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
	AL11953279	A. BUILDING: _____ B. WING _____	01/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALMS OF PUNTA GORDA (THE)	2295 SHREVE STREET PUNTA GORDA, FL 33950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced complaint survey for complaint #2019018676 was conducted on . . . . . at The Palms of Punta Gorda, an assisted living facility in Punta Gorda, Florida. Complaint #2019018676 was substantiated at tag A0010 and A0025. The following is description of the deficiencies.	A 000		
A 010	429.26(&9) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (2) A physician, physician assistant, or nurse practitioner who is employed by an assisted living	A 010		

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A 010	Continued From page 1 facility to provide an initial examination for admission purposes may not have financial interest in the facility. (9) A [illegible] ill resident who no longer meets the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a [illegible]-to-[illegible] medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 59A-36.002, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days. (b) A resident requiring care of a [illegible] may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider,	A 010		

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A 010	Continued From page 2 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from the facility. (c) A . , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training.	A 010		

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A 010	Continued From page 3 (g) Continued residency criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review, staff and resident interview, the facility failed to issue a 45 day discharge notice to 1 (Resident #7) of 3 residents review for appropriateness of continued residency. Due to Resident #7's of over , , the facility is unable to meet residents needs if she . The facility does not have the capacity to lift the resident up off the floor if needed and needs to call outside help, such as the fire department to lift her up. The findings included: On at 10:53 a.m., in an interview with Resident #5, husband of Resident #7 who lives in the same room, said he does remember the incident his wife had when she tried to sit on her recliner, and she slid down and went to the floor. He said that he called for help and the staff came but said they could not pick her up. He said once the firemen came it took quite a few of them, they were able to get her up and into her recliner. Observation on at 11:40 a.m. revealed that Resident #7 was a large person who appeared to weigh well over , and she utlized a power chair. On at 11:40 a.m., in an interview with Resident #7, she said she did in her room before Christmas. She said she was in her recliner and she sat a little too close to the edge and the recliner tipped over onto her. She said she was so upset and embarrassed. She said her	A 010		

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A 010	Continued From page 4	A 010		

husband was in the room and called 911. The care givers came into the room, but they could not pick her up because of her . She said that her is over and it is hard for the staff. She said she does not want anyone getting hurt trying to help her. She said she was just so upset and when the firemen came there were only 2 of them and they had to call 2 other firemen so they could pick her up. She said that she was not hurt and did not go to the hospital they just put her in the chair

On at 1:55 p.m., in an interview with Resident Aide ( ) Staff R, she said that Resident #7 in her room sometime before Thanksgiving. Staff R said she was on duty at the time and the nurse told her that she went into the room and the resident was sitting on the floor with her to the recliner. Then the nurse called the lift assist and they came but they said we would have to help them lift her up and the nurse said we cannot help because some of us have issues with our backs. She said that she had problems. She said the resident was crying because she was embarrassed that she .

On at 4:05 p.m., the interim administrator said she has to be honest, she does not have the staff in the facility to pick Resident #7 off the floor if she , She said even when they did assist her the 2 other times that she they had 6 people and they had to use a sheet to get her up. She said most of the time the facility only has caregivers and a nurse in the whole facility.

On at 5:10 p.m., the director of nursing said she agreed with the interim administrator, the facility does not have the staff and the ability to lift Resident #7 off the floor if she and would need to call for outside help.

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A 010	Continued From page 5 Review of Resident #7's record on did not reveal any discharge notice. Class III	A 010		
A 025	429.26(7) FS; 59A-36.007(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. 59A-36.007 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 59A-36.012, 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 6 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 staff and resident interview, the facility failed to provide personal supervision for Resident #2 and keep an awareness of his general health, safety and physical and emotional well-being. The facility failed to maintain a general awareness of the resident's whereabouts which resulted in Resident #2 sustaining multiple injuries off property while intoxicated and using his motorized power chair. Resident #2 needed to be transferred to a higher level of care on 3 different occasions after injuries were sustained while operating his motorized power chair while intoxicated. The facility failed to put into place immediate measures after these incidents to intervene in Resident #2's unsafe and harmful behavior. No documented referrals were made to a treatment center or program for help with his known addiction. These systemic failures put this resident and others in imminent danger of being injured in the same way in the future.	A 025		

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A 025	Continued From page 7 The findings included: 1. Review of Resident #2's records showed he is a male with a known addiction. Resident #2 also has a diagnosis of , , , , , and , . The resident's medication record showed he was also receiving medication for memory loss, , , , , and , . 2. On at 10:46 a.m., in an interview with Resident #2, he said he is allowed to go off property in his motorized power chair. He said he is happy in the facility and he does not have any problems. Resident #2 said to the administrator that he will continue to go out of facility to drink. 3. Progress notes revealed the resident's history of being out of the facility on a motorized power chair and drinking and intoxication and a history of poor judgment and injury. The following facility progress notes show a history of Resident #2's risky unsafe behavior and injuries: On at 10:30 p.m., Resident returned to the facility on a motorized power chair. Resident was observed striking the front door very hard. Resident smelled very strongly of . Resident refused to alert nursing of where he had been since about 6:30 p.m. Resident began yelling rudely at staff when questioned. Resident said he wasn't hurt and refused a hospital evaluation for possible unknown injuries. On at 8:30 p.m., another resident reported Resident didn't sign out of the facility while a mortized power chair and was out for hours with another resident. Resident didn't sign out of the facility per staff's written note.	A 025		

