Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910377	A. BUILDING: _____ B. WING _____	06/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF DELRAY EAST	14555 SIMS ROAD DELRAY BEACH, FL 33484

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A 000	Initial Comments A licensure complaint survey, Complaint Number #2019008315, was conducted on - and at Grand Villa of Delray East. The facility had deficiencies found at the time of the survey.	A 000		
A 025 SS=J	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the	A 025		

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A 025	Continued From page 1 resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide appropriate supervision of care by not assisting 1 out of 8 sampled residents (Resident #1) with her activities of daily living (ADLs). The facility failed to assist with ambulation and toileting activities, after the resident was readmitted from the hospital with changes in her condition that required an increased level of supervision of care. In addition, the facility failed to implement their policy and procedure related to Do Not Orders by withholding when the resident did not have an order to withhold for 1 out of 8 sampled residents (Resident #1). The Assisted Living Facility's noncompliance placed all the residents at imminent risk of harm. The findings included: Review of Resident #1's hospital medical record on , indicated that she was transported	A 025		

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A 025	Continued From page 2 from the facility to the hospital on [redacted] at approximately 1:00PM due to an episode of [redacted] and [redacted] with her inability to get up from the toilet. This medical record indicated the resident also complained of right [redacted], had history of [redacted] and was admitted to the hospital on [redacted] at approximately 2:09PM with diagnoses of [redacted] and [redacted]. Review of Resident #1's hospital discharge record dated on [redacted] at 4:54PM and 5:04PM indicated that the hospital discharge planner notified a facility nurse and caregiver respectively, that Resident #1 had arrangements to be transported by ambulance to the facility on [redacted] at around 9:00pm. Further review of the resident's hospital discharge record indicated that Advanced Registered Nurse Practitioner (ARNP)#1 developed a health assessment to represent the resident's most recent medical condition due to her admission to the hospital on [redacted]/2019. This health assessment was to be provided to the facility when the resident was discharged from the hospital. Review of this discharge record indicated that the resident was discharged from the hospital on [redacted] at 8:10PM. In an interview with Resident #1's Orthopedic Surgeon on [redacted] at 1:55PM, he stated that he consulted with Resident #1 when she was hospitalized from [redacted] to [redacted] and that the resident had a post/ [redacted] necrosis of her right [redacted] which required [redacted] replacement surgery. He stated that the resident had significant functional limitations that prevented her to walk independently due to [redacted] and [redacted]. He stated that the resident required physical assistance with her Activities of Daily	A 025		

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A 025	Continued From page 3 Living (ADL), including ambulation and transfers. In an interview with Resident #1's hospital ARNP#1 on at 2:55PM, she stated that she was responsible for the resident's discharge from the hospital on . She stated that due to the resident's and , the resident required assistance with her ADLs after discharge. She stated that it was hospital procedure to include discharge instructions and health assessments to reflect the resident's condition and required services upon discharge from the hospital. In an interview with the hospital ARNP #2 on at 4PM, she stated that she was notified that the resident was planning on discharging to the Assisted Living Facility (ALF) on in the evening. ARNP#2 stated that she signed the AHCA Health Assessment Form 1823 (Health Assessment) at around pm on and it was placed into the resident's discharge packet. Review of the undated Health Assessment included in the hospital discharge documentation indicated that the resident needed assistance with ambulating, bathing, , self/care, toileting (cannot ambulate alone - uses bedpan) and transferring (limited by ,). Resident had a significant change of medical condition, diagnosed with , and requiring increased assistance with ADL care per the Health Assessment completed by hospital ARNP#1. Review of the ambulance transportation records on indicated that the ambulance transportation from the hospital to the facility was requested on at 4:56PM. Ambulance	A 025		

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personnel reached Resident #1's side in the hospital at 8:52PM and transported the resident to the facility at 9:41PM. Review of this record indicated that the resident was due to and complained of left . Review of this record indicated that the ambulance personnel delivered the resident's hospital discharge documentation to the nursing station when they arrived to the facility and they assisted the resident into her bed. Further review of this record indicated that the ambulance personnel notified Caregiver C that Resident #1 was discharged from the hospital and returned to the facility, and Caregiver C signed the ambulance transportation's log to represent the facility's acknowledgement for the continued care of the resident.

