STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968608	R 04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDIAN GARDENS ASSISTED LIVING FACILITY	**17250 SW 137 AVENUE MIAMI, FL 33177**

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

A Standard Biennial Survey revisit was conducted from through at Floridian Gardens Assisted Living Facility with Limited Mental Health, Limited Nursing Services and Extended Congregate Care Services Components (License # AL 12489), had the following deficiencies identified at the time of the visit:

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review and interview the facility failed to provide care and offer personal supervision appropriate to the needs of residents, in order to prevent six out of 52 residents' and injury or (Resident #37, Resident #4, Resident #31, Resident #24, Resident #30, and Resident #44). Resident # 37 while staff who were present failed to secure appropriate medical care. Resident #4 two weeks after experiencing two with injury within two days.

Findings Include:

1) Resident #37- at the facility; staff did not perform , , ( )
The facility's internal incident report completed on at 00:08 showed "On at 22:00 Patient #37 was in bed requested his 23:00 medications and wanted to get up and sat by the South station. Staff positioned him in a recliner with legs up. The night shift supervisor rounded the South wing around 23:30. Her description of the event was reported in a Resident's observation log. Type of injury: "Resident was no in distress, Staff only noticed that he stopped talking and started moaning."
Emergency treatment given: "Call 911 to be transferred to a hospital."
"Witness: Staff GG and HH."

Further review showed that an unsigned observation note attached to the facility incident report read: "On at around 11:30 PM, I went to the nursing station of South Side where I saw resident #37 sit on a chair recliner. I noticed that something was going wrong because he had a tremor on the body and he had a voice of Lamentation. Various times I tried to ask him how he felt and at the beginning he answered, but then he stopped answering. At this time he was still breathing well but I thought that was better to send him to the hospital. So I tried to call his wife who didn't answer, then I called his son who told me to wait for his return call before calling the hospital (he wanted to call his mother first). During this time was at the front desk and I decide to call 911 when the Certified Nursing Assistant (CNA) next to him told me that he was getting worse. I did 3 calls to phone 911 and they arrived after 8-10 minutes (12:00 AM) Police arrived at the facility and soon after (5 minutes) paramedics arrived making procedure. Resident #37 was declared at 12:08 AM of ." Signature of

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person completing report missing. Review of Resident #37's Health Assessment dated showed the resident had the following diagnoses: , , , , ( ), and II. Resident was independent eating, needed supervision with self- care, toileting and transferring and needed assistance with ambulation/wheelchair, bathing and dressing. The resident needed precautions. Further record review of the 'Policy on and Advance Directives' showed it was signed by resident #37 on 3/7/`8 with boxes checked indicating " I do not have ." " I do not have an Advance Directive."
Fire rescue incident report dated at 12:11:42 reads:
Ambulance dispatched at 23:51:22
At scene: at 00:02:41
At patient: at 00:02:00
Aid: 00:12:18 Type of aid: none
Narrative: "Staff at facility stated patient was found unresponsive sitting in a chair stated last seen 10 minutes prior to calling 911. On arrival crew found MDPD (Miami Dade Police Department) officer performing . PI assessment found patient in . Patient was to the touch. No obvious signs of life. showed , (no heartbeat) on the monitor. efforts were discontinued and scene was released to MDPD."
Disposition: at scene.

A review of the facility's video tapes of the showed that the staff stood by the resident for around one hour and fifty minutes resident while the resident face showed distress before he became unresponsive. Staff did not attempt to perform .

2) Resident injuries and subsequent -Resident #4

Resident #4 four times in the facility (On , , , and), with two or more of those resulting in injury and hospitalization. The resident was hospitalized once more, two weeks after the last and hospitalization with injury, and . There was no documentation of follow up medical care provided outside of the hospital after any of the .

Resident #4's health assessment dated showed diagnoses of , , , , . The resident was under precautions, was listed as independent with activities of daily living except for needing supervision with self-care.

A review of hospital records indicated the following: The resident was admitted to the hospital on via ambulance from the facility with complaints of injury. According to the facility's in-house report of the incident, the resident stated she was trying to sit down and . A review of the

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facility internal incident report showed: On at 2:40 AM, the resident was transferred to the hospital for falling. A progress note in the resident's record stated "Nurse was informed by CNA that resident had in the dining . Nurse evaluated resident with emphasis on status. Resident did not lose and is AAOX3 (Awake, alert and oriented to date, place and person). Nurse decided to send resident to the ER for further evaluation and treatment. Resident son was left a voicemail. Administration notified. Resident transferred to the hospital via Ambulance at 2:40 AM." The hospital record from the incident reflected that the resident should receive follow up care with a primary care physician within one-two days because the problem was ongoing and was worsening. There was no documentation in the resident's record that the resident received follow up care. Interviewed on at around 11:00 am, the Administrator reiterated that there were no other records, and that if follow up care was coordinated, documentation would be found in the resident record.

