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
	AL11968808	A. BUILDING: _____ B. WING _____	09/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET GARDENS ALF LLC	372 SW TODD AVENUE PORT SAINT LUCIE, FL 34983

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A 000	Initial Comments An unannounced licensure complaint survey, Complaint #2019009445 and #2019012738, was conducted on to . The facility had deficiencies identified 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 resident's whereabouts. The resident may travel	A 025		

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A 025	Continued From page 1 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 care and supervision for 1 out of 4 residents (Resident #4) by failing to notify a physician when the resident exhibited signs of , and altered . The facility failed to provide adequate supervision and allowed the opportunity for Resident #4 to gain access to the facility's pool area without a system in place to alert the facility staff, which ultimately led to this resident's . The findings included: Review of Resident #4's health assessment dated on indicated that Resident #4 was , and was determined to be legally and diagnosed with , generalized , (GAD) and with . This health assessment indicated that the resident must receive supervision with all her activities of daily living (ADLs), including transfers	A 025		

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A 025	Continued From page 2 and ambulation. Further review of this health assessment indicated that the facility did not complete page 5 to confirm the care and services provided and arranged by the facility for the resident. Review of the resident's record indicated that the resident did not have a . . . . . (.). In observations of the facility during this inspection on and , the facility did not implement safety and security measures to prevent and alert the facility staff in the event any resident would access the patio and pool area from Resident #4's bedroom. In observations throughout this inspection, the doorway from the resident's bedroom to the patio and pool area did not have the individual alarm sensor in working order. In further observations during this inspection, the pool did not have any remote alarming system to alert entry into the pool and the perimeter fencing around the pool did not have any locking device so to stop or prevent opening its latching mechanism to open the fence panel to enter the pool. In an interview with the Administrator on at 4:30pm, she stated that sometime in , , Resident #4 became upset that the facility's previous caregiver did not work at the facility anymore. She stated that the resident requested for her to hire . . . the previous caregiver and she told her that she could not do so. She stated that sometime in late , . . . the resident's niece was looking to move the resident out of the facility, but the resident told her that the resident wanted to stay in the facility. She stated that Caregiver B was working in the facility on , and on at about 7:00am, she received a telephone call from Caregiver B who told her that Resident #4 was floating, -down in the pool.	A 025		

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A 025	Continued From page 3 She stated that Caregiver B was frantically describing to her how Resident #4 was not moving and she instructed her to call the police or 911. In an interview with Resident #1 on at 5:10pm, he stated that he knew Resident #4 and that the resident was usually reserved. He stated that on . . . at about 7:00am, Caregiver B began screaming and "lost it" when she saw Resident #4 floating in the pool from the kitchen window. He stated that he took over the 911 telephone call from Caregiver B in the morning of because Caregiver B was frantic and lost her composure. He stated that the pool safety fence was installed throughout the perimeter of the pool this morning and a single fence panel was opened which provided access into the pool. He stated that Resident #4 likely opened this pool fence panel to enter the pool this morning. He stated that Caregiver B did not perform . on Resident #4 and she may have gotten to resident #4's body from the edge of the pool to possibly perform , but he was not certain of this because of her frantic reaction. He stated that the emergency personnel arrived to the facility within minutes and took over the scene. In an interview with Resident #4's family member on at 8:30am, she stated that sometime in the beginning of . , . . . she noticed that resident #4 became a little depressed that the facility's previous caregiver would not return to work at the facility. She stated that she felt that the resident was saddened, but she felt it was not proportional to the resident seeking to eventually drown herself in the facility pool. She stated that she believed the facility Administrator was aware that Resident #4 became saddened because the previous caregiver was no longer working in the	A 025		