In an interview conducted on at 3:06PM with Nurse C, she stated she worked and received call from hospital case manager, informing her that resident would be returning sometime in evening that day. She stated she questioned if resident had any medical changes in condition, since she was sent to hospital for would she need to go to rehab instead and was told resident was being transferred to the ALF and was stable.

In an interview with Caregiver C on at 3:45 PM, Caregiver C stated she signed for the resident's return after being notified of the resident's return by the transport company. Caregiver C retrieved the discharge packet, took packet to the second floor nurse's station and left it on the desk. Caregiver C stated she then texted the Resident Care Supervisor to notify her of the resident's return. No further communication with the Resident Care Supervisor was had for the rest of her shift. No nurse was on duty to update

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A 025	Continued From page 5 resident status in the computer/ kiosk. She stated that she went to the resident's room to observe the resident and the resident was lying on her bed on at approximately 10:00 PM. In an interview with Caregiver F on at 4:00PM, she stated she received shift report from Caregiver C. Caregiver F stated she checked on the resident around 11PM, the resident was observed resting in bed and did not communicate any distress. She stated that the resident seemed to be fine and appeared normally alert and oriented and she reminded the resident to use her call bell for assistance. Caregiver F left and did not return to check on resident for the rest of her shift due to an emergency with another resident on the second floor. Caregiver F stated after the other resident's emergency she was distracted with the nightly count and failed to report to the oncoming shift (6a/2p) that Resident#1 returned to the facility. In an interview with Caregiver D on at 12:45PM, she stated that on at about 9:30AM, Nurse A asked her to come along with her to check on Resident #1. She stated that when they arrived to Resident #1's room at around 9:35am, the resident was in the bathroom sitting on the toilet, slouched on the wall next to the toilet. She stated that the resident presented to be at that time. In a continued interview with Caregiver D on at 11:30 AM, Caregiver D stated she worked on from 6AM to 2PM; Caregiver D reviewed the kiosk and saw the Resident #1 was not identified in the kiosk as present in the facility. Caregiver D stated that she did not go into room since she thought Resident	A 025		

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A	Continued From page 6 #1 was still in hospital. She stated that the only resident she received report on from the previous shift was a resident from the second floor. She stated that Resident #1 routinely was a late sleeper and preferred to sleep in and just get up and go to lunch at 11AM. She stated Resident #1 was independent and was able to wheel herself via wheelchair prior to going to the hospital. She stated Resident #1 was able to make her needs know and was alert and oriented. Caregiver D stated that she observed Nurse A walking toward the residents' room with a , cuff the morning of . Caregiver D stated that she argued with Nurse A about the resident's return but was informed that Resident #1 returned in the night on . Caregiver D stated Nurse A stepped into the room first and found Resident #1 unresponsive on the toilet. Caregiver D stated that Nurse A pushed the wheelchair that was in front of resident into the shower and assessed Resident #1's . Caregiver D stated that Resident #1 was , stiff and was leaning against wall next to toilet. Caregiver D stated that the resident was naked and had no emergency call pendant around her . Caregiver D stated that Nurse A stated to her that she couldn't lift Resident #1 off toilet due to a injury and told Caregiver D she was "on her own" to lift the resident. Caregiver D stated that Nurse A called for help and asked someone to call 911 on the walkie-talkie. Caregiver D stated that Nurse A left the room and went to the second-floor nurses' station to obtain Resident #1's ( ) status. Caregiver D stated that Nurse A could have looked in the hallway kiosk instead of going upstairs. Caregiver D stated that when Nurse A returned she had the Automated External Defibrillator ( ) unit but Emergency Medical Services ( ) was already on the scene.	A 025		

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A 025	Continued From page 7 Caregiver D stated that unit was in the medication room, down the hallway near the kiosk. Caregiver D stated that she attempted to lift the resident and while reaching under the resident's she heard a crack, as if a bone broke. She stated neither she nor Nurse A performed because the resident was stiff and . She stated personnel arrived and assessed the resident. was upset with the nurse for not performing . In an interview with Nurse A on at 7:55PM, she stated she had just returned to duty on after being off for a injury. Nurse A stated that the Resident Care Supervisor told her on at approximately 8:45am to check up on Resident #1, who returned from the hospital the previous night. She stated that she was not aware of the resident's condition or status after her hospitalization on because she did not review the resident's health assessments or the hospital's discharge documentation to determine if the resident's present care needs. She stated that when she responded to Resident #1's room on at approximately 9:30AM, she saw the resident was in the bathroom sitting unresponsive on the toilet seat and slouched on the wall next to the toilet. In an additional interview with Nurse A on at 12:09 PM, Nurse A stated she had not made any corrections to the kiosk system indicating that resident was in the facility because she was unaware of the resident's return. She stated that she was instructed at 8:45 AM on by the Resident Care Supervisor to go check on Resident #1 and complete an assessment. Nurse A stated that she went to room around 9:45AM to check on Resident #1. She stated she knocked on the	A 025		

