STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

AHCA No. 2014011690

SUMMERVILLE 17, LLC d/b/a EMERITUS AT DEER CREEK,

Respondent.
_____/

FINAL ORDER

Having reviewed the Administrative Complaint, and all other matters of record, the Agency for Health Care Administration finds and concludes as follows:

1. The Agency issued the attached Administrative Complaint and Election of Rights form to the Respondent. (Ex. 1) The Election of Rights form advised of the right to an administrative hearing. The Respondent received the Administrative Complaint and Election of Rights form (Ex. 2), but did not timely file the Election of Rights form or other hearing request with the Agency Clerk. The Respondent thus waived the right to a hearing to contest the allegations and sanction sought in the Administrative Complaint. Cann v. Department of Children and Family Services, 813 So.2d 237 (Fla. 2d DCA 2002).

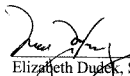
Based upon the foregoing, it is **ORDERED:**

2. The findings of fact and conclusions of law set forth in the Administrative Complaint are adopted and incorporated by reference into this Final Order.

3. The Respondent shall pay the Agency $10,000.00. If full payment has been made, the cancelled check acts as receipt of payment and no further payment is required. If full payment has not been made, payment is due within 30 days of the Final Order. Overdue amounts are subject to statutory interest and may be referred to collections. A check made payable to the "Agency for Health Care Administration" and containing the AHCA ten-digit case number should be sent to:

Central Intake Unit
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 61
Tallahassee, Florida 32308

ORDERED at Tallahassee, Florida, on this 31 day of August, 2015.



Elizabeth Dudek, Secretary
Agency for Health Care Administration

NOTICE OF RIGHT TO JUDICIAL REVIEW

A party who is adversely affected by this Final Order is entitled to judicial review, which shall be instituted by filing one copy of a notice of appeal with the Agency Clerk of AHCA, and a second copy, along with filing fee as prescribed by law, with the District Court of Appeal in the appellate district where the Agency maintains its headquarters or where a party resides. Review of proceedings shall be conducted in accordance with the Florida appellate rules. The Notice of Appeal must be filed within 30 days of rendition of the order to be reviewed.

CERTIFICATE OF SERVICE

I CERTIFY that a true and correct copy of this Final Order was served on the below-named persons by the method designated on this 31st day of August, 2015.

Richard J. Shoop, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308
Telephone: (850) 412-3630

Facilities Intake Unit Agency for Health Care Administration (Electronic Mail)	Central Intake Unit Agency for Health Care Administration (Electronic Mail)
Lourdes A. Naranjo, Senior Attorney Office of the General Counsel Agency for Health Care Administration (Electronic Mail)	Summerville 17, LLC 3131 Elliott Avenue Seattle, Washington 98121 (U.S. Mail)

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

AHCA No.: 2014011690
Return Receipt Requested:
7002 2410 0001 4240 1424

SUMMERVILLE 17, LLC d/b/a EMERITUS AT DEER CREEK,

Respondent.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW State of Florida, Agency for Health Care Administration ("AHCA"), by and through the undersigned counsel, and files this administrative complaint against Summerville 17, LLC d/b/a Emeritus at Deer Creek (hereinafter "Emeritus at Deer Creek"), pursuant to Chapter 429, Part I, Chapter 408, Part II, and Section 120.60, Florida Statutes (2014), and alleges:

NATURE OF THE ACTION

1. This is an action to impose an administrative fine of $10,000.00 pursuant to Sections 429.14 and 429.19, Florida Statutes (2014), for the protection of public health, safety and welfare.

JURISDICTION AND VENUE

2. This Court has jurisdiction pursuant to Sections 120.569 and 120.57, Florida Statutes (2014), and Chapter 28-106, Florida Administrative Code (2014).

3. Venue lies pursuant to Rule 28-106.207, Florida Administrative Code (2014).

EXHIBIT 1

PARTIES

4. AHCA is the regulatory authority responsible for licensure and enforcement of all applicable statutes and rules governing assisted living facilities pursuant to Chapter 429, Part I, Chapter 408, Part II, Florida Statutes (2014), and Chapter 58A-5 Florida Administrative Code (2014).