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A 025	Continued From page 4 facility, and the resident was vocal about this. In an interview with Caregiver B on at 9:05am, she stated that she worked in the facility from approximately to and she knew Resident #4 well. She stated that on or about , Resident #4 asked about the previous caregivers who worked in the facility and presented to be that these employees no longer worked there. She stated that she , missed one of the previous caregivers who used to work in the facility. She stated that she told the Administrator about the resident's concern and the Administrator talked to the resident after this. Caregiver B further stated on at approximately 9:10am, that on at around 7:00am, she saw from the kitchen window, Resident #4 floating in the pool and she became shocked to see the resident like this. She stated that she called 911 and Resident #1 continued this phone call because she was too distraught. She stated that she last saw Resident #4 on the evening of and she did not check up on the resident from about 9:00pm until she saw the resident floating in the facility pool after she woke up on at approximately 7:00am. She stated that she did not know when the resident left her bedroom and entered the pool. She also confirmed that she was the only caregiver on duty the prior night and at the time of the incident. Review of the Police Department case report dated on at 7:02am, it indicated that the police officer found Resident #4 lying down inside the facility pool, the resident presented to be and the police officers removed the resident's body out of the pool. This report indicated that Caregiver B last saw the resident	A 025		

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A 025	Continued From page 5 on at around 9pm before finding the resident in the pool on at around 7am. There was no mention of Caregiver B checking on the resident through the night at any time. This report indicated that the Administrator told the police officer that Resident #4 seemed or depressed the last couple weeks. This report indicated that the police officer noticed that the resident's bedroom door leading to the patio and pool area did not chime when opened. This report indicated that the resident's niece told the police officer that the resident presented to have been depressed over the past weeks because the resident missed the previous caregivers that used to work in the facility. This report indicated that Caregiver B told the police officer that the resident had slight and had been very moody recently. Review of the Medical Examiner's report dated on indicated that Resident #4's cause of on was for drowning and the manner of was . Review of facility records revealed the facility had no written policies and procedures established to address the safety of residents which have access to the patio/pool area or for residents who had . This record review also revealed that there were no documented staff training or drills to adequately perform facility-specific emergency procedures and to maintain resident health, safety and well-being. Review of Resident #4's medications observation records (MORs) revealed the resident suffered from and restlessness. Further review of the resident's MORs indicated that she did not receive any medication specifically for . The MORs for the months of	A 025		

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A 025	Continued From page 6 2019 to revealed, the resident received the following: a. 10mg tablets once daily at 8pm for restlessness. b. 10mg tablets once daily at 8am c. 10mg tablets once daily at 8am for restlessness d. 10mg tablets once daily at 8am e. 10mg tablets once daily at 8am f. 10mg tablets twice daily at 8am and 8pm on , noted on the MOR. (Photographic evidence obtained). Review of , medication's side effects as per WebMD website at https://www.webmd.com/drugs/2/drug-6306/diazepam-oral/details, indicated that a physician prescribed this medication because he or she has judged that the benefit to the resident is greater than the risk of side effects. Review of this website indicated to notify a resident's physician right away if a resident had any serious side effects, including: mental/ changes, such as memory problems, agitation, , restlessness, . In an interview with the Administrator on at 5:50pm, the Administrator stated that she did not know the reason why Resident #4 was prescribed the , medication or the medication's potential side effects. She stated that it was up to the physician to determine this and the facility did not communicate with the physician to discuss this medication's therapeutic or side effects on the resident at any time.	A 025		

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A 025	Continued From page 7 In an interview with the Administrator on at 9:00am, she stated that she wrote Resident #4's MORs to indicate the resident's condition, she felt this was adequate for each medication the resident received and this written information in the MOR did not reflect the residents actual clinical reason the physician prescribed the medications for the resident. She reported, she wrote "restlessness" in the resident's MOR and " ," in the MOR for the resident's administration of because she determined these two conditions were the same. She stated, she was not aware if the was prescribed by the physician on an "as needed" (PRN) or on a routine basis, despite the fact that the facility administered this medication daily and routinely since . She reported, she believed that the reason why the resident was prescribed the medication was because the resident was restless, paced the floor at night and could not sleep sometimes. She stated, the facility did not have written procedures to supervise residents who were or restless, but it was her expectation that the caregiver on duty would check on Resident #4 during the night. She stated, Caregiver B slept through the night on without checking resident #4 in the middle of the night and the individual chirping door alarm inside the resident's room did not have a battery and it did not function to alert anyone in the facility that the resident used this exit to reach the pool area before the resident was found floating in the pool on . Class I	A 025		
A 027 SS=J	58A-5.0182(3) FAC Resident Care - Arrangement for Health Care	A 027		