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door, there was no answer and she entered through the unlocked door. She stated that she stepped inside and noted the bathroom light was on and Resident #1 was observed sitting naked on the toilet. The Resident's wheelchair was positioned directly in front of the resident's . Nurse A stated that she pushed the wheelchair into the shower stall and checked Resident #1's ; she had none and was unresponsive. Nurse A stated that the resident's skin was to touch, she was stiff, and her lower were bluish. She stated that the resident's was leaning against the wall next to the toilet. Nurse A stated that she immediately called for assistance on the walkie-talkie and asked someone to call 911. She stated that Caregiver D was present at that time and she informed Caregiver D that she could not lift Resident #1 off the toilet to perform . Nurse A stated that she made the decision to leave the unresponsive resident and go upstairs to the second-floor nurse's station to review the paper chart for Resident #1's status. She stated she took the elevator to go upstairs. Upon returning to the room, she arrived with the machine, but had already arrived at that point. She stated that pronounced the resident and left her on the toilet until police arrived.

Review of the emergency response records on indicated that the emergency response personnel were dispatched on at 9:51 AM, arrived to the facility at 9:56am and reached Resident #1's side at 10:00AM. Review of this record indicated that the emergency response personnel found the resident sitting on the toilet seat with signs of "lividity" to her lower extremities. Further review of this record indicated that the resident was to the touch, unresponsive and was declared by

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A 025	Continued From page 9 confirmation of [illegible] results. Lividity is defined by Merriam/Webster Dictionary as, "Reddish to bluish/ purple discoloration of the skin due to the settling and pooling of [illegible] following [illegible]". In an interview with the Resident Care Supervisor, on [illegible] at 10:00 AM, she stated she was aware Resident #1 was returning from the hospital on [illegible] but had no exact time. She stated she spoke with the hospital floor nurse on [illegible] and was told that the resident had "a small [illegible]" and corrective surgery was to be schedule in the future. She stated that she was informed that the resident was "mobile "and "could get around". She stated that she believed the resident continued to be independent as she was prior to hospitalization and would be returning to the ALF but was not certain of when the resident would be discharged from the hospital. The Resident Care Supervisor did not receive information from the facility staff on [illegible] to confirm that Resident #1 was to be discharged from the hospital on the night of [illegible]. She stated that she did not inquire if Resident #1 had any specific additional ADL requirements and did not request the updated Health Assessment to be sent prior to Resident #1's readmission for her review of resident's continued appropriateness. In an additional interview with the Resident Care Supervisor on [illegible] at 1:36 PM she stated that she was asleep when she received a text message from Caregiver C, letting her know Resident #1 returned to the facility on [illegible]. She stated that she texted Caregiver C [illegible], asking, "How is she?" but Caregiver C never texted [illegible], so she went [illegible] to sleep. The Resident Care Supervisor stated that only nurses	A 025		

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can re/activate a resident from being labeled in kiosk system as "out of facility" to "readmitted" in the kiosk system. This allows all direct care staff in the facility to view the resident's actual status. She stated that she did not ensure that this was done for Resident #1 on or on when she returned to the facility the next morning. The supervisor stated that she had the capability from her home to reactivate the resident by accessing the facility's remote kiosk system. She stated her I/, was being repaired but she could have used her I/phone but chose not to due to the inconvenience. She stated that she didn't feel any negative results occurred from not reactivating the resident that night. She stated she did not know if the night staff (Caregiver F) had reported to the morning shift staff (Caregiver D) that Resident #1 was . She stated since no nurse was on duty in the late evening and night, she would wait until the following morning to return to the facility and assess the resident. She stated that she did not inquire about the resident any further until 8:45AM the next morning ( ) when she returned to the building. At that time, she instructed the on/duty nurse (Nurse A) to check on the resident. She stated she did not inform the Administrator of the Resident #1's return. When asked if she had reviewed the completed Health Assessment from the hospital, she stated that the form did not come along with the hospital discharge instructions and added, "Those 1823's are always inaccurate anytime the hospital fills them out". The Resident Care Supervisor stated that the facility has not implemented any changes as a result of Resident #1's incident.