A further review of hospital records showed the resident was admitted to the hospital on via ambulance from with complaints of injury. The resident stated she used a walker and was being helped with walking and the person who was helping her and she attempted to aid in the breaking of the . CT (computed tomography) scan of the lumbar spine indicated: , disc bulges in the L5-S1, and T12-L1 levels. The resident was discharged on with diagnoses of Hypertensive , and low back pain: The hospital recommended the resident be given a rolling walker with a seat and continuity of care on an outpatient basis. There was no documentation in the resident record of the rolling walker having been given. A recommendation was made in the hospital record that the resident receive work within 3 days of discharge, a consultation with a neurologist, and follow up care with a primary care physician one week later. There was no documentation in the resident record that the resident received the follow up care. Interviewed on at around 11:00 am, the Administrator reiterated that there were no other records, and that if follow up care was coordinated, documentation would be found in the resident record.

A review of the facility's on-site incident and hospital transport records indicated the following: On at 1:13 AM, the resident was transferred to the hospital for falling, Rule Out Hip . "CNA reported to nurse that resident was found on the floor in the stated she had . Nurse evaluated resident and resident stated the right side of her hip was hurting. Nurse decided to send resident to the ER for further evaluation and treatment for a hip . The resident was transferred to the hospital via ambulance at 1:13 AM." The hospital discharge instructions were that the resident receive a rolling walker and "continuity of care on an outpatient basis". While the resident did receive a rolling walker, there was no documentation in the resident record of any other follow up or coordinated of care.

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A review of hospital records indicated the resident was admitted the hospital on via ambulance from the facility with complaints of abnormal lab results and low back pain. The resident was discharged on with a diagnosis of . She was supposed to receive a urinalysis within one week and visit with her primary care physician within 3-4 days of discharge. A review of the resident record and facility incident records found no documentation of the hospitalization on and no coordination of care or follow up regarding the hospitalization. Interviewed on at around 11:00 am, the Administrator reiterated that there were no other records, and that if follow up care was coordinated, documentation would be found in the resident record.

A review of the resident record showed that there was no further documentation of the resident's condition, and no indication of coordination with the resident's health care provider. On at 10:00 PM, the resident was transferred to the hospital with complaints of , X4 (times four), and Dark colored with foul odor. "Resident today was not able to keep anything down that she was given to eat. The resident proceeded to 4 times. Also the resident presents with , and dark, foul odor . Resident will be transferred to the hospital for further evaluation. Resident family as well as administration was notified." On , the hospital was contacted as per nurse, that the resident . A review of hospital records showed that Resident #4 entered the hospital on and on at 7:50 AM. Primary cause of was listed as , and multi-organ failure. Secondary cause of is listed as follows: Acute , distress, acute sinus , HCAP (Health care Associated), severe , 2/2 to C. Diff ( ), acute kidney injury, and Lactic Acidosis, , ( ), and Benzodiazepines withdrawals.

3. Resident #31- while under staff supervision and received a black eye.

Observation on at 8:15 AM showed Resident #31, an , had a black eye. Review of Resident #31's health assessment dated showed diagnoses of , Deep Thrombosis ( ), Acute , ( ), , osteopenia. Limitations: functional decline, wheel chair. The resident was hard of hearing and was alert and oriented times 3, and had advance . The resident needed assistance with ambulation, bathing, dressing, eating, , toileting and transferring. A review of the resident record showed that the resident was under hospice care.

Interviewed on between 8:00 and 5:00 pm, a hospice nurse onsite at the facility reported the resident obtained the black eye during a at the nurse's station. Interviewed on and again on , the Administrator. Facility staff was unable to provide information about how the occurred or if staff was present and the resident was being assisted by staff. Record review showed that two months

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of progress notes prior to the , which resulted in hospitalization, were not found in the file. Hospital record review showed the resident was admitted on , diagnosed with right /frontal scalp /hematoma and a and of right . The resident was released to hospice care. There was no documentation of follow up other than the resident returning to the facility. There was no documentation of a review/reassessment of risk in the facility's record or the hospice record, and there was no record of precautions being put in place.

Interviewed on at 12:31 PM the Administrator reported, "Resident #31 was in the west nursing stating laying down in a recliner she tried to fix her socks and ." Resident #31 was observed on , and being moved from one seated position to another by staff. The resident did not participate in the movements.

4. On Resident #24, a , and had a head resulting in hospitalization. Resident #24's health assessment dated showed a diagnosis of , ( ), , , ( ), Parkinson, , , . The resident used a wheelchair and needed precautions. A ½ bed rail prescription dated was found in the resident record. Progress notes dated stated that the resident trying to pick up a napkin from the floor. The date of the was unclear and was assumed to be the date of the progress note. Hospital records dated showed a laceration to the forehead right side and hematoma. The hospital discharge recommendation was that the resident follow up with the primary care physician in two weeks. There was no documentation in the facility records of follow up related to the , and no coordination with medical providers. No post- care documentation was found. There was no documentation in the resident's record that the resident received follow up care. Interviewed on at around 11:00 am, the Administrator reiterated that there were no other records, and that if follow up care was coordinated, documentation would be found in the resident record.