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A 027	Continued From page 8 (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making , , and remind residents about scheduled , , for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a , health care provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to arrange and facilitate the receipt of care and services from a physician and a home health provider for 3 out of 3 sampled residents (Residents #2, #3 and #4) that required services. As evidenced by the facility's failure to ensure that residents prescribed physical and , , had received the services, for 2 out 3 sampled residents (Resident #2 and #3) and that a resident's physician was notified of mental health status changes, for 1 out 3 sampled residents (Resident #4) . The findings included: a.) In an interview with Resident #4's family member on at 8:30am, she stated that sometime in the beginning of , , she noticed that Resident #4 became a little depressed that the facility's previous caregiver would not return to work at the facility. She stated, she felt that the resident was saddened.	A 027		

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A 027	Continued From page 9 She stated, that she believed the facility Administrator was aware that Resident #4 became saddened because the previous caregiver was no longer working in the facility, and the resident was vocal about this. In an interview with Caregiver B on . . . . at 9:05am, she stated that she worked in the facility from approximately . . to . . . . . and she knew Resident #4 well. She stated, on or about . . . ., Resident #4 asked about the previous caregivers who worked in the facility and presented to be . . . that these employees no longer worked at the facility. She stated, she , ... , missed one of the previous caregivers who used to work in the facility. She stated that she told the Administrator about the resident's concern and the Administrator talked to the resident after this. In an interview with the Administrator on . . . . at 4:30pm, she stated that sometime in , . . ., Resident #4 became upset that the facility's previous caregiver did not work at the facility anymore. She stated, that the resident requested for her to hire the previous caregiver and she told her that she could not do so. She stated that sometime in late , the resident's niece was looking to move the resident out of the facility, but the resident told her that the resident wanted to stay in the facility. Record review of the facility records did not indicate any changes in the resident's mental status. However, on . . . . . the records indicated a conversation between the Administrator and the resident regarding taking the previous employees. The Administrator at this time explained to the resident that she could not hire them . . . Record review failed to	A 027		

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A 027	Continued From page 10 indicate any further indications about the resident's mental status and/or her concerns voiced about previous employees. During an interview with the Administrator on at 9 AM, she was asked if the physician had ever been notified of the resident's , as voiced by the niece. She stated, that she had not notified the resident's physician and had no further documentation of any other follow-up regarding Resident #4's behavior or concerns voiced. Review on of Resident #4's medications observation records (MORs) revealed, the resident suffered from , and restlessness. Further review of the resident's MORs indicated that she did not receive any medication specifically for , . The MORs for the months of , to revealed, the resident received , 10 mg once daily. , was written on the MOR for the , medication. (Photographic evidence obtained). Review of , medication's side effects as per WebMD website at https://www.webmd.com/drugs/2/drug-6306/diazepam-oral/details, indicated that a physician prescribed this medication because he or she has judged that the benefit to the resident is greater than the risk of side effects. Review of this website indicated to notify a resident's physician right away if a resident had any serious side effects, including: mental/ changes, such as memory problems, agitation, , , restlessness, , . In an interview with the Administrator on at 5:50pm, the Administrator stated that she did not know the reason why Resident #4 was	A 027		