In an interview with the Administrator on at 1:40PM, she stated that the Resident Care Supervisor informed her that the

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reason why Resident #1 was hospitalized on was due to a . She stated that she did not verify the information the Resident Care Supervisor provided to her regarding Resident #1 any further at that time. She stated that she was not informed by any facility staff member that Resident #1 was readmitted to the facility on and the Resident Care Supervisor told her on at 8:45AM, that Resident #1 returned to the facility on . She stated that she did not become immediately aware of the resident's readmission condition when she learned the resident returned to the facility on . She stated that during a staff meeting she attended on at 8:45AM, the Resident Care Supervisor did not discuss with her Resident #1's readmission status or if the resident was properly assessed by the facility to receive assisted living services that meet the needs of the resident. She stated that she learned of Resident #1's passing away shortly after the facility staff found the resident in her bathroom on at around 10:00AM. She stated that she was also not aware that the facilities direct care staff did not immediately perform on Resident #1. She stated that she was not aware that the resident received a recent medical examination or health assessment when she was hospitalized from to that reflected the resident's increased level of care and assistance with her activities of daily living, including ambulation and toileting. She stated that the resident's facility record did not indicate that the resident received any assistance with her ADLs from when the resident was readmitted to the facility on to when she was found unresponsive by the facility staff in the morning of . She stated that she was aware that Nurse A was on "light duty" due to a injury and this was not to deter

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A 025	Continued From page 12 Nurse A from performing on any resident in the facility. In an interview with the facility Regional Quality Manager on at 11:55AM, she stated that she was told by facility administration that the hospital did not notify the facility when the resident was going to be discharged from the hospital and was to be readmitted to the facility. She stated that regardless of when the resident was discharged, the facility must follow its policies and procedures relating to the continued care of any resident when readmitted to the facility and that the facility did not follow its policies and procedures. She stated that she did not know if a facility nurse was onsite on to evaluate Resident #1's condition and that it was the facility's to properly readmit the resident regardless of the nurse's scheduling availability. She stated that the facility had the responsibility to re-admit Resident #1 with a proper assessment prior to re-admission. She stated that this is the reason why the facility has policies and procedures in place to ensure that every resident receive consistent and adequate care, even in situations like Resident #1 on . Review of the facility's "Resident Return Assessment" policies and procedures dated on , indicated that every resident must be assessed by the facility prior to returning to the facility from another facility of higher/level of care, to determine the resident's appropriateness and provision of care services in the facility (copy obtained). Review of the facility's "Alert Observation" policies and procedures dated on , indicated that every resident who has	A 025		

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GRAND VILLA OF DELRAY EAST	14555 SIMS ROAD DELRAY BEACH, FL 33484

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 13 experienced a change in condition, an unexpected change in status or ability to perform activities of daily living (ADLs) must be monitored and documented on the alerted charting log (copy obtained). Review of the resident observation notes dated on indicated that the resident was sent to the hospital due to and . Review of the resident observation notes dated on documented at 3:30PM, indicated that Nurse A was notified by the Resident Care Supervisor that the resident returned to the facility on and was found on the toilet seat. Review of the resident's record on did not indicate that the facility assessed the resident prior to her readmission from the hospital on or that the staff assisted the resident with ambulating or toileting from to . Further review of the resident's record on indicated that the facility staff did not actively observe or maintain an "alert observation" log for Resident #1 when the resident was readmitted to the facility on . Review of the facility " & Advanced Directives Policies and Procedures" dated , was conducted on . The policy read the following: "It is the policy of the company to honor our resident's rights to refuse medical treatment Through Advance Directives and Advance Directive and/or Florida ( ) DH Form1896 / Procedures: Upon discovery and/or witnessing a resident in distress:	A 025		