5. Emeritus at Deer Creek operates a 168-bed assisted living facility located at 2403 West Hillsboro Blvd., Deerfield Beach, Florida 33442. Emeritus at Deer Creek is licensed as an assisted living facility under license number 9401. Emeritus at Deer Creek was at all times material hereto a licensed facility under the licensing authority of AHCA and was required to comply with all applicable rules and statutes.

COUNT I

EMERITUS AT DEER CREEK FAILED TO PROVIDE APPROPRIATE CARE AND SERVICES TO MEET THE NEEDS OF RESIDENTS.

RULE 58A-5.01852(1), FLORIDA ADMINISTRATIVE CODE

(RESIDENT CARE/SUPERVISION STANDARDS)

CLASS I VIOLATION

6. AHCA re-alleges and incorporates paragraphs (1) through (5) as if fully set forth herein.

7. Emeritus at Deer Creek was cited deficient practice as the result of a complaint investigation survey that was conducted on October 23, 2014 through November 4, 2014 and November 7, 2014.

8. A complaint investigation survey was conducted on October 23, 2014 through November 4, 2014 and November 7, 2014. Based on interview and record review, it was

determined that the facility failed to provide appropriate care and services to meet the needs of 1 of 3 residents (Resident #1) while residing in the facility.

9. Record review revealed Resident #1 was admitted to the facility on 10/06/14 with diagnoses of Insulin Dependent Diabetes Mellitus (IDDM), Lewy Body Dementia, Glaucoma, and a history of Prostate Cancer. His AHCA 1823 Assessment form, dated 10/2/14, indicated he was alert to name and needed assistance with medical management and activities of daily living (ADL's). His record reflected he wore glasses and hearing aids.

10. The resident expired in the facility on 10/12/14. The resident resided in the facility 10/6/14-10/12/14.

11. His service plan was dated 9/29/14 pre-admission, and updated on 10/13/14 after he passed away, the form was unsigned. The form reflected he was alert, oriented to person, could make himself understood with clear ideas expressed, understood others, and could make safe decisions in familiar situations.

12. It reflected he was unable to identify the name of the facility and needed occasional reminders to find areas in the community.

13. An interview with the assigned Aide A on 10/28/14 at 3:04 PM was conducted and revealed the resident was able to make his needs known.

14. According to Aide A on 10/12/14 at 7:45 AM she entered his (Resident #1) room to provide morning care. She expressed the resident told her he felt as if he was having a heart attack and was guarding his side near his abdomen. He stated he did not feel well. She expressed she went and found the Med Tech and reported the resident's complaints to her. Aide A did not call 911. Aide A told the Med Tech to call 911. According to Aide A, she stated the Med Tech looked at the resident and indicated the pain was not in his chest area and made remarks

indicating if 911 was called it would pose a problem for her, and the family would be charged monies.

15. An interview with the Med Tech was conducted on 10/28/14 at 11:00 AM. The Med Tech stated she was told by Aide A the resident was not feeling well and she went to see him. She stated the resident nodded his head indicating he was ok and she gave him his medications at 8:00 AM. The record reflected he received Levothryoxine and Namenda. She did not call 911. She stated she was unable to find the nurse, however failed to provide details of steps she took to summon the nurse.

16. There was no evidence found the Med Tech attempted to page the nurse on duty at the time. There was no evidence Aide A attempted to summon the nurse either. There were no attempts made to notify the physician or the daughter.

17. The interview with Aide A on 10/28/14 at 3:04 PM revealed she proceeded to provide morning care and the resident was perspiring. She stated she assisted him in the bathroom to stand and he was perspiring profusely. She reported the resident was "clammy" to the Med Tech. The Med Tech denied the resident was clammy per interview. Aide A indicated she told the Med Tech to call 911 again.

18. There was no evidence found the staff attempted to summon the nurse at this time, nor call 911. The Resident was placed in the hallway in his wheelchair before 8:15 AM, according to Aide A.

19. An interview with the nurse on 10/29/14 at 8:30 AM revealed the nurse on duty arrived at the resident's room at 8:15 AM and performed an accu-check. The results were 137. There was no further assessment of the resident's condition performed. The nurse revealed the actual time she performed the accu-check was around 8:00AM-8:30AM. She was unaware the

resident complained to the staff about not feeling well feeling as if he was having a heart attack, and was perspiring. She stated no staff member notified her that the resident expressed concerns nor informed her he had been perspiring prior.