5. A review of facility incident records showed Resident #30, a , , in facility on . The resident's wife, who did not live in the facility, called to let the staff know that he . There was no documentation of which facility staff received the report. He was taken to Hospital on . Hospital records revealed a Diagnosis of " of right orbital floor, severe with extensive intraorbital , , and of right eye, right wrist , . A with apparent intra- extension." The hospital record further stated that the resident had an accidental from bed.

A review of the facility records showed no documentation other than the internal incident report stating that the resident's wife called staff to report the . No documentation of follow up with medical

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provider, or notes about actions to prevent re-occurrence on resident file. Hospital records showed that the resident needed to follow up with a facial surgeon within 1-2 days. There was no documentation of follow up with any physician. Resident # 30's health assessment dated showed diagnoses of, prostatic hyperplasia, , Parkinson, , OA ( ). precautions. Resident needed supervision with ADLs.

6. A review of facility internal incident reports showed that Resident #44, a , in facility resulting in right femur The resident's health assessment dated showed diagnoses: type II, . The resident was independent with ambulation and eating, needed supervision with self-care, toileting and transferring, need assistance with bathing and dressing and needed precautions (despite independence with ambulation).

The facility's incident report stated that on Resident while getting up from the couch, unassisted, in the common area. Incident report says she over another resident's legs. Admitted to Hospital, diagnosed with broken intra- through the right femur. Resident received surgery to repair the injury. Transferred to the rehabilitation center on , and on and she was re-hospitalized due to complaints of shoulder pain. On readmission it was discovered that the resident had also acquired a shoulder due to the .

On at 12:31 PM the Administrator reported, "When residents have an incident the follow ups are developed when received the discharge notes. The team in service had to develop the follow up. Then they place it in residents' records. If the recommendation is that Resident has to go to a Doctor, we assist them with appointments, if the doctor comes to the facility he sets the appointment."

Class I

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on record review, observation and interview the facility failed to provide one of 52 sampled residents with access to adequate and appropriate health care (Resident #37), who onsite. The resident presented as being in pain for almost two hours and did not receive medical care. When the resident became unresponsive, facility staff failed to bhonor the resident's right to be .

Findings:

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During a routine revisit survey on , review of a facility incident report completed on at 00:08 showed (quoted as written) :
"On at 22:00 Patient #37 was in bed requested his 23:00 medications and wanted to get up and sat by the South station. Staff positioned him in a recliner with legs up. The night shift supervisor rounded the South wing around 23:30. Her description of the event was reported in a Resident's observation log.
Type of injury: "Resident was no in distress, Staff only noticed that he stopped talking and started moaning."
Emergency treatment given: "Call 911 to be transferred to a hospital."
Witness: Staff GG and HH.
Further review of the report showed: "On at around 11:30 PM, I went to the nursing station of South Side where I saw resident #37 sit on a chair recliner. I noticed that something was going wrong because he had a tremor on the body and he had a voice of Lamentation. Various times I tried to ask him how he felt and at the beginning he answered, but then he stopped answering. At this time he was still breathing well but I thought that was better to send him to the hospital. So I tried to call his wife who didn't answer, then I called his son who told me to wait for his return call before calling the hospital (he wanted to call his mother first). During this time was at the front desk and I decide to call 911 when the Certified Nursing Assistant (CNA) next to him told me that he was getting worse. I did 3 calls to phone 911 and they arrived after 8-10 minutes (12:00 AM) Police arrived at the facility and soon after (5 minutes) paramedics arrived making (, ,) procedure. Resident #37 was declared at 12:08 AM of ." The signature of the person completing the report was missing.

Review of a Fire Rescue incident report dated at 12: 11:42 reads: "Ambulance dispatched at 23:51:22. Staff at facility stated patient was found unresponsive sitting in a chair stated last seen 10 minutes prior to calling 911. On arrival crew found MDPD (MIami Dade Police Department) officer performing . PI assessment found patient in . Patient was to the touch. No obvious signs of life. showed (no heartbeat) on the monitor. efforts were discontinued and scene was released to MDPD. Disposition: at scene."

Review of the facility's video recordings from the event showed this timeline:

On at 10:12 pm Resident #37 was transferred into a recliner at the the South Wing Nurse's Station by 3 staff. From 11:23 pm to around 11:45 pm, the resident is seen with convulsive movements, grimacing in pain and looking as if he is gasping for air. The resident does not receive medical care from a physician or other licensed health care provider, or from emergency medical services.

