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
	AL11953207	A. BUILDING: _____ B. WING _____	10/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAINVIEW	145 EXECUTIVE CENTER DRIVE WEST PALM BEACH, FL 33401

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A 000	Initial Comments An unannounced licensure complaint survey, #2019009060, was conducted on . . . . . and through at Fountainview Assisted Living Facility. 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 record review and interview, it was determined the facility failed to arrange and facilitate medical care and services, for 1 out of 3 sampled residents (Resident #1) that demonstrated a significant health change. As evidenced by the facility failure to ensure that Resident #1's physician was notified when the resident exhibited signs of a significant health change and/or to contact Emergency Medical Services (. . .) for further assessment and treatment. In addition, the facility failed to maintain a written record of significant health changes for Resident #1 that required medical attention and how the facility had planned to monitor the resident due to these changes. The finding included: During an interview with the Administrator on at 9:14 AM, the facility's policy regarding assessing a resident upon significant changes was requested. The Administrator stated, the	A 025		

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A 025	Continued From page 2 facility didn't have a policy and procedure for Staff/Caregivers to follow regarding appropriate notification to the resident's physician regarding health changes. The Surveyor asked the Administrator, how is the staff supposed to know when to contact the physician and/or (Emergency Medical Services), regarding a change in condition or a resident emergency. The Administrator just stated again, there is no written policy in place and that she is always available, and staff will call her if they have any questions. At this time, she was asked if the Caregivers on duty (A, B, C, D and E) contacted her for guidance regarding Resident #1's significant health changes and unresponsiveness reported by the residents daughter on . She stated, "No", the Caregivers only contacted her on , after the resident was found in her room and declared by . During a telephone interview on at 9:35 AM with a Medical Office , , a representative from Resident #1's physician office, she stated, the office had no record of the facility contacting the office regarding Resident #1 on . She stated, the only notification the office received regarding Resident #1 was the notification of resident #1's on at approximately 3:00AM from the local police department via the answering service. Review of Resident #1's file revealed, she was admitted to the Assisted Living Facility Unit on and came from the facility's Independent Living Unit. Resident #1 was a with diagnoses to include MCI (Mild ,), AR/MR (and Valve Regurgitation) and . The residents and behavioral status was noted as alert and oriented times three with forgetfulness. The	A 025		

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A 025	Continued From page 3 resident was independent with all Activities of Daily Living. Review of the facility's staffing schedule for [redacted] through [redacted] revealed the following Caregivers/Direct Caregivers were assigned to work at the facility on [redacted] and [redacted] and were assigned as Caregivers for Resident #1. Caregiver C, was the nurse on duty and cargiver E was scheduled to work on [redacted] for the 3:00 PM to 11:00 PM shift. Caregiver A, B and D were assigned to work the 11:00 PM to 7:00 AM shift on [redacted] (starting on [redacted] and ending on [redacted] at 7:00 AM). During an interview with the Administrator on [redacted] at 11:00 AM, she confirmed the staffing hours and shifts for Caregivers A, B, C, D and E for [redacted] and [redacted] as documented on the schedule provided to the Surveyor. During an interview with Caregiver E on [redacted] at 11:14AM by telephone, she stated, when she arrived on [redacted] at 3:00PM, she checked on the Resident #1, the resident said she was not feeling well and requested to have dinner in her room. Resident #1 was assisted with dinner in her room by Caregiver E. While assisting another resident close by, she received a call from Resident #1's life alert, the exact time was unknown. She entered the residents room and the resident's daughter was there. The daughter told her Resident #1 was unresponsive and [redacted] when she arrived. Caregiver E stated, she immediately called the Nurse (Caregiver C) and assisted the daughter with changing her linen and undergarments, Resident #1 was responsive at this time. When Caregiver C arrived to Resident #1's room, she informed her that she observed the resident awake and	A 025		