20. The nurse stated she was paged by the Med Tech at approximately 9:00 AM the resident was unresponsive in the dining room. She stated she was unable to get a pulse and respirations at that time. She stated when she arrived in the dining room the resident was "blue" and she could not elicit a response from him.

21. Further interview with Aide A on 10/28/14 at 3:04PM revealed she placed the resident outside his door after morning care in order for a staff member to transport him downstairs to the dining room for breakfast at 8:30 AM daily, as was customary. Aide A expressed the Med Tech usually transports the resident to the dining room. Aide A stated she did not transport the resident. The Med tech denied she transported the resident. She stated in interview on 10/28/14 at 11:00 AM, she transported another resident to the dining room, but was unable to supply the name of the resident she assisted to the dining room.

22. The facility did not determine which staff member transported the resident, and therefore was unable to determine the resident's clinical condition at that time. The facility's investigation suggested another resident instead of a staff member, transported Resident #1, however, the elevators are locked on the unit and only staff are able to open them for the residents.

23. The facility did not thoroughly investigate the events. Review of the facility's filed adverse report indicated the resident was transported to the dining room at 8:50 AM, however, there was no proof found to support this time as accurate. Aide A also revealed during the 10/28/14, 3:04 PM interview she did not believe the nurse completed the accu-check at 8:15

AM and said there was a discussion between her and the nurse regarding supplying a fictitious reading in an acceptable range. The nurse denied this conversation occurred.

24. Further interview with the Med Tech on 10/28/14 at 11:00AM revealed she told the kitchen staff to feed the diabetic residents first, as Resident #1 was diabetic. Aide B was present and commented to the staff in the dining room and to the Med Tech there was no need to feed the resident, as the resident was dead.

25. In an interview with Aide B on 10/28/14 at 2:40 PM, she stated the resident did not look well when he arrived in the dining room. She did not recall who transported him off the elevator when he arrived or what time he arrived. She expressed he was seated in his wheelchair at the table, with his head down and to the side. He was not slumped on the table as the adverse report documents. She stated she told the Med Tech, "Don't feed him, he is dead."

26. The Med Tech stated on 10/28/14 at 11:00AM the resident was unresponsive and she called the concierge to page the nurse. She did not call 911, nor did other staff. The Med Tech during the interview with the surveyor stated she told the concierge to call 911. The concierge validated during an interview with the Administrator on 10/29/14 at 11:12 AM, he was notified by the Med Tech to page the nurse at 9:00 AM. He denied the Med Tech asked him to call 911.

27. During further interview with the med tech as noted on 10/29/14 11:00 AM, the nurse on 10/29/14 at 8:30 AM and Aide A on 10/28/14 at 3:04 PM, revealed the following events regarding Resident #1 in the dining room. The nurse, as noted above, arrived in the dining room at approximately 9:00 AM and found Resident #1 unresponsive with no pulse or respirations and the resident's color was "blue."

28. She directed the Med Tech to take the resident up the elevator to his room via

wheelchair to initiate Cardiopulmonary Resuscitation (CPR). Staff were unaware of the resident's code status. She called 911 and retrieved the resident's chart from the nurse's station to determine his code status and went to his room on the second floor. The Med Tech summoned Aide A to assist her in the transport. Aide A stated she questioned the Med Tech why the resident was being removed in an emergency situation. The Med Tech revealed in her interview she realized this course of action was wrong after it occurred. The nurse stated to the surveyor she "lost her head" in making the right decision for a resident who may need CPR.

29. She expressed when she arrived in the dining room and saw the resident unresponsive she was upset with staff to the point of tears as she felt no one was intervening on behalf of the resident and were solely relying on her. She indicated she was covering the supervising nurse duties at the facility, along with the duties of a Med Tech on another unit in the facility, outside of the memory unit where Resident #1 resided and the incident occurred.

30. The nurse expressed when she arrived in the resident's room the paramedics were there assessing the resident. She informed them the resident had a Do Not Resuscitate Order in place. The paramedics contacted law enforcement. The concierge confirmed that both the paramedics and law enforcement arrived at the facility by 9:15 AM. CPR was not performed on the resident and he was pronounced dead by paramedics and law enforcement at 9:15 AM. The nurse reported that the law enforcement said that the body could be removed. The resident's record reflected upon death, his body was to be sent to a cremation provider.