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At 11:47 pm-Staff K obtains a chair, covers it with a disposable liner, and places the resident's arm onto it.
At 11:48 pm- Staff K looks distressed, stares at Resident #37, and appears worried, no action taken.
11:52, Resident #37's resident's arm becomes limp arm never moves again. For the next 11 minutes Staff OO is seen standing next to the resident. Her lips are moving constantly, and in a later interview the Administrator stated that the staff was praying. Staff OO is seen making the sign of the cross over the resident, and using both hands to gesture 'no' to Staff K, who walks over to look at Resident #37. Staff K walks away to wipe her eyes, and uses one hand to make a 'flat line' gesture to someone off camera. Shift Supervisor Staff GG comes by and glances at the resident, then uses cell phone at 11:59 pm. No pulse or breathing is checked and is not provided.
12:01 am- A Miami Dade Police Officer arrives, asks staff a question, uses two hands to gesture 'no', and checks Resident #37's pulse. The officer then obtains gloves.
12:03 The Officer gets help from a male staff from the other wing (Staff NN) to move Resident #37 to the floor
12:04 pm, The Officer begins chest compressions. Staff OO, GG, NN, and K watch the officer, but provide no assistance.
12:07 pm- Paramedics arrive, connect their , machine and/or Automated Electronic Defibrillator ( ). There is no response from the resident.
12:09 pm- Paramedics place a sheet over Resident #37.

Review of Resident #37's Health Assessment dated (form1823) review showed resident had the following diagnoses: , , , , ( ), and II. The resident was independent for eating, needed supervision with self- care, toileting and transferring and needed assistance with ambulation/wheelchair, bathing and dressing. The resident needed universal and precautions. Further record review of the resident record showed that the Policy on and Advance directives was signed by the resident, who had checked the lines stating " I do not have ." " I do not have an Advance Directive."
Additional review of Resident #37's record showed that the resident did not have a Power of Attorney or Health Care Surrogate assigned.

Review of the personnel record showed documentation that Shift Supervisor Staff GG received training on and the training expires in .

On at 1:26 pm, Staff K stated she began working at 10:30 PM and Resident #37 was sitting down in a recliner at the nursing station. Resident #37 was not responding to any questions and was in pain. Resident #37 would only respond by moaning. Staff K stated Shift Supervisor Staff GG saw Resident #37 and contacted the resident's wife to see if they could call 911. Staff K stated that on

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, Resident #37 wife contacted the facility because the resident did not want to take his medications and wanted to go to the hospital instead. Resident #37's wife spoke to the resident and made him take his medications. Staff K stated Resident #37's wife then instructed the facility to not allow the resident to go to the hospital unless the facility contacted her first. Staff K stated she and Staff OO were with Resident #37 the entire time and Staff L would occasionally come to the nursing station briefly. Shift Supervisor Staff GG was in the front lobby until police came and started on Resident #37. Paramedics came around 5 minutes later and started the machine."

On at 8:06 am, Staff OO stated "On , I was working the midnight shift. I got to work around 10:30 PM. Resident #37 was already on the recliner in front of the nursing station. Staff OO stated she found out by speaking with her co-workers that the resident was not feeling well and wanted to by the nursing station. Around 11:00 PM, Resident #37 started to moan as if he was not feeling well. I asked him if he was ok and he did not respond with words, only moaning." Staff OO stated that to her, the resident looked normal. She stated "The entire night I was working with Staff K, Staff L, and Shift Supervisor Staff GG. For the most part I was with Resident #37 the entire night." Staff OO stated Shift Supervisor Staff GG passed by Resident #37 and decided to notify the family members that the resident should be taken to the emergency . Staff OO stated someone had checked the , of Resident #37 and found it to be normal. Staff OO stated she does not remember who checked the resident's vital signs. Staff OO stated Shift Supervisor Staff GG contacted 911. Staff OO stated a police officer came first, and immediately began doing . Staff OO stated the officer asked for help to move the resident off of the chair and to the floor, but they had to call another co-worker to assist. Staff OO stated herself and her co-workers did not conduct because Resident #37 was still alive and breathing. Staff OO stated Paramedics arrived after and started with the Automated Electronic Defibrillator ( ) machine. Paramedics stated that Resident #37 was no longer breathing. Staff OO stated she did not know what meant: Staff OO stated she knew what meant and she is certified. A review of the personnel filed showed that there was no documentation of certification for Staff OO.

On 6:50 AM Shift Supervisor Staff GG stated "I did not perform on Resident #37 because he was still breathing: is performed on someone who has stopped breathing. When I first observed Resident #37 I was going to call 911 services again until I heard the police sirens. I had to leave the area to the front door because I am the only person who has the entrance door key. Staff OO, HH and L were all working that night and were with Resident #37 that night. When I was in the front, I went to see Resident #37 around 10:30-11:00 PM. when I saw him, he was sitting on a recliner and he appeared ok. The second time I saw him was around 11:10 PM and Resident was still able to respond. I asked him, "Are you ok, do you feel any pain?" He responded "no." I was worried about him because his hand was tremoring and convulsing. I contacted Resident #37's wife and she did not respond, so I

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contacted Resident's son and he told me not to contact 911 until he was able to get in contact with Resident's wife. I called the Administrator and gave her an update and about a minute later, Staff L told me to contact 911 because Resident's #37's condition worsened. I contacted 911 about 3 times due to the phone call disconnecting. About 10 minutes later, a police officer came to the facility and began performing . Both times I observed Resident #37, his hand was moving.

