with the following:

1) Your facility must audit the records of each facility resident and compile an accurate list of residents with . Your facility must then designate locations for the list of residents and the residents' and implement a system for staff to identify whether a resident has a . This information must be communicated to direct care staff and the information must be accessible during each shift. This must be completed **within 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. Your facility is directed to review and revise any current policies regarding emergency procedures, and resident to ensure they are consistent and do not contradict each other. The emerger policy must include:

- Directions for staff on the importance of initiating unless a resident has a
- Directions on calling emergency personnel.
- Directions on what staff in charge are to be notified and are responsible for follow-up.

A plan for making all resident records (including medical records, medication records, resident emergency contacts and available to direct care staff and emergency personnel.
The location of the list of residents and the location of the hard copies of resident

This must be completed within **5 calendar days** from the date of this letter.

3) All facility employees must be retrained on the facility's emergency policy, and policy and procedures after the policies are written/revised. A roster of these employees and written verification of the training and training materials must be available for AHCA staff to review. This must be completed within **5 calendar days** from the date of this letter.

4) Your facility must review the staffing schedule and designate a staff person in charge who is the point of contact for direct care staff on each shift. This must be reflected on the staffing schedule. Your facility must also implement a way to communicate this information to staff so they know who the person in charge is during each shift.
Your facility must also ensure a staff person trained in First Aid and is on duty in the facility at all times. This information must be reflected on the staff schedule and communicated to all staff on duty in the facility. This must be completed within **5 calendar days** from 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 contact the local Delray Beach Field Office at (561) 381-5840.

Sincerely,

for Arlene Mayo-Davis
Field Office Manager
Division of Health Quality Assurance
Delray Beach Field Office