31. An interview with the Resident's physician on 10/30/14 at 10:00 AM confirmed that the physician was not notified of the resident's complaints beginning at 7:45 AM on 10/12/14, but was made aware on 10/12/14 later in the day that the resident had expired. The physician stated he signed the death certificate himself, and attributed cause of death as

Atherosclerosis. He expressed he would have transferred the resident to the hospital for evaluation, if the clinical condition including the expression by the resident, about he felt he was having a heart attack would have been reported to him right away.

32. Review of the progress notes in the medical record recorded by the nurse of the events of 10/12/14 began when the resident was returned to bed. The notes did not contain information about his condition prior to 10/12/14 at 9:15 AM. There was no mention of the resident's condition or when and where he was actually found unresponsive. There was no mention that the staff transported him to the dining room for breakfast. The nurse stated she notified the Health and Wellness Director at home on 10/12/14.

33. An interview with the Administrator and Health and Wellness Director (HWD) beginning on 10/28/14 at 10:02AM and 10/29/14 at 3:00PM, indicated the facility does not have a system in place to review deaths occurring in the facility as part of Quality Assurance measures. The HWD confirmed that she was made aware that the resident expired at the facility on 10/12/14, Sunday, by the nurse. She expressed she was told the resident was found unresponsive in his room. The Administrator said that he was made aware of the death on 10/13/14. He said that he mentioned the resident's passing during a weekly telephone conference call with corporate staff the next day, 10/14/14.

34. He said that a corporate staff member arrived at the facility on 10/15/14 to investigate the case. The Administrator stated that he was informed by the corporate staff member that as a result of the corporate investigation it was mentioned about the resident being in the dining room for breakfast and that this should be looked into. This prompted him to investigate the details of the resident's death.

35. The Administrator, at this time, reported that his investigation revealed that Aide

A and the Med Tech had knowledge of the resident complaining of not feeling well and measures were not taken on their part to meet the needs of the resident, as noted above. He became aware Aide A and Med Tech were involved in transporting the resident back to his/her room while he was unresponsive. They did not provide the information until asked. He confirmed that the nurse did not reveal the entire account of the incident to administration until the death was under review.

36. Aide A stated on 10/28/14 at 3:04PM to the administration and to the surveyor during interview that she was pressured by the nurse, the Med Tech, and Aide B not to disclose that the resident went to breakfast and was returned to his room. The nurse denied this to the surveyor. Aide B did not report to administration what she observed on 10/12/14 until she was asked to disclose.

37. Aide A during the interview with the surveyor offered a voicemail cellphone message left on her personal phone to be heard. She stated she received the message after administration began questioning staff. The audible message revealed, "We have to say the same thing.about him coming down...doesn't know...didn't see him" Aide A stated that the message was sent to her by Aide B. The voice on the message was consistent with the voice of Aide B the surveyor heard during interviewing Aide B. Aide B was interviewed on 10/28/14 at 2:40 PM.

38. Aide A was interviewed by the surveyor on 10/28/14 at 3:04 PM. The HWD confirmed that Aide A, Aide B, the Med Tech, and the Nurse are mandatory reporters of neglect and did not bring complete information forward until asked.

39. The Administrator stated on 10/29/14 at 3:00PM, that the events of 10/12/14 constituted an adverse incident which he reported to the Agency for Health Care Administration on 10/17/14. He stated the nurse and Med Tech were suspended immediately, however, Aide A

and B were permitted to remain working in the facility.

40. During the survey, the nurse and Med Tech were not on duty, however, Aide A and Aide B were observed caring for the residents. When asked what preventative measures were put in place, the Administrator expressed he believed the situation was an isolated incident and two staff directly involved were removed. He stated that Aide A was permitted to remain on duty for "telling the truth" when asked.

41. The HWD expressed on 10/28/14 at 10:02AM, she was planning to in-service staff, but had not had a formal plan in place. She began providing in-services after surveyor intervention. She attributed it to the prior week spent completing the investigation.

42. The HWD began creating a formal in-service plan immediately after discussing the issue with the surveyor and in-serviced 22 staff members on 10/28/14. The topics included "CPR, DNR, Forms on Doors, Activating 911, and Initiating CPR" as documented on the sign-in sheets. On 10/28/14, after in-servicing 4 random 2PM-10PM staff members on duty were questioned about the in-service.