On at 11:51 am, Resident #37's son stated "My mom tells me that the night he passed, they call her around 11 pm but she could not get to the phone on time. She returned the call but no one picked up; they left a message telling her "We think, he needs to go to the hospital." They called my brother and left a message, and then they both tried to call back but no answer. They called the hospital and they gave them a number where they could speak. The second call to my mom stated that he had ."

On at 4:30 pm, Resident # 37's wife stated "The night that he , they [facility staff] called me around 11:25 pm but I missed the call; I called the nursing home number but the number is disconnected; I called his [Resident #37] cell but he did not answer; I called the hospital and they gave us another number to call. They also called my son. I received a phone call from the police officer and asked me who I was and he is the one who told me that my husband was ." She further stated "When we arrived, we asked if they gave him , and they say yes. Then the police officer told them, "No, I told you he was , I took him out of the chair. I went ahead and gave him ." "

Class I

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation, record review and interview, the Assisted Living Facility failed to ensure that staff members signed the Medication Observation Record (MOR) after giving the medications to one of 52 sampled residents when he assisted with self administration of medications (Resident #28). The facility also failed to ensure that medications were given at the time prescribed for one of 52 sampled staff (Resident #33).

Findings included:

Observation on at 12:15 PM revealed Staff unlocked the cart, took the medication for Resident #28 and a disposable cup, marked the MOR as medications given, then went to the dining , (Resident was sitting at the dining table, water was served). Staff called resident by name and told

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her was going to give noon medications. Staff dropped the medications in the cup, gave it to resident, observed that she swallowed the medications, then returned the medication to the cart.

Medications given were:
, 0.5 mg 1 tab by mouth 3 times a day 7 am 12 noon 7 pm
, 20 mg 1 cap by mouth once daily 12 noon.

On at 12:25 Staff stated " I mark it before giving it to the resident and if the resident refuses the medications I circle the initial."

On at 9 AM Medication Technicians Staff P and Staff O were on the South Wing assisting with self-administration of medication. The medication reconciliation for Resident 33 revealed that all morning medicines scheduled at 7 AM still were in the medication cards.

Review of Resident 33's Medication Observation Record on at 9:17 AM revealed that Staff did not initial medicines scheduled at 7 AM as given.

On at 9:20 AM Staff P revealed that he was almost ready to assist Resident 33 with the medicines, and that she would be the next one that he helped.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview, the facility failed to keep over the counter medications in a secure place out of sight of other residents, for two of 52 sampled residents, (Residents 48 and 49).

Findings:

On between 8:13 am and 8:47 am, and on between 1:40 pm and 1:50 pm , observed prescribed medication, eye drops, located on top of Resident #50's computer stand.

When asked why the medications were unlabeled, Staff PP stated on , 2018 around 1:40 pm, "I don't know why he has this medication in his : sometimes when the residents visit their doctor, they come back with medications and do not tell the staff."

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FLORIDIAN GARDENS ASSISTED LIVING FACILITY	**17250 SW 137 AVENUE MIAMI, FL 33177**

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

On between 8:07 am and 9:30 am during the facility tour, observed prescribed medications for Resident 52, Inhalation solution in a tube inside of a cup on the nightstand in resident .

On at 8:20 AM observed in , Resident 48 had over the counter medications (CVS Ointment and 12 Suppositories) inside an unlocked refrigerator that was shared with Resident 33.

On at 8:25 AM observed in , Resident # 49 had over the counter medication (Vapo-Rub) on the nightstand, next to the window. The shared with Resident 22.

On during exit interview the Administrator stated, "We will look into that and it will be corrected".

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on observation, interview and record review, the facility failed to ensure that medications were labeled with resident names and instructions for use, and that a physician's order for the medication was on file for two of 52 sampled residents (Residents # 50 and 52).

Findings:

On between 8:13 am and 8:47 am during the facility tour, observed prescribed medications for Resident 50, eye drop medication located on top of resident computer stand in resident's . The medication was unlabeled. A review of the medication observation record for Resident #50 showed that the eye drops were not listed. A review of the health assessment showed that Resident #50 needed assistance with self-administration of medication. There was no documentation that the resident had clearance from a physician to self-administer they eye drops without assistance.

When asked about the medication, Medication Technician Staff PP stated on , , 2018 around 1:40 pm, "I don't know why he has this medication in his : sometimes when the residents visit their doctor, they come back with medications and do not tell the staff."

On between 8:07 am and 9:30 am during the facility tour, observed prescribed medications for Resident 52, Inhalation solution in a tube inside of a cup on the nightstand in resident . The medication was unlabeled.

