STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911288	07/25/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Beggs Pointe Alf	4711 Beggs Road Orlando, FL 32810	
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
St - A - 0077 - 58a-5.019(1) Fac - Staffing Standards - Administrators S-S= J
St - A - 0083 - 58a-5.0191(4) Fac - Training - First Aid And S-S= D

Specific Tag Findings:
0000-Initial Comments
Complaint Inspection #2014007016 was conducted on and Beggs Pointe Assisted Living Facility had deficiencies found at the time of the visit.

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

Based on observations, interview and record review, the facility failed to honor the resident's rights to provide adequate and appropriate health care free from medical neglect, and did not initiate life saving measures and perform for 1 of 6 sampled residents (#3) who was unresponsive and did not have a

Findings:

Review of an Adverse Incident report that was dated read, "At approximately 02:00 resident approached kitchen asking for something to eat. Overnight staff obliged, gave the resident two bite-sized cinnamon rolls and resident made his way over to the living Overnight staff went to assist other residents with bathing and dressing. When staff went to check on resident at 04:00, she noticed resident was Staff noticed resident was no longer breathing and eyes were open and lifeless. Resident was not moving and would not respond to verbal commands. 911 was called and the Emergency Medical Team (EMT) arrived at the facility approximately 04:14. Staff did not initiate and resident did not have a on file. Resident was declared shortly thereafter and Orange County Sheriff's Department (OCSD) was called. Staff provided OCSD with a written statement."

Record review for resident #3 revealed a Resident Health Assessment form that was dated that included diagnoses of Parkinson's Chronic Type II, and A was not found in his record. Further record review revealed a Resident Observation Log on at 7:30 AM which read, "Per Caregiver, client asked for something to eat and was given 2 small doughnuts at 2 AM. Resident seen ... on lounge chair and he went to sofa. At about 4 AM the

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resident was seen lying in his stomach with face on the side and unable to be awakened. 911 called....5 AM-Police man came and was waiting for coroners decision if case will be taken. 7 AM- Per Sheriff Coroner will not be coming here. He declared it 'a natural

A review of the OCSD statement from staff A was noted on at 5:55 a.m. The time of the offense was noted at 4:25 a.m. The staff noted that between 2 AM and 3 AM she gave the resident 2 mini cinnamon rolls and the resident made his way to the living She proceeded to assist other residents with bathing and dressing. At approximately 4 AM, she checked resident #3, who was She called 911 shortly after the EMT arrived, and after EMT examination, staff A was informed the resident had expired.

A review of the OCSD Report revealed on at 5:08 a.m., the detective responded to the facility in reference to a investigation. He arrived on scene and Orange County Fire and Rescue (OCFR) was already on scene with the victim (resident #3). paramedic (name mentioned) pronounced victim at 4:25 a.m. Nothing appeared suspicious in reference to the victim passing away. The report noted the same medical diagnoses and listed his medications.

The detective notified the Medical Examiner's Office and spoke with a staff (name mentioned) who advised they will not respond due to the natural circumstances of the He notified the victim's primary doctor (name mentioned). He left a message regarding the victim passing away and in reference to her signing the certificate.
The facility notified the next of kin.

During an interview with Staff A on at 6:45 a.m., the resident approached the kitchen to ask for something to eat. She said she gave resident #3 two bite-sized cinnamon rolls and the resident went to a chair in the living She said she went to give another resident a shower. Resident #3 was lying on the couch and was alright. When she returned around 30-45 minutes later, she observed resident #3 lying on his side on the couch with his feet hanging off the couch. She said she called his name he did not respond. She said she touched him on the arm for some reason and noticed his hands and feet were dark. She said she did not check to see if the resident was breathing and did not attempt to perform because she was upset with the condition of the resident. She stated all she could think about doing is to call 911. She stated resident #3 did not have a Staff A stated this was the first time she observed a resident and she panicked. Staff A explained that resident #3 would walk during the night and early morning asking for food and would sleep on the couch and chairs in the facility most of the time because he did not want to sleep in his bed. It was normal for him to be lying on the couch in the position that he was found in.