43. Record review showed 35 residents out of 152 had a Do Not Resuscitate (DNR) order in place. CPR training with current certification of direct care staff was reviewed and expired CPR training records were found. Aide A's CPR training record expired on 8/2012.

44. Based on the foregoing facts, Emeritus at Deer Creek violated Rule 58A-5.0182(1), Florida Administrative Code, herein classified as a Class I violation, which warrants an assessed fine of $5,000.00.

COUNT II

EMERITUS AT DEER CREEK FAILED TO ENSURE ACCESS TO ADEQUATE AND APPROPRIATE HEALTH CARE CONSISTENT WITH ESTABLISHED AND RECOGNIZED STANDARDS WITHIN THE COMMUNITY AS EVIDENCED BY FAILURE TO CALL 911 OR THE RESIDENT'S PHYSICIAN FOR A RESIDENT

COMPLAINING TO STAFF MEMBER HE MAY BE EXPERIENCING A HEART ATTACK.
SECTION 429.28, FLORIDA STATUTES
RULE 58A-5.0182(6), FLORIDA ADMINISTRATIVE CODE

(RESIDENT CARE/RIGHTS & FACILITY PROCEDURES STANDARDS)

CLASS I VIOLATION

45. AHCA re-alleges and incorporates paragraphs (1) through (5) as if fully set forth herein.

46. Emeritus at Deer Creek was cited deficient practice as the result of a complaint investigation survey that was conducted on October 23, 2014 through November 4, 2014 and November 7, 2014.

47. A complaint investigation survey was conducted on October 23, 2014 through November 4, 2014 and November 7, 2014. Based on interview and record review, it was determined that the facility failed to ensure access to adequate and appropriate health care consistent with established and recognized standards within the community, as evidenced by a failure to call 911 or the Resident's physician for a resident complaining to a staff member that he may be experiencing a heart attack for 1 of 3 residents reviewed, (Resident #1).

48. Record review revealed Resident #1 was admitted to the facility on 10/06/14 with diagnoses of Insulin Dependent Diabetes Mellitus (IDDM), Lewy Body Dementia, Glaucoma, and a history of Prostate Cancer. His AHCA 1823 Assessment form dated 10/2/14 indicated he was alert to name and needed assistance with medical management and activities of daily living (ADL's).

49. The resident expired in the facility on 10/12/14. The resident resided in the facility 10/6/14-10/12/14.

50. His service plan was dated 9/29/14 pre-admission, and updated on 10/13/14 after he passed away; the form was unsigned. The form reflected he was alert, oriented to person, could make himself understood with clear ideas expressed, understood others, and could make safe decisions in familiar situations.

51. It reflected he was unable to identify the name of the facility and needed occasional reminders to find areas in the community.

52. An interview with the assigned Aide A on 10/28/14 at 3:04 PM was conducted and revealed the resident was able to make his needs known.

53. According to Aide A on 10/12/14 at 7:45 AM she entered his (Resident #1) room to provide morning care. She stated that the resident told her he felt as if he was having a heart attack and was guarding his side near his abdomen. He stated he did not feel well.

54. She stated that she went and found the Med Tech and reported the resident's complaints to her. Aide A did not call 911. Aide A told the Med Tech to call 911. According to Aide A, she stated the Med Tech looked at the resident and indicated the pain was not in his chest area and made remarks indicating if 911 was called, it would pose a problem for her, and the family would be charged monies. The Med Tech did not call 911. The Med Tech designated to supervise the aide did not contact the nurse nor call the resident's physician.

55. An interview with the Med Tech was conducted on 10/28/14 at 11:00 AM. The Med Tech stated she was told by Aide A the resident was not feeling well and she went to see him. She stated the resident nodded his head indicating he was ok and she gave him his medications at 8:00 AM. The record reflects that he received Levothryoxine and Namenda. She did not call 911. She stated she was unable to find the nurse, however, failed to provide details of any steps she took to summon the nurse. There was no evidence found that the Med Tech

attempted to page the nurse on duty at the time. There was no evidence Aide A attempted to summon the nurse either. There were no attempts made to notify the physician or the resident's family member.

56. The interview with Aide A on 10/28/14 at 3:04 PM revealed she proceeded to provide morning care and the resident was perspiring. She stated she assisted him in the bathroom to stand and he was perspiring profusely. She reported the resident was "clammy" to the Med Tech. When the Med Tech was interviewed, Med Tech denied the resident was clammy. Aide A indicated she told the Med Tech to call 911 again. There was no evidence found that the staff attempted to summon the nurse at this time or call 911. The Resident was placed in the hallway in his wheelchair before 8:15 AM, according to Aide A.