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On during exit interview the Administrator stated, "We will look into that and it will be corrected".

Class III

0057 - Medication - Over The Counter (OTC) Products - 58A-5.0185(8) FAC

Based on observation and interview, the facility failed to ensure that over the counter medications for 2 of 52 sampled residents were labeled with the residents' names and the manufacturer's label with directions for use (Residents 48 and 49).

Findings included:

On at 8:20 AM observed, during tour, in , Resident 48 had over the counter medications (CVS Ointment and 12 Suppositories) inside an unlocked refrigerator that is shared by Residents 48 and Resident 33.

On at 8:25 AM observed, during tour, in , Resident # 49 had over the counter medication (Vapo-Rub) on the bed, next to the window. The shared with Resident 22.

On during exit interview the Administrator stated, "We will look into that and it will be corrected".

Class III

0058 - Pharmacy & Dietary; Uncorrected Deficiencies - 429.42(1-2) FS; 58A-5.033(3)(a) FAC

Based on observation, interview and record review, the facility failed to correct deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, deliver, or administration during a survey. The facility is required to employ the consultant services of a licensed pharmacist or a licensed registered nurse who will, at a minimum, provide onsite quarterly consultation until an inspection by the Agency's personnel determines that such consultation services are no longer required.

Findings:

On , the facility was found to have deficient practice in the areas of: Assistance with Self administration of medication; medication records; medication storage and disposal, medication labeling and orders; over the counter products.

During a revisit inspection ending on , the facility was found to have uncorrected deficient

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practice in the areas of: Assistance with self-administration of medication; medication storage and disposal; medication labeling and orders; and over-the-counter medications.

Class III

0076 - ( ) - 58A-5.0186 FAC

Based on record review and interview, the facility failed to provide documentation that Form SCHS-4-2006, "Health Care Advance Directives -The Patient's Right to Decide," was provided to one of 52 sampled residents.

Findings:

A review of the facility's incident reports, video recordings and the resident record showed that Resident #37 onsite on was not provided. Further review of the resident record showed that there was no documentation of a for Resident #37. A review of the

A review of Facility Policies and procedures review regarding and showed that in the admission package, policies and procedures stated: " It is the policy of the Assisted Living Facility top honor properly executed and followed the position in Section 429.255, F.S and Chapter 58A-5 .0186 F.A.C." "The ALF will document in the resident's record indicating whether or not he or she has executed a . If a has been executed, a copy of that document must be made a part of the resident's record. If the ALF does not received a copy of the resident's executed , the ALF must document in the resident's record that it has requested a copy." "In the event of a resident experience , distress, staff trained in , ( ) , or a license health care provider present in the ALF, may withhold , "

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on observation, interview, and record review, the facility failed to ensure that staff were qualified to perform their assigned duties, and failed to ensure that staff exercised their responsibilities for resident care. Four staff were observed on video failing to provide access to medical care or perform for one of 52 residents who became unresponsive and then

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(Resident #37; Staff K, L, OO, GG) . All four staff were home health aides, and one of the four was the shift supervisor, who held valid training.

Findings:

A review of the video tapes showing the facility's recordings of activities at the the South Wing Nurse's Station on beginning at 10:12 pm and continuing through 12:09 am on showed Resident #37 in distress, becoming unresponsive, and passing away, then being covered by with a white sheet at around 12:09 am by the paramedics.

A review of facility records showed a sign posted at the South Wing Nurse's Station listing 14 residents who had a ( ). Resident #37 was not listed.

Review of the Job description for Administrator revealed:
" The Administrator/Manager, at this ALF will be in charge of the entire operation.
" The Administrator/Manager is responsible for all personnel supervision to ensure that the residents' needs are met."
" The Administrator/Manager will be responsible for orienting and overseeing the training of employee in all necessary area."
" The Administrator/Manager is responsible that all employees perform their duties and responsibilities within the scope of ALF rules and regulations."

Review of the Job description for a Direct Care Staff review revealed:
"The direct care Staff must assist the following trainings in order to successfully perform his/her duties in the ALF."
Letter F on the job description showed: "Receive training in First Aid and ."

Review of the staff schedule showed the Shift Supervisor Staff GG, Staff K, Staff L and Staff OO worked from 10:30 pm on through 7:00 am on . An initial review of the personnel records showed that Shift Supervisor Staff GG was trained in 2017 and the training certificate expired in 2019. There was no documentation of training was found in the personnel records for Staff K, Staff L, Staff OO however Staff L brought in a valid card later.

Further review of the video tapes showing the facility's recordings of activities at the the South Wing Nurse's Station show that on at 10:12 pm Resident #37 was transferred into a recliner by three staff. From 11:23 pm to around 11:45 pm, the resident is seen with convulsive movements, grimacing in pain and looking as if he is gasping for air. The resident does not receive medical care. A

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review of the resident's Medication Observation Record shows that he was prescribed inhalation solution as needed for difficulty breathing. There was no documentation that the medication was used.