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A 025	Continued From page 14 1. Assess scene for safety. 2. If resident is in medical distress call 911. 3. Determine unresponsiveness by: a. Opening airway and check for breathing. b. Check for signs of circulation such as a , . . . , coughing or moving. 4. If there are no signs of circulation: a. Request a second staff member to bring the . . . and the . . . binder b. Perform and/or First Aid and utilize the . . . as necessary. 5. Second staff member is to bring the and the . . . . binder to the emergency location and then: a. Review the binder to positively identify the resident using the resident photos. i. If the photo matches the resident; 1. Confirm the presence of a valid Florida . . . . ( ) DHForm1896. 2. If the Florida ( ) DH Form 1896 is valid, request that the responding staff member stops performing . 3. If the responding staff member is only performing First Aid, DO NOT withhold treatment. 4. Provide copies of Florida . . . . . ( ) DH Form1896 to responding emergency personnel. b. If you are unable to locate a , but the resident has a living will and/or health care surrogate designation DO NOT withhold life saving techniques. i. Provide copies of these documents to responding emergency personnel. c. If you are unable to locate advance directives and , DO NOT withhold life saving techniques."	A 025		

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A 025	Continued From page 15 Class I	A 025		
A 077 SS=J	429.176 FS; 429.52( ),58A-5.019(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52( ), FS (4) A new facility administrator must complete the required training and education, including the competency test, within 90 days after date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 58A-5.019 Staffing Standards. (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by Part II, Chapter 408, F.S., Part I, Chapter 429, F.S., Rule Chapter	A 077		

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A 077	Continued From page 16 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to Sections 408.809 and 429.174, F.S.; and 4. Complete the core training and core competency test requirements pursuant to Rule 58A-5.0191, F.A.C., no later than 90 days after becoming employed as a facility administrator. Individuals who have successfully completed these requirements before [illegible], are not required to take either the 40 hour core training or test unless specified elsewhere in this rule. Administrators who attended core training prior to [illegible], are not required to take the competency test unless specified elsewhere in this rule. 5. Satisfy the continuing education requirements pursuant to Rule 58A-5.0191, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the [illegible] of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraphs (1)(a)4. of this rule to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to Rule	A 077		

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A 077	Continued From page 17 58A-5.0191, F.A.C.; and 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile [illegible] of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements of an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to [illegible], are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not [illegible], serve as an administrator of any other facility. (e) Pursuant to Section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, [illegible], which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04002.	A 077		

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A 077	Continued From page 18	A 077		

This Statute or Rule is not met as evidenced by:
Based on interview and record review, the facility Administrator failed to provide adequate management of its direct care staff and failed to ensure that appropriate care to 1 out of 8 sampled residents (Resident #1) upon re-admission from a higher level of care. In addition, the Administrator failed to ensure that the facility wide policies and procedures were implemented placing all 161 residents at imminent risk of harm.

The findings are:

In an interview with Nurse A on at 7:55 PM, she stated that the Resident Care Supervisor (RCS) told her on at around 8:45AM to check up of Resident #1, who returned from the hospital to the facility on . She stated that she was not aware of the resident's condition or status when the resident returned to the facility from the hospital on because she didn't review the resident's health assessments and hospital discharge documentation to determine the resident's care needs. She stated that she didn't know for how long or the specific reason the resident was hospitalized for. She stated that when she responded to Resident #1's room on at approximately 9:30AM, she saw the resident was in the bathroom sitting on the toilet seat and slouched on the wall next to the toilet. She stated that the resident presented to be and stiff.

In an interview with the Administrator on

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A 077	Continued From page 19 . . . . . at 10:50AM, she stated that she was not aware when Resident #1 was discharged to the hospital and she needed to review the resident's records to reveal the hospitalization dates, the reason for hospitalization and the resident's status upon return to the facility. In an interview with the facility Regional Quality Manager on . . . . . at 11:55AM, she stated that she was told by facility administration that the hospital did not notify the facility when the resident was going to be discharged from the hospital and was to be readmitted to the facility. She stated that regardless of when the resident was discharged, the facility must follow its policies and procedures relating to the continued care of any resident when readmitted to the facility and that the facility did not follow its policies and procedures. She stated that she did not know if a facility nurse was onsite on . . . . . to evaluate Resident #1's condition and that it was the facility's to properly readmit the resident regardless of the nurse's scheduling availability. She stated that the facility had the responsibility to re-admit Resident #1 with a proper assessment prior to re-admission. She stated that this is the reason why the facility has policies and procedures in place to ensure that every resident receive consistent and adequate care, even in situations like Resident #1 on . . . . . . In an interview with the Administrator on at 1:40PM, she stated that the Resident Care Supervisor informed her that the reason why Resident #1 was hospitalized on . . . . . was due to a . . . . . She stated that she did not verify the information the Resident Care Supervisor provided to her regarding Resident #1 any further at that time. She stated	A 077		