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A 025	Continued From page 4 responsive, and reported to the Nurse what the daughter stated about the condition of the resident upon her arrival to the facility. Caregiver E stated, that she requested Caregiver C send Resident #1 to the hospital in front of the daughter, and the daughter refused, and stated watch her closely and see what happens. Caregiver E stated, she left the room with the daughter and the Nurse, still present. Caregiver E stated, she never witnessed Resident #1 refuse to go to the hospital. She stated, that she checked often throughout her shift to ensure the resident was okay, but no specific times were given for these checks after the daughter had left the facility the evening of . . . . . She stated, throughout the checks, Resident #1 was okay. Caregiver E expressed to the Nurse (Caregiver C) to keep an , on the resident and document, due to the daughter refusing to send her to the hospital for an assessment. Her last check was done at approximately 10:50PM on . . . . . right before her shift ended. The resident was lying in bed and was asked if she was okay and the resident responded, "yes". She turned out the lights and left the room. Staff E stated, she made sure that everyone on the oncoming shift (Staff A, B, D) were aware to keep a close , on the resident, due to her daughter reporting she was unresponsive earlier that day. Interview with Caregiver A by telephone on . . . . . at 10:38AM, she stated she arrived to work on . . . . . at 11:00PM. Upon her arrival, Caregiver A stated she was informed by Caregiver E that Resident#1 was not feeling well and to keep an on her. She stated,she questioned Caregiver C, the . . . Nurse on duty as to why the resident was not sent to the hospital, and she was told that the family stated not to send her to the hospital. Caregiver A	A 025		

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A 025	Continued From page 5 stated, she informed Caregiver C, that you are responsible for the resident not the family, and 911 or the doctor should have been called. Caregiver A stated, on at approximately 11:30PM, she went in to check on Resident #1. At this time, Resident #1 was laying on her . . . in the bed and sounded sleep and appeared to be sleeping. Caregiver A stated, she did not try to wake her or assess/arouse Resident #1; she felt uncomfortable about the report she got from Caregiver E regarding Resident #1. Therefore, she called for Caregiver B to assist her with Resident#1. Caregiver A stated, she didn't know, at that time, that Resident #1 was unresponsive . Caregiver A stated, she called Caregiver B to the room and called 911. Caregiver A was on the phone with Emergency Medical Services (.) and they asked if Resident#1 was a Do Not Resuscutate ( )? Caregiver B went to inquire if the resident had a on file and as she returned to the room, Emergency Medical Services ( ) had arrived. Caregiver A stated, she did not think the resident needed . , so that is why she did not start it. She was not aware that the resident was . . . until . . . arrived. arrived, and the resident was pronounced . . . by the Emergency Medical Technician (EMT). Caregiver A reported, no was initiated by Caregiver A or Caregiver B. When asked why was not initiated, Caregiver A stated she thought the resident was sleeping. Caregiver A stated, she knows what to do for residents in case of any emergency. Interview with Caregiver B by telephone on /019 at 12:00PM, revealed she was not aware of any issue with Resident #1 until she received a call on the two-way radio close to	A 025		

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A 025	Continued From page 6 12:00AM on [redacted] from Caregiver A requesting me to come to Resident#1's room. She stated, she told Caregiver A she was on break and told her to call Caregiver D. Caregiver B stated, Caregiver A called her again, and stated she could not reach Caregiver D on the two-way radio. At this time, I was told by Caregiver A to call 911, she did not say what the problem was, but was not sure if the resident was okay. Caregiver B stated, she does not remember exactly what was said. Caregiver B stated, she told Caregiver A to call from the resident's room, so that she could answer [redacted] questions. During this time, Caregiver B went to retrieve the resident's documents; since she was in Building #5, the location of the resident #1's file and the resident was in Building #4. At this time, she was not aware what was wrong with resident #1. During an interview with Resident #1's POA (her daughter) on [redacted] at 2:00PM, she stated on [redacted], the exact time was unknown, but the evening before the resident #1's [redacted], she had visited her mother at around 8:00PM, at the facility. She reported, her mother did not look good, could not complete sentences and was [redacted]. I requested Caregiver E call 911. My mother insisted sharply "Do Not Call", and said, I am not going to the hospital. The suggestion was made again to call 911, and my mother insisted that 911 not be called. My mother usually seemed [redacted], but insisted she was okay, she was not on any [redacted]. She seemed to be down or depressed, but she always says she is okay and refused to investigate anything. I was not aware of any medical issues leading up to her [redacted], but I do believe something was going on, but she did not want to address it. Record review of Resident #1's observation notes	A 025		