57. An interview with the nurse on 10/29/14 at 8:30 AM revealed the nurse on duty arrived at the resident's room at 8:15 AM and performed an accu-check. The results were 137. There was no further assessment of the resident's condition performed. The nurse revealed the actual time she performed the accu-check was around 8:00AM-8:30AM. She was unaware the resident complained to the staff about not feeling well, feeling as if he was having a heart attack, and was perspiring. She stated no staff member notified her that the resident expressed concerns, nor informed her that he had been perspiring.

58. The nurse stated she was paged by the Med Tech at approximately 9:00 AM when she found the resident unresponsive in the dining room. She stated she was unable to get a pulse and respirations at that time. She stated when she arrived in the dining room the resident was "blue" and she could not elicit a response from him.

59. Further interview with Aide A on 10/28/14 at 3:04PM revealed, she placed the resident outside his door after morning care, in order for a staff member to transport him

downstairs to the dining room for breakfast at 8:30 AM, as was customary. Aide A expressed the Med Tech usually transports the resident to the dining room. Aide A stated she did not transport the resident. The Med tech denied she transported the resident.

60. When interviewed on 10/28/14 at 11:00 AM, the Med Tech stated that she transported another resident to the dining room, but was unable to supply the name of the other resident she assisted. The facility did not determine which staff member transported the resident, and therefore was unable to determine the resident's clinical condition at that time. The facility's investigation suggested another resident instead of a staff member transported Resident #1, however, the elevators are locked on the unit and only staffs are able to open them for the residents.

61. In an interview with Aide B on 10/28/14 at 2:40 PM, she stated that the resident did not look well when he arrived in the dining room. She did not recall who transported him off the elevator when he arrived or what time he arrived. She stated that he was seated in his wheelchair at the table with his head down and to the side. He was not slumped on the table as the adverse report documents. She stated she told the Med Tech, "Don't feed him, he is dead."

62. The Med Tech stated on 10/28/14 at 11:00AM, the resident was unresponsive and she called the concierge to page the nurse. She did not call 911, nor did other staff. During the interview with the surveyor, the Med Tech stated she told the concierge to call 911. The concierge confirmed during an interview with the Administrator on 10/29/14 at 11:12 AM, that he was notified by the Med Tech to page the nurse at 9:00 AM. He denied the Med Tech asked him to call 911.

63. During further interviews with the Med Tech as noted on 10/29/14 11:00 AM, the nurse on 10/29/14 at 8:30 AM and Aide A on 10/28/14 at 3:04 PM, revealed the following events

regarding Resident #1 in the dining room. The nurse, as noted above, arrived in the dining room at approximately 9:00 AM and found Resident #1 unresponsive with no pulse and he was not breathing and the resident's color was "blue." The nurse directed the Med Tech to take the resident up the elevator to his room in his wheelchair to initiate Cardiopulmonary Resuscitation (CPR).

64. Staff were unaware of the resident's code status. She called 911 and retrieved the resident's chart from the nurse's station to determine his code status, and went to his room on the second floor. The Med Tech summoned Aide A to assist her in the transport. Aide A stated she questioned the Med Tech why the resident was being removed in an emergency situation. The Med Tech revealed in her interview she realized this course of action was wrong after it occurred. The nurse stated to the surveyor she "lost her head" in making the right decision for a resident who may need CPR.

65. She expressed when she arrived in the dining room and saw the resident unresponsive, she was upset with staff to the point of tears, as she felt no one was intervening on behalf of the resident and were solely relying on her. The nurse stated that when she arrived in the resident's room, the paramedics were there assessing the resident. She informed them the resident had a Do Not Resuscitate Order in place.

66. An interview with the Resident's physician on 10/30/14 at 10:00 AM confirmed the physician was not notified of the resident's complaints beginning at 7:45 AM on 10/12/14, but was made aware on 10/12/14 later in the day that the resident had died. The physician stated he signed the death certificate himself, and attributed cause of death as Atherosclerosis. He expressed he would have transferred the resident to the hospital for evaluation if the clinical

condition including the expression by the resident about he felt he was having a heart attack, would have been reported to him right away.