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Observations of the facility video on at 9:45 AM revealed the following:
3:53 AM - Staff A was seen coming into the dining She turned on the TV and light in that area.
3:56 AM - Staff A went to the living where the resident was located and ran out.
3:57 AM - Staff A was on the telephone pacing back and forth, but never went in the area where the resident was. The area was still dark.
3:57-4:12 AM - Staff A was pacing from one area to another, peeping at times in the area where the resident was located.
4:12 AM - Staff A took paper work out and placed it on the table.
4:15 AM - Staff A ran to answer the door.
4:15 AM - The paramedics were seen at the door. They went into the area where the resident was and shined their flashlight. There was still no light in the area where the resident was located. They were seen over the resident. What they were doing was not viewable. There was no equipment used. Someone turned on the light. The paramedics walked outside. One remained at the table with staff A looking at the paper work. The resident was seen on the couch on his side with his feet hanging off the couch.

On staff B and staff C were interviewed to determine if they were trained on what to do if they found a resident Staff B was interviewed at 7:20 AM and stated she would call 911 and follow what EMT told her to do. She had no experience to give If the resident was choking, she would give the Heimlich maneuver. Staff C was interviewed at 7:30 AM and stated she would call 911, check the resident's vital signs, give after turning the resident over face up and punch/push his chest.

During an interview with the facility manager on at approximately 7:30 AM, he stated resident #3 would always lay in different positions on the couch. He explained that possibly when Staff A looked at him in the dark, she thought he was sleeping until she turned on the TV and the light reflected in the living was when she noticed something was wrong.

During an interview with the administrator on at approximately 8:15 AM, she stated that she was informed that the staff A knew that the resident was not breathing when she found him. She was not aware staff A did not check if the resident was breathing and did not check his vital signs.

A review of the OCFR Report on noted the following on
Alarm: 4:10 a.m.
Dispatch: 4:12 a.m.
In Route: 4:13 a.m.
Arrival: 4:21 a.m.

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Patient Contact: 4:22 a.m.
The report noted that the patient was and not breathing, "no chest rise, carotid pulse not present."
Presumed Not Witnessed.
- Not Attempted.

Further review of the report revealed the staff did not immediately call 911. Staff A found resident #3 , panicked, did not check to see if resident #3 was breathing, did not check his vital signs and did not attempt to provide any lifesaving measures including She did not call 911 until approximately 13 minutes after she noticed the resident was unresponsive. The resident did not have A

Class I

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

Based on personnel record review, observations and interview, the administrator failed to conduct a thorough investigation regarding the 1 of 6 sampled residents (#3), resulting in 1 staff (A) working alone with the residents of the facility after she did not perform life-saving measures including on a resident because she panicked when the resident became unresponsive, and did not ensure there was always one staff present at all times with a current First Aid and certificate, and was not aware that the facility staff wasn't aware of what to do in the event of an emergency.

Findings:

Review of an Adverse Incident Report revealed that resident #3 was observed to be on at around 4 PM and the facility staff did not perform

1. Observations on at approximately 5 AM, revealed that Staff A was working alone with the residents of the facility.

During an interview with Staff A on at approximately 5:15 AM, she stated she was working alone and Staff B was upstairs sleeping. Staff A stated there were currently 13 residents present in the facility.

During an interview with Staff A on at 6:45 AM, she stated resident # 3 approached the kitchen to ask for something to eat. She said she gave resident #3 two bite-sized cinnamon rolls and the resident went to a chair in the living She said she went to give

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another resident a shower and she stated before she left to give the resident her shower, resident #3 was lying on the couch and was alright. When she returned around 30-45 minutes later, she observed the resident lying on his side on the couch with his feet hanging off the couch. She called his name but he did not respond. She further stated that she touched him on the arm for some reason and noticed his hands and feet were dark. She said she did not check to see if the resident was breathing, and did not attempt to perform because she was upset with the condition of the resident. She stated all she could think about doing was to call 911. She stated resident #3 did not have a Staff A stated this was the first time she observed a resident and she panicked.

2. During an interview with the facility's manager on at approximately 7:45 AM, he stated an investigation was conducted and it was written in the resident's record.