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A 027	Continued From page 11 prescribed the medication or the medication's potential side effects. She stated, that it was up to the physician to determine this and the facility did not communicate with the physician to discuss this medication's therapeutic or side effects on the resident at any time. Review on of Resident #4's health assessment dated on indicated that Resident #4 was and was determined to be legally and diagnosed with wet , generalized (GAD) and with . This health assessment indicated that the resident must receive supervision with all her activities of daily living (ADLs), including transfers and ambulation. Further record review revealed on , Resident #4 between the late hours of and early morning hours of , entered the facility's swimming pool unsupervised and drowned. Review on of the Medical Examiner's report dated on indicated that Resident #4's cause of on was for drowning and the manner of was . b.) In an interview with Resident #3 on at 3:45pm, she stated that she was aware that she needed to get physical and , but the facility did not assist her to arrange the initial with her home health agency to provide the therapies. She stated that she told the administrator about this several weeks ago and she has yet to be evaluated or treated by a physical or occupational . Review of Resident #3's health assessment dated on indicated that the resident was diagnosed with 's ,	A 027		

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A 027	Continued From page 12 and . This health assessment indicated that the resident had a stable and was , and she required assistance with ambulation, toileting and transferring. Further review of this health assessment indicated that the resident was required to receive physical and . c.) In an interview with Resident #2 on at 3:55pm, she stated that she was aware that she needed to get physical and , but the facility did not assist her to arrange the initial with her home health agency to provide the . She stated that the facility did not tell her when she was to begin her physical or occupational . Review of Resident #2's undated health assessment indicated that the resident was diagnosed with , history of , abnormal gait, and . This health assessment indicated that the resident was alert x 3 and forgetful at times, and she required supervision with ambulation, toileting and transferring. Further review of this health assessment indicated that the resident required to receive physical and occupational therapies. In an interview with the Administrator on at 4:15pm, she stated that she was aware that Resident #2 was required to receive physical and , and that she did not actively seek to arrange these services for the resident. She stated, that the resident told her the specific home health agency provider that she wanted to use and that she did not have an opportunity to	A 027		

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A 027	Continued From page 13 schedule for a physical and . . . . . evaluation for the resident. She stated that she was aware that resident #3 also was required to receive physical and occupational therapies and that the resident's undated health assessment was from when she was admitted to the facility on . . . . . She stated that she did not actively seek to arrange these services for the resident. She stated that she thought that her representative would arrange for these services, and that she did not check with the representative to ensure that the resident will be evaluated by the physical and occupational . . . . . Class I	A 027		
A 030 SS=J	58A-5.0182(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 58A-5.0182 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 58A-5.0181, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in	A 030		

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	AL11968808	A. BUILDING: _____ B. WING _____	09/23/2019

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A 030	Continued From page 14	A 030		

full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 58A-5.0181, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and universal precautions; and,
8. The requirements for coordinating the delivery of services to residents by third party providers.
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the

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A 030	Continued From page 15 resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical . . . . . by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and	A 030		

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A 030	Continued From page 16 visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident ' s representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care ..., and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days ' notice of relocation or	A 030		

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A 030	Continued From page 17 termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without . . . . , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state	A 030		

Agency for Health Care Administration

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A 030	Continued From page 18 that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident ' s access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder . . . . . Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27(1)(a), FS Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated . . . . . or . . . . . under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by:	A 030		

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A 030	Continued From page 19 Based on interview and record review, the facility failed to honor the rights of 1 of 4 residents (Resident #4) by failing to perform ( ) on a nonresponsive resident who did not have a ( ) to withhold life sustaining treatment. The findings included: Review of the facility's "Advance Directive and Policy", signed and dated by the Facility Administrator and Resident #4 on revealed, that Resident #4 had a living will and a health care surrogate. The Yes and No boxes for Durable Power of Attorney and ( ) Orders were left blank. Review of the facility's " ( ) Policy and Acknowledgement" form revealed, the form was dated and signed by the Facility Administrator and Resident #4 on . The form acknowledges that the facility "requires a copy of a form in the event that the patient has one or a copy of the living will, if applicable. The facility's policy documents, this facility calls 911 if a patient requires emergency medical attention. [The Facility] does not make any medical decisions in the event of a medical emergency even if the patient has a signed. If the patient is unable to make decisions, a family member can refuse transport to the hospital if present in the facility and able to sign a release form for the emergency personnel. [The Facility] will not use a defibrillator for a patient with a signed." Review of Resident #4's record revealed, the resident was admitted to the facility on . The Resident's Health Assessment dated on	A 030		