67. Review of the progress notes in the medical record recorded by the nurse of the events of 10/12/14 began when the resident was returned to bed. The notes did not contain information about his condition prior to 10/12/14 at 9:15 AM. There was no mention of the resident's condition or when and where he was actually found unresponsive. There was no mention staff transported him to the dining room for breakfast. The nurse stated she notified the Health and Wellness Director at home on 10/12/14.

68. An interview with the Administrator and Health and Wellness Director (HWD) beginning on 10/28/14 at 10:02AM and 10/29/14 at 3:00PM, both confirmed that the staff should have called 911 immediately and notified the nurse. Both stated that the staff are trained to call 911 for a resident and any staff member is permitted and advised to do so.

69. Both the Administrator and HWD confirmed there were no attempts made to notify the physician. Both confirmed that the resident was denied access to 911 services, as well as direction from his physician. Measures should have been taken when the resident said he felt like he was having a heart attack.

70. During an interview on 10/29/14 at 3:00 PM, the HWD stated that Cardiopulmonary Resuscitation (CPR) can also be initiated on any resident by staff, and then withdrawn when the chart retrieved reveals a Do Not Resuscitate Order (DNR). She confirmed that staff would not have memorized whether a resident had a DNR, and would have to go to the nurse's station on the first floor in an attempt to find out.

71. She described the facility documents DNR orders on a list kept behind the nurse's station door on the first floor, as well as, each medical record contains the DNR as the first page

of the record. The outside binder of the record for a resident with a DNR contains a hand-drawn black circle to indicate to staff the DNR. She confirmed that this was the only place in the entire facility that DNR information could be obtained. She stated staff should have called 911, and then taken measures to determine code status.

72. The facility's policies and procedures were reviewed for CPR and DNR. The policies do not contain details regarding what steps need to be taken, including retrieving the resident's chart to check code status, as stated by the HWD, if a resident is found unresponsive. The facility consists of several floors and units as well as a locked memory unit where Resident #1 resided. Access to the units from the first floor is provided by elevators and stairs. The facility has a capacity to hold 168 residents. The census during the survey was 152. Thirty five (35) residents were found to have DNR orders.

73. Review of staff records revealed 22 direct care staff were not current with CPR training, including Aide A.

74. Based on the foregoing facts, Emeritus at Deer Creek violated Section 429.28 Florida Statutes and Rule 58A-5.0182(6), Florida Administrative Code, herein classified as a Class I violation, which warrants an assessed fine of $5,000.00.

CLAIM FOR RELIEF

WHEREFORE, the Agency requests the Court to order the following relief:

1. Enter a judgment in favor of the Agency for Health Care Administration against Emeritus at Deer Creek on Counts I and II.

2. Assess an administrative fine against Emeritus at Deer Creek based on Counts I and II for the violations cited above.

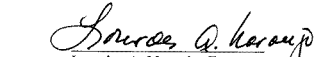
3. Assess costs related to the investigation and prosecution of this matter, if the Court finds costs applicable.

4. Grant such other relief as this Court deems is just and proper.

Respondent is notified that it has a right to request an administrative hearing pursuant to Sections 120.569 and 120.57, Florida Statutes (2014). Specific options for administrative action are set out in the attached Election of Rights. All requests for hearing shall be made to the Agency for Health Care Administration, and delivered to the ***Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, MS #3, Tallahassee, Florida 32308.***

RESPONDENT IS FURTHER NOTIFIED THAT THE FAILURE TO RECEIVE A REQUEST FOR A HEARING WITHIN TWENTY-ONE (21) DAYS OF RECEIPT OF THIS COMPLAINT WILL RESULT IN AN ADMISSION OF THE FACTS ALLEGED IN THE COMPLAINT AND THE ENTRY OF A FINAL ORDER BY THE AGENCY.

IF YOU WANT TO HIRE AN ATTORNEY, YOU HAVE THE RIGHT TO BE REPRESENTED BY AN ATTORNEY IN THIS MATTER



Lourdes A. Naranjo, Esq.
Fla. Bar No.: 997315
Assistant General Counsel
Agency for Health Care Administration
8333 N.W. 53rd Street, Suite 300
Miami, Florida 33166
305-718-5906

Copies furnished to:

Arlene Mayo-Davis
Field Office Manager
Agency for Health Care Administration
5150 Linton Blvd. – Suite 500
Delray Beach, Florida 33484

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by U.S. Certified Mail, Return Receipt Requested to Summerville 17, LLC, 3131 Elliott Avenue, Seattle, Washington 98121 on this 3rd day of June, 2015.