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A 025	Continued From page 7 dated . . . . . at 8:00PM, documented the following, "Resident is alert with . Family call, the nurse said her mom might have a . . Wants to order sample. Nurse called doctor, waiting for doctor to call . . . ". The observations notes failed to document the concerns and observations from the daughter regarding Resident #1 and the concerns voiced by Caregiver E and A on . . . . . . Furthermore, the records failed to indicate whether the facility Nurse (Caregiver C) had assessed the resident after being notified multiple times by Caregiver E and A of Resident #1 not feeling well, and unresponsiveness upon arrival of the daughter to the facility on the evening of . The facility failed to document the steps and procedures that would be implemented by staff to monitor and assess the resident throughout the night. Class I	A 025		
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	A 030		

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A 030	Continued From page 8 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 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	A 030		

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A 030	Continued From page 9 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 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	A 030		

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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 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 . . . . . .

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A 030	Continued From page 11 for health care services, the provision of or arrangement of transportation to health care [illegible], 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 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 [illegible], 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 [illegible], 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, [illegible], 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	A 030		

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A 030	Continued From page 12 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 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	A 030		

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A 030	Continued From page 13 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: Based on interview and record review, the facility failed to honor the rights of 1 of 3 sampled residents (Resident #1) by failing to perform ( ) on a nonresponsive resident who did not have a ( ) to withhold life sustaining treatment. The findings included: A review of the facility's Emergency Response Guideline policy, policy date and revised on , states the following. Purpose: Provide guidance on staff response to Resident emergencies that require intervention or treatment in an acute care setting. Examples of such emergencies include, but not limited to the following: , , , , Suspected , Severe , Severe reactions and Life-threatening changes in the Resident's medical status. General Information: Community Staff Access to Resident Documentation. Residents who have an executed may be identifiable by: * Yellow visual identifier (specify)_____ on the Resident's apartment nameplate * Yellow form in the Resident record * Yellow form placed in a binder in the community bus/vehicle * Yellow form placed in a binder located	A 030		

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A 030	Continued From page 14 near dining area Initial Response: 1. The first staff responder on the scene shall call the receptionist or another staff member (from the Resident's apartment/location) and let them know the location/nature of the emergency. 2. The Receptionist/staff member will contact 911 and a trained staff member. 3. In the event of or : a. Determine the Residents / Advanced Directive if possible and proceed accordingly. b) If the Residents status is unknown or does not have a order in place: *Initiate * Verify call to 911 initiated. *Instruct someone to bring if not present at the location of the incident. *The responder shall initiate use of device in accordance with the device guidelines and instructions. 4) The Receptionist/staff member should direct the emergency response team to the Resident's apartment/location. 5) Notify physician and family representative as soon as practicable. Review of documents submitted to the Agency for Health Care Administration by the facility on and regarding the events surrounding Resident #1's revealed the following. Caregiver A entered Resident #1's room and noticed that the resident's were off the side of the bed and her upper was lying on the bed. Caregiver A called Resident #1's name and received no response. Caregiver A touched the resident and found her warm. Caregiver A called for help from other Caregivers working on the shift which included Caregiver B and D by two-way radio and 911 emergency response was called. [Caregiver B] was the only	A 030		