Resident #37's Health Assessment dated (form1823) review showed resident had the following diagnoses: ( ), and II. The resident was independent eating, needed supervision with self- care, toileting and transferring and needed assistance with ambulation/wheelchair, bathing and dressing. He needed universal and precautions. Further review of the resident's record showed that the Policy on and Advance directives was signed by the resident on and statements" I do not have " and " I do not have an Advance Directive" were checked off. Further record review showed Resident #37 had no Power of Attorney or health care surrogate.

Staff interviews regarding Resident #37's on were conducted on and revealed
at 1:27 PM Staff DD (assistant administrator) stated "I walked to the office to ask the Administrator and the detective was in the office in reference to Resident #37. After the detective left, the Administrator told me that " we were assisting him all the time and his wife did not want to send him to the hospital." " In this specific incident the Administrator gives the orientation to Staff to contact the Resident's husband before transferring him to the hospital."

On at 1:50 PM Staff L Home Health Aide (HHA) stated that when she first observed Resident #37 he was sitting down in a recliner by the nursing station on the South wing. "I didn't really spend that much time with Resident #37 because I was assisting Resident #33 due to her Parkinson's , and Resident 29 because he himself. I was not present at the time the police and paramedics came to assist Resident #37. They told me to stand at the front door when the paramedics came to assist Resident #37 to make sure no residents left the facility. A review of the video tape showed that between 10:12 pm and Resident #37's , Staff L was present for at least one hour.

On at 4:13 PM by phone interview to Staff N stated "I started work at 10:30 PM and did not come into contact with Resident #37 until GG contacted me to assist the officer move resident to the floor from the chair. GG called me over around midnight. I cannot say if he was or not because I am not a doctor: I work at the facility as a CNA (certified nursing assistant)."

On 6:50 AM Staff GG stated "I did not perform on Resident #37 because he was still breathing: is performed on someone who has stopped breathing. When I first observed Resident #37 I was going to call 911 services again until I heard the police sirens. I had to leave the area to the

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front door because I am the only person who has the entrance door key. Staff OO, HH and L were all working that night and were with Resident #37 that night. When I was in the front, I went to see Resident #37 around 10:30-11:00 PM: when I saw him, he was sitting on a recliner and he appeared ok. The second time I saw him was around 11:10 PM and Resident was still able to respond. I asked him, "are you ok, do you feel any pain?" He responded "no". I was worried about him because his hand was tremoring and convulsing: I contacted Resident #37's wife and she did not respond, so I contacted Resident's son and he told me not to contact 911 until he was able to get in contact with Resident's wife. I called the Administrator and gave her an update and about a minute later, Staff L told me to contact 911 because Resident's #37's condition worsened. I contacted 911 about 3 times due to the phone call disconnecting. About 10 minutes later, a police officer came to the facility and began performing . Both times I observed Resident #37, his hand was moving.

Staff interviews about the knowledge of ( ), and First Aid revealed the following:

On at 7:20 AM Staff A "I know what is, and I know who has because I remember the names or the faces of the residents who have it." When asked if Staff A can remember who is on the list, she stated Resident #12 and #45 are both on the list, "I do not remember who else is on the list, but there is a list by the nursing station where these names can be identified." When asked what she would do if there is a resident who is unresponsive in the front of the facility, Staff A responded she would first check the list by the nursing station to make sure before conducting .

On at 7:22 AM Staff O stated he does not know what is. He stated he would contact Staff A if a resident needed .

On at 7:33 AM Staff V, who is a part of the administrative staff who helps resident complete move-in paperwork which includes forms, stated she knows what is, but does not remember everyone on the list. A review of several resident records showed that the form was not available and there was no documentation of whether the form had been made available to residents.

On at 7:41 AM Staff M stated "I know what is, there is a list by the nursing station that has everyone in the facility that has ." When asked what she would do if there is a resident who is unresponsive in the front of the facility, Staff responded she was told she is not able to perform and to contact the HHA or nurse on duty.

On at 7:44 AM Staff Q stated she does not know what means. She said she is not

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certified to perform . When asked what she would do if there is a resident who is unresponsive in the front of the facility, she responded she was told she is not able to perform and to contact the HHA or nurse on duty.

On at 7:46 AM Staff T stated "I know what is, and I remember who has because I remember the names or the faces of the residents who have it." When asked Staff T if can remember who is on the list, Staff stated there is a list by the nursing station that has everyone who is . When asked what she would do if there is a resident who is unresponsive in the front of the facility, Staff responded she would contact the nurse or call out for help because she does not know how to perform .

On at 8:10 AM Staff Y stated she does not know what means. Staff stated she knows and how to perform it. When asked what the process of is, she responded with: "it begins with checking the breathing of the person, then calling 911 for help or yelling out for someone to contact 911. Afterwards you begin by compressing the lungs with both hands in a series of 30 compressions to every 2 breaths until help arrives." When asked what she would do if there is a resident who is unresponsive in the front of the facility, she responded she would follow protocol. When asked how she would know if the person wanted to be or not. Staff Y stated she does not know, but she would not let someone die in front of her.