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indicated that Resident #4 was and was determined to be legally and diagnosed with generalized (GAD) and with This health assessment indicated that the resident must receive supervision with all activities of daily living (ADLs), including transfers and ambulation. Further review of this health assessment indicated that the facility did not complete page 5 to confirm the care and services provided and arranged by the facility for the resident. Review of the resident's record indicated that the resident did not have a ( ).

A review of the facility's "Demographic Data Information" sheet for Resident #4 revealed, that the answer to the question, "Does Resident have a ?" was left blank.

In an interview with Resident #1 on at 5:10pm, He stated that on at about 7:00am, Caregiver B began screaming and "lost it" when she saw Resident #4 floating in the pool from the kitchen window. He stated, that he took over the 911 telephone call from Caregiver B because Caregiver B was frantic and lost her composure. He stated, that Caregiver B did not perform on Resident #4 and she may have gotten to Resident #4's body from the edge of the pool to possibly perform , but he was not certain of this because of her frantic reaction. He stated, that the emergency personnel arrived to the facility within minutes and took over the scene.

In an interview with Caregiver B on at 9:05am, she stated that she worked in the facility from approximately to and she

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A 030	Continued From page 21 knew Resident #4 well. She stated that on . . . at around 7:00am, she saw from the kitchen window, Resident #4 floating in the pool and she became shocked to see the resident like this. She stated, that she called 911 and Resident #1 continued this phone call because she was too distraught. She stated that she did not evaluate the resident's breathing or , and did not perform . on the resident because she was too frightened. She stated that she last saw Resident #4 on the evening of and she did not check up on the resident from about 9:00pm until she saw the resident floating in the facility pool after she woke up on at approximately 7:00am. A review of Caregiver B personnel file revealed the Caregiver B received a basic life support and . . . certification dated . . . . . In an interview with the Facility Administrator on at 4:30pm, she stated that Caregiver B was working in the facility on . . , and on at about 7:00am she received a telephone call from Caregiver B who told her that Resident #4 was floating, -down in the pool. She stated that Caregiver B was frantically describing to her how Resident #4 was not moving and she instructed her to call the police or 911. She stated that she was aware that Caregiver B did not perform . . . , ... , ... (.) on Resident #4 at that time because she knew that Caregiver B could not swim, and she did not instruct Caregiver B to perform immediately to attempt to save the resident during this call. Review on . . . . of the police department case report dated on at 7:02am, indicated that the responding police officers and fire rescue found Resident #4 inside the facility pool. The	A 030		

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A 030	Continued From page 22 responding officers removed Resident #4 from the pool. Resident #4 was pronounced at 7:10 AM. Caregiver B reported to law enforcement that she "recalled awaking around 6am, and going about her morning routine, and noticing one panel from the mesh fence around the pool was taken down. Caregiver B stated she rushed out to the patio and saw Resident #4 floating down in the pool. Caregiver B immediately called 911." There was no mention in the report of Caregiver B attempted to remove Resident #4 from the pool or attempting to perform . Review of the Fire Rescue report dated revealed Fire Rescue was dispatched to the Facility on at 7:02 AM and arrived at 7:07AM. Upon arrival, the report noted that Resident #4, "is in the pool down. PSLPD (Police Department) is in the process of pulling the , (patient) out of the pool upon arrival. is , unresponsive, with fixed and dilated pupils. has to her extremities. Obvious noted. DOA (on arrival) time is called at 0710." The report does not reflect Staff B performed on Resident #4 as the resident was still in the pool upon arrival of police and Fire Rescue. Class I	A 030		