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A 030	Continued From page 15 person that responded to [Caregiver A's] call for assistance. Caregiver A nor Caregiver B had performed on the resident. During an interview on at approximately 12:00PM, Caregiver A and B's certification cards were requested from the Administrator. It was noted that Caregiver A's card was expired. The Administrator provided a card for Caregiver A that was dated and expired on . At this time, the Administrator was provided an opportunity to provide current documentation. During an interview with the Administrator on at approximately 1:15 PM, the Administrator confirmed that Caregiver A and B had not performed or used the (Automated External) on Resident #1. She further stated, Caregiver A was terminated shortly after the incident and Caregiver B is still employed at the facility. During an interview with the Administrator on at approximately 2:15PM, the Administrator was unable to provide current documentation for Caregiver A. Review of Resident #1's file revealed, she was admitted to the Assisted Living Facility Unit on and came from the facility's Independent Living Unit. Resident #1 was a with diagnoses to include MCI (Mild), AR/MR (and Valve Regurgitation) and . The residents and behavioral status was noted as alert and oriented times three with forgetfulness. The resident was independent with all Activities of Daily Living.	A 030		

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A 030	Continued From page 16 Review of the facility's staffing schedule for the week of [redacted] through [redacted] revealed the following Caregivers (Direct Care Staff) were assigned to work at the facility on [redacted] and and were assigned as Caregivers for Resident #1. Caregiver C, was the Nurse on duty and Cargiver E was scheduled to work on [redacted] for the 3:00 PM to 11:00 PM shift. Caregiver A, B and D were assigned to work the 11:00 PM to 7:00 AM shift on [redacted] (starting on and ending on at 7:00 AM). During an interview with the Administrator on [redacted] at 11:00 AM, she confirmed the staffing hours and shifts for Caregivers A, B, C, D and E for [redacted] and [redacted] as documented on the schedule provided to the Surveyor. Interview with Caregiver A by telephone on [redacted] at 10:38AM, she stated she arrived to work on at 11:00PM. Upon her arrival, Caregiver A stated she was informed by Caregiver E that Resident#1 was not feeling well and to keep an [redacted] on her. She stated,she questioned Caregiver C, the Nurse on duty as to why the resident was not sent to the hospital, and she was told that the family stated not to send her to the hospital. Caregiver A stated, she informed Caregiver C, that you are responsible for the resident not the family, and 911 or the doctor should have been called. Caregiver A stated, on [redacted] at approximately 11:30PM, she went in to check on Resident #1. At this time, Resident #1 was laying on her in the bed and sounded sleep and appeared to be sleeping. Caregiver A stated, she did not try to wake her or assess/arouse Resident #1; she felt uncomfortable about the report she got from Caregiver E regarding Resident #1.	A 030		

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A 030	Continued From page 17 Therefore, she called for Caregiver B to assist her with Resident#1. Caregiver A stated, she didn't know, at that time, that Resident #1 was unresponsive. She called Caregiver B to the room and called 911. Caregiver A was on the phone with Emergency Medical Services ( ) and they asked if Resident#1 was a Do Not Resuscutate ( )? Caregiver B went to inquire if the resident had a on file and as she returned to the room, Emergency Medical Services ( ) had arrived. Caregiver A stated, she did not think the resident needed , so that is why she did not start it. She was not aware that the resident was until arrived. arrived, and the resident was pronounced by the Emergency Medical Technician (EMT). Caregiver A reported, no was initiated by Caregiver A or Caregiver B. When asked why was not initiated, Caregiver A stated she thought the resident was sleeping. Caregiver A stated, she knows what to do for residents in case of any emergency. Interview with Caregiver B by telephone on /019 at 12:00PM, revealed the following, she stated, on , she was not aware of any issue with Resident #1 until she received a call on the two-way radio close to 12:00AM on from Caregiver A requesting me to come to Resident#1's room. She stated, she told Caregiver A she was on break and told her to call Caregiver D. Caregiver B stated, Caregiver A called her again, and stated she could not reach Caregiver D on the two-way radio. At this time, I was told by Caregiver A to call 911, she did not say what the problem was, but was not sure if the resident was okay. Caregiver B stated, she does not remember exactly what was said. Caregiver B stated, she told Caregiver A to call from the resident's room, so that she could answer	A 030		

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questions. During this time, Caregiver B went to retrieve the resident's documents; since she was in Building #5, the location of the Resident #1's file and the resident was in Building #4. At this time, she was not aware what was wrong with Resident #1.