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A 077	Continued From page 20	A 077		

that she was not informed by any facility staff member that Resident #1 was readmitted to the facility on [redacted] and the Resident Care Supervisor told her on [redacted] at 8:45AM, that Resident #1 returned to the facility on [redacted]. She stated that she did not become immediately aware of the resident's readmission condition when she learned the resident returned to the facility on [redacted]. She stated that during a staff meeting she attended on [redacted] at 8:45AM, the Resident Care Supervisor did not discuss with her Resident #1's readmission status or if the resident was properly assessed by the facility to receive assisted living services that meet the needs of the resident. She stated that she learned of Resident #1's passing away shortly after the facility staff found the resident in her bathroom on [redacted] at around 10:00AM. She stated that she was also not aware that the facilities direct care staff did not immediately perform [redacted] on Resident #1. She stated that she was not aware that the resident received a recent medical examination or health assessment when she was hospitalized from [redacted]/2019 to [redacted] that reflected the resident's increased level of care and assistance with her activities of daily living, including ambulation and toileting. She stated that the resident's facility record did not indicate that the resident received any assistance with her ADLs from when the resident was readmitted to the facility on [redacted] to when she was found unresponsive by the facility staff in the morning of [redacted].

Review on [redacted] of Resident #1's hospital medical record indicated that she was transported from the facility to the hospital on [redacted] at approximately 1:00PM due to an episode of [redacted] and [redacted] with her inability to get up from the toilet. This medical

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A 077	Continued From page 21 record indicated the resident also complained of right , , , had history of and was admitted to the hospital on at approximately 2:09PM with diagnoses of , , and . Review on of Resident #1's hospital discharge documentation, which was placed in the facility's resident record, indicated that the resident receive a health assessment and was discharged to the facility on with diagnoses of , , , , and . Review of the health assessment included in the hospital discharge documentation indicated that the resident needed assistance with ambulating, toileting and transferring due to right , , , her inability to ambulate alone and must use a bedpan. Review of the resident observation notes dated on indicated that the resident was sent to the hospital due to and . Review of the resident observation notes dated on indicated that Nurse A was notified by the Resident Care Supervisor that the resident returned to the facility on and was found on the toilet seat. Review of the resident's record did not indicate that the facility assessed the resident prior to her readmission from the hospital on or that the staff assisted the resident with ambulating or toileting. Further review of the resident's record indicated that the facility did not maintain an alert observation charting log. Review on of Resident #1's hospital discharge planner note dated on at 4:54PM and 5:04PM indicated that the hospital notified a facility nurse (Nurse C) and caregiver (Caregiver B) respectively, that the resident was arranged to be transported by ambulance to the facility on at or before 9:00pm. Further	A 077		

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A 077	Continued From page 22 review of the resident's hospital discharge record indicated that Advanced Nurse Practitioner #1 (ARNP#1) developed a health assessment to represent the resident's most recent medical condition due to her admission to the hospital on and this health assessment was to be provided to the facility when resident was discharged from the hospital. Review of this discharge record indicated that the resident was discharged from the hospital on at 8:10 PM. In an interview with Caregiver C on /2019 at 3:45 PM, Caregiver C stated she signed for the resident's return after being notified of the resident's return by the transport company. Caregiver C retrieved the discharge packet, took packet to the second floor nurse's station and left it on the desk. Caregiver C stated she then texted the Resident Care Supervisor to notify her of the resident's return. No further communication with the Resident Care Supervisor was had for the rest of her shift. No nurse was on duty to update resident status in the computer/ kiosk. She stated that she went to the resident's room to observe the resident and the resident was lying on her bed on at approximately 10:00 PM. Review of the facility's "Resident Return Assessment" policies and procedures dated on , indicated that every resident must be assessed by the facility prior to returning to the facility from another facility of higher/level of care, to determine the resident's appropriateness and provision of care services in the facility (copy obtained). Review on of the facility's Alert Observation policies and procedures dated in	A 077		

Agency for Health Care Administration

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A 077	Continued From page 23 , , it indicated that every resident who has experienced a change in condition, an unexpected change in status or ability to perform activities of daily living (ADLs) must be monitored and documented on the alerted charting log (copy obtained). Class I	A 077		