On /8 at 1:33 PM Staff N stated "I worked that day until about 8 PM, I last saw Resident #37 after lunch time around 12:00 PM because I had to give him by injection. Staff DD called me on to advise me of what happened with Resident #37 because I was not scheduled to work the next day. Staff MM was the medical technician working the shift after me, she worked until 11:00 PM. Staff MM explained to me on she gave Resident #37 medications at 11:00 PM based on his request because he was not feeling well. Staff MM stated she assisted with moving Resident #37 to the nursing station from his .

1:52 PM Staff MM stated "I worked that night until 11:00 PM. I gave Resident #37 his four medications at his request. Resident #37 told me he wanted to go to the nurse's station. He was complaining of pain, I guess that was pain that he had and he was calling a person, may be his son or his wife."

On at 8:06 AM Staff OO interviewed stated "I was working the midnight shift: I got to work around 10:30 PM. Resident #37 was already on the recliner in front of the nursing station. Staff OO stated she found out by speaking with her co-workers that Resident #37 was not feeling well and wanted to sit by the nursing station. Around 11:00 PM Resident #37 started to moan as if he was not feeling well: I asked him if he was ok and he did not respond with words, only moaning. Staff OO stated

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that to her, Resident #37 looked normal. The entire night I was working with Staff K, Staff L and Staff GG.. She expressed " for the most part I was with Resident #37 the entire night. Staff OO stated GG passed by Resident #37 and decided to notify the family members that Resident #37 should be taken to the emergency . Staff OO stated someone had check the , of Resident #37 and resulted in normal , : Staff OO stated she does not remember who checked vitals. Staff OO stated Staff GG contacted 911. Staff OO stated a police officer came first, and immediately began doing . Staff OO stated the officer asked for help to move Resident #37 off of the chair and to the floor, but they had to call another co-worker to assist. Staff OO stated herself and her co-workers did not conduct is because Resident #37 was still alive and breathing. Staff OO stated Paramedics arrived after and started with the defibrillator machine. Paramedics stated that Resident #37 was no longer breathing. Staff OO stated she does not know what means. She said she knows what means and she is certified. When asked what the process is for , she stated first she checks the persons pulse and breathing, if they are not breathing then call out for help and begin compressions. Staff OO stated to start with compressions of 30 to every 2 breaths and to continue until help arrives. Staff OO stated if she remembers who is on the list because of her memory. She stated she can remember from names and faces of the residents. She mentioned the names of 9 residents. Record review showed that there were 14 residents on the list

A review of Facility Policies and procedures review regarding and showed that in the admission package, policies and procedures stated: " It is the policy of the Assisted Living Facility top honor properly executed and followed the position in Section 429.255, F.S and Chapter 58A-5 .0186 F.A.C." "The ALF will document in the resident's record indicating whether or not he or she has executed a . If a has been executed, a copy of that document must be made a part of the resident's record. If the ALF does not received a copy of the resident's executed , the ALF must document in the resident's record that it has requested a copy." "In the event of a resident experience , distress, staff trained in , ( ) , or a license health care provider present in the ALF, may withhold , , ."

A review of Resident #37's record showed that the resident did not sign a order and did not have a Power of Attorney or a Health Care Surrogate.

Class I

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and interview, the facility failed to submit an adverse incident report within one

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business day after the incident for one of 52 sampled residents who onsite (Resident 37).

Findings included:

A review of the facility's in-house incident report completed on at 00:08 showed:

"On at 22:00 Patient #37 was in bed and requested his 23:00 medications and wanted to get up and sat by the South station. Staff positioned him in a recliner with legs up. The night shift supervisor rounded the South wing around 23:30. The Supervisor's description of the event was reported in a Resident's observation log.
Type of injury: "Resident was no in distress, Staff only noticed that he stopped talking and started moaning."
Emergency treatment given: "Call 911 to be transferred to a hospital." At 12:00 AM Police arrived at the facility and soon after (5 minutes) paramedics arrived and did procedure. Resident #37 was declared at 12:08 AM of ." Witnesses: Staff GG and HH.

A review of a fire-rescue report of the incident showed that Resident #37 was when paramedics arrived at the facility at approximately 12:09 am on . The report further stated that the resident had last been seen alive 10 minutes before the staff called 911, and that a police officer was found performing ( ).

A review of the state incident report database showed that no account of the on-site had been filed.

On , , 2018 at 11:55 am, the Administrator stated, "I thought I wasn't supposed to report deaths if they were from natural causes."

A review of the resident record showed that there was no documentation of the , and therefore no cause of was documented in the file.

A review of the state incident report database showed that the Administrator filed an account of the incident during the survey at the facility on , , 2018.

Class III