According to Caregiver B, once paperwork was gathered, she went to the resident's room and Caregiver A was inside the room in the doorway on the phone with 911/. . . . EMS asked if the resident was a . There was no sticker outside of door, and I was unable to get to the of the door, to check for the yellow form. I asked Caregiver A for the med cart keys (near Resident #1's room) to check the Medication Observation Record (MOR) for the . While at the med cart, security called me to say was here and I left to go down stairs to unlock the door. went upstairs, and I had to wait on an additional . . person that was coming. Once, the second person arrived they were allowed inside of the building and took the elevator and I took the stairs up to the resident's room. When I got . . . upstairs, . . was telling Caregiver A to call the Administrator. I called the Administrator, who informed me to call the police and the family. I never returned to the resident's room. I did not realize that was needed and that it had not been started. Caregiver B was questioned as to how, she would know a resident has a . Caregiver B stated, the documentation is kept on the . . . of the resident's door, MORs, the resident's chart, activity room, dining room, and transportation. It's all over the place.

During the event in question, Resident #1 was on the 2nd floor of Building #4. The facility has 1 primary nursing station located in Building #5 on

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A 030	Continued From page 19 the first floor. The facility has 1 for both buildings and the device is kept in Building #5 on the first floor outside of the nursing station. On the morning in question, after receiving the call from Caregiver A, Caregiver B retrieved Resident #1's documents from the nursing station in Building #5 prior to going to the resident's room, however, she did not obtain the machine. Review of the Emergency Medical Services ( ) report, indicated that was dispatched on at 1:07 AM. reached the residents beside at 1:15AM. The report documented, the resident was found down resting on her just off the side of the bed. The disposition was documented as, resident on scene, cool, pale, with lividity in both , and were fixed. The report does not indicate was in progress by the facility staff upon arrival. During an interview with the Administrator on at 1 PM, the surveyor requested documentation/evidence of steps the facility implemented to investigate the incident and circumstances surrounding Resident #1's and the Caregivers not seeking medical attention and performing on Resident #1. The following was noted. 1) The Administrator revealed the facility has written Emergency Response Guidelines dated: and revised . Staff were not in-serviced until , which was over a month after the incident Regarding Resident #1. Topics of the training included: Role of First Responder, (ASPEN Regulations), and Adverse Incident reporting. 2) Staff/Caregiver record review revealed Caregiver A, B, and D had all received	A 030		

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training within 30 days of hire. However, the staff had not received an updated in-service after the incident involving Resident #1. Facility Emergency Response Guidelines documents if status is unknown Initiate . However, this was not implemented for Resident #1.
3) According to the Administrator the facility purchased more two-way radios, and batteries to ensure two- way radios are charged at the start of each shift (no date given as to when this was completed). However, the facility does not have any policy or procedures for testing and maintaining the radios; to ensure failure of the communication system is not repeated as on regarding Resident #1. The facility was not able to demonstrate this step completely eliminated or resolved the problem. No reassessment of this step by the Administrator or Executive Director.
4) The Administrator stated that the facility ensured all Staff/Caregivers working on shift had current and Training. However, no proof of audit of the files or system implemented to ensure routine compliance was available.
5) The Administrator stated, weekly audits are completed by the Administrator and Caregiver F (a Nurse that helps with audits) to ensure policy and procedure are being followed and all residents information is documented in the policy related areas. The list was provided to the surveyor, however, no specific information was provided to verify when audits were completed, results of the audits or continued monitoring to ensure compliance.
6) The Administrator stated the facility will conduct Mock / Full Code Drill Protocol to be implemented . However, no drills were implemented prior to .
7) The Administrator stated, the facility will implement a Shift Change Communication Policy

Agency for Health Care Administration

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A 030	Continued From page 21 effective . . . . However, no shift change communication policy implement prior to . . . . The facility assessments and correction plan only started with surveyor intervention upon initiation of the survey. Facility has not thoroughly evaluated or assessed the circumstance based on review of their investigation form titled, Internal Investigatory Interview form: Employee interview for Caregiver A, B and D dated . . . . Which does not allow direct investigation of the incident based on responses of witnesses and those directly involved. The form also does not identify steps to prevent reoccurrence Class I	A 030		