Lourdes A. Naranjo

Lourdes A. Naranjo, Esq.

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

RE: Summerville 17, LLC d/b/a Emeritus at Deer Creek **AHCA No: 2014011690**

ELECTION OF RIGHTS

This Election of Rights form is attached to a proposed action by the Agency for Health Care Administration (AHCA). The title may be **Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine** or **Administrative Complaint.**

Your Election of Rights must be returned by mail or by fax within 21 days of the day you receive the attached Administrative Complaint.

If your Election of Rights with your selected option is not received by AHCA within twenty-one (21) days from the date you received this notice of proposed action by AHCA, you will have given up your right to contest the Agency's proposed action and **a final order will be issued.**

(Please use this form unless you, your attorney or your representative prefer to reply according to Chapter120, Florida Statutes (2008) and Rule 28, Florida Administrative Code.)

PLEASE RETURN YOUR ELECTION OF RIGHTS TO THIS ADDRESS:

Agency for Health Care Administration
Attention: Agency Clerk
2727 Mahan Drive, Mail Stop #3
Tallahassee, Florida 32308.
Phone: 850-412-3630 Fax: 850-921-0158.

PLEASE SELECT ONLY 1 OF THESE 3 OPTIONS

OPTION ONE (1) ____ **I admit to the allegations of facts and law contained in the Administrative Complaint and I waive my right to object and to have a hearing.** I understand that by giving up my right to a hearing, a final order will be issued that adopts the proposed agency action and imposes the penalty, fine or action.

OPTION TWO (2) ____ **I admit to the allegations of facts contained in the Administrative Complaint, but I wish to be heard at an informal proceeding** (pursuant to Section 120.57(2), Florida Statutes) where I may submit testimony and written evidence to the Agency to show that the proposed administrative action is too severe or that the fine should be reduced.

OPTION THREE (3) ____ **I dispute the allegations of fact contained in the Administrative Complaint, and I request a formal hearing** (pursuant to Subsection 120.57(1), Florida Statutes) before an Administrative Law Judge appointed by the Division of Administrative Hearings.

PLEASE NOTE: Choosing OPTION THREE (3), by itself, is NOT sufficient to obtain a formal hearing. You also must file a written petition in order to obtain a formal hearing before the Division of Administrative Hearings under Section 120.57(1), Florida Statutes. It must be received by the Agency Clerk at the address above **within 21 days** of your receipt of this proposed administrative action. The request for formal hearing must conform to the requirements of Rule 28-106.2015, Florida Administrative Code, which requires that it contain:

1. Your name, address, and telephone number, and the name, address, and telephone number of your representative or lawyer, if any.
2. The file number of the proposed action.
3. A statement of when you received notice of the Agency's proposed action.
4. A statement of all disputed issues of material fact. If there are none, you must state that there are none.

Mediation under Section 120.573, Florida Statutes, may be available in this matter if the Agency agrees.

License type: _____(ALF? nursing home? medical equipment? Other type?)

Licensee Name: _____License number:_____

Contact person: _____
Name Title

Address: _____
Street and number City Zip Code

Telephone No. _____Fax No. _____Email(optional)_____

I hereby certify that I am duly authorized to submit this Notice of Election of Rights to the Agency for Health Care Administration on behalf of the licensee referred to above.

Signed: _____ **Date:**_____

Print Name:_____ Title:_____

SENDER: *COMPLETE THIS SECTION*

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Summerville 17, LLC

3131 Elliott Avenue

Seattle, Washington

98121

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X [signature] ☐ Agent ☐ Addressee

B. Received by *(Printed Name)* ROLLE HANSON C. Date of Delivery 6/6/15

D. Is delivery address different from item 1? ☐ Yes

If YES, enter delivery address below: ☐ No

3. Service Type

☒ Certified Mail ☐ Express Mail

☐ Registered ☐ Return Receipt for Merchandise

☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? *(Extra Fee)* ☐ Yes

2. Article Number *(Transfer from service label)* 7002 2410 0001 4240 1424

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

EXHIBIT 2