Record review for resident #3 revealed that staff A gave the resident a doughnut around 2 AM, and he went to the lounge chair and then to the sofa. At around 4 AM, the resident was observed lying on his stomach and was unable to be awakened. 911 was called. The notes were written by the facility administrator. Further review of the investigation notes revealed that there was no documentation found that the administrator had questioned the staff regarding any attempts of life saving measures including and whether she had checked to see if the resident was breathing and had checked his vital signs.

During an interview with the administrator on at approximately 8:15 AM, she stated she thought that the resident was not breathing and that was why the staff did not perform any life saving measures. She stated she was not aware that staff A did not check to see if the resident was breathing and did not check for vital signs. She stated she knew that staff A called another staff member that usually slept upstairs and was not there the day of the incident. she said that staff told Staff A to call 911.

The administrator did not conduct a thorough investigation which resulted in staff A panicking and did not know what to do in an emergency when she found resident #3 unresponsive, and continued to work alone with the other residents of the facility.

Because the investigation was not thorough, the administrator was not aware that the other staff who worked at the facility was not sure of what to do if a resident became unresponsive. The administrator was asked to provide her training materials that she provided to the staff for the emergency procedure training but she did not have any documentation of the training. The administrator stated she had all of the information in her head about what she trained her staff because she had been providing the training for a long time.

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3. Personnel record review for staff B, Staff C, Staff D and Staff E revealed that during the time of the incident, staff B, staff C and staff D, who worked together at times, did not have current . . . and First Aid certification. Staff E did not have current . . . certification at the time of the incident. Staff A was the only staff that had Current First Aid and . . . .

Class I

0083-Training - First Aid and . . . 58A-5.0191(4) FAC

Based on personnel record review and interview, the facility failed to ensure that a staff member, who held a current and valid card that documented the completion courses in First Aid and . . . was in the facility at all times.

Findings:
Review of the staff schedule for . . . through . . . revealed the following:
Staff B and C Worked the 7 AM-7 PM and 7 AM-3 PM shift
Staff D worked the 7 PM-7 AM shift only
Staff E worked the 7 AM-7 PM shift only.
Further review of the scheduled revealed that Staff B worked alone
Two of the 7 AM-7 PM staff would rotate and work together on some days.

1. Personnel record review for staff B revealed that her First Aid and . . . certification was taken on . . . and would expire on . . . Prior to renewing the First Aid and . . . staff B's First Aid and . . . expired on . . . . Staff B had worked over 6 months without having current First Aid and . . . certification.

2. Personnel record review for staff C revealed her first aid and . . . expired on . . . .

3. Personnel record review for staff D revealed her . . . expired on . . . .

4. Personnel record review for staff E revealed that her . . . had expired in . . . .

At approximately 2 PM, the administrator provided a card for Staff E on . . . with the date of . . . . She stated the staff had just taken the course. There were 5 staff who worked at the facility and only 1 staff had current . . . and First Aid certification.

During an interview with the administrator on . . . . at approximately 2 PM, she confirmed the findings.
Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

Beggs Pointe ALF
4711 Beggs Road
Orlando, Florida 32810
Attn: Erlinda Santos, Administrator

Dear Santos:

This letter reports the findings of a complaint inspection survey (CCR# 2014007016) conducted from and 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 and failed to follow emergency procedures and administer to a resident. The non-compliance posed a direct threat to the resident. 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, failed to conduct a thorough investigation regarding a resulting in a Left a staff working alone with other residents of the facility after she did not perform life-saving measures including on a resident because she panicked when the resident became unresponsive and did not ensure there was always one staff present at all times with current first aid and training and was not aware the facility staff wasn't aware of what to do in the event of an emergency.

Your facility must comply with the following:

1) Your facility must re-train all of the facility staff on emergency policy and procedures. Ensure that all staff has full understanding what needs to be done in the case of an emergency and a resident is found unresponsive. 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,

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including when a resident is found unresponsive. Your facility is directed to review and revise any current policies regarding emergency procedures.

3) The emergency 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.

4) All facility employees must be retrained on the facility's emergency policy, and policy and procedures after the policies are written and 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.

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 Field Office at

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be

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