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A 025	Continued From page 8 On , the police notified the facility Resident had a outside the facility. A resident's family member reported Resident was observed in the middle of an intersection laying in the road near CVS and Charlotte State Bank. Fire/Rescue was observed on premises at 4:50 p.m. A fireman's wife entered the facility asking for assistance in getting Resident in the building on his motorized power chair and he was refusing. She had witnessed someone picking the resident up off the roadway and called 911. The firemen followed Resident to the facility while the resident drove his motorized power chair. A rescue associate dressed skin on right after cleaning the . Emergency Medical Technicians (EMTs)/Rescue encouraged the resident to go to the hospital for evaluation several times and the resident refused. This writer also spoke with resident about a hospital evaluation and he continued to refuse. Resident did not sign out prior to leaving the facility. Resident was intoxicated on return to the facility per the administrator and director of nursing in an interview. On at 8 p.m., Resident returned from being out of the facility with a gauze wrapped . He explained he had tipped his motorized power chair and several of his had been cut. The areas were cleaned & dressed. When speaking with Resident, this writer noted his speech was slurred and he smelled of . An incident report that was filled out records while the resident was off facility grounds, he flipped his motorized power chair and cut several of his on the left . Resident was sent to Bayfront Hospital for evaluation and treatment. On at 7:30 p.m., Resident was observed	A 025		

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A 025	Continued From page 9 laying on his bed with . . . . on his sock and floor. Resident displayed slurred speech & refused to tell the writer what had happened. Resident may have been drinking . There was a light odor of . . . . in the room. 911 was called and the resident refused this writer to remove bloody stained sock on right . . . Emergency Medical Services ( ) came and the resident was taken to the hospital and did not return . . . to the facility until . On Resident was out of the facility with another resident since 2 p.m. and returned at 5 p.m. Resident was slurring his speech & smelled strange of . . . . when speaking with him. On at 4:45 p.m. the police notified the facility nurse the resident was taken by ambulance to the hospital after a . from his electric power chair in the vicinity of a local bar. Resident returned from the hospital with 2 to the right & inside arm (a little deeper). Per the emergency room nurse, the resident's level was 2.24. The national limit of a . . . . . concentration (BAC) of 0.08% or higher to be established as a federal standard to define legal intoxication. State of Florida has a 0.20 % limit. Per hospital nurse - resident's sister who is power of attorney (POA) was notified and she has concerns of the resident drinking . . . . , she was then directed to call the director of nursing (DON). On at 4:00 p.m., an aide reported Resident was suspected to be intoxicated, could smell on the resident as he entered the facility from an outing with the electric power chair. The Palms' director and nurse assessed the resident and observed him lying on the bed, very difficult to arouse. Resident was mumbling;	A 025		

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A 025	Continued From page 10 unable to answer questions. Emergency 911 was called and he was transported to the hospital. Resident returned later, about 8:30 p.m. with a diagnosis of intoxication. 4. Review of physician's progress notes revealed: On advanced registered nurse practitioner (ARNP) saw Resident. Note documents that resident had accident after ETOH (alchol) intake. ALF considering notice due to poor judgement. The ARNP states alert and oriented mostly. Document sensorium memory. On the facility notified physician and ARNP of resident not responding appropriately and mumbling words after returning from an outing on the electric power chair, notified that 911 was called. Response by physician and ARNP on to discontinue all medication ordered by him/her. Resident needs management. On follow up for medication management. Nursing reports resident is still consuming ETOH. Nursing reports he lost his . Resident has had several accidents with his electric power chair, was brought to the emergency room (ER) after falling from a concrete step while in the chair. Resident was alert and oriented mostly initially , then declined/refused to answer anymore questions. He said "I don't want to talk about it I have it under control." Assessment diagnosis: . ETOH . Resident is in denial, refuses to talk about his drinking. The facility is going to issue a 45 day notice due to the inability to keep him from drinking.	A 025		

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A 025	Continued From page 11 On [redacted] mental health progress note. Resident immediately indicated he wanted to stop therapeutic session. When asked why, he said he was disgusted to know the facility and providers were talking to him about his drinking and behaviors. He said every time there is an incident, they call my mom or sister and blow it out of proportion. Discussed risks of behavior and the resident stated, "I know what I have to do." Preventative actions were discussed. Consequences to these behaviors were discussed and the resident stated, "What's it to them." Managing the behaviors in a more responsible manner was discussed. Resident #2 stated, "I just don't feel I need to talk about it with anyone." Discussed self-awareness. On [redacted] the physician's progress note the ARNP [redacted] diagnosis by history resident has [redacted], [redacted], judgement [redacted], [redacted] secondary to ETOH use and intoxication. 5. A review of the policy regarding the use of motorized wheelchairs, carts, and scooters revealed it was signed by Resident #2 on [redacted]. Guideline #2: Resident must be able to demonstrate safe vehicle operation skills. 6. On [redacted] at 2:10 p.m., in an interview with the interim administrator she said they were aware since 2017 that Resident #2 was drinking and driving his motorized power chair and also taking other resident out with him. She said that Resident #2 has had a drinking problem for many years, but recently it has become much worse. She said they noticed this increase in drinking since [redacted], that he has been going out more and drinking and driving his electric power chair off property. The interim administrator said it has become a problem again and today the	A 025		

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A 025	Continued From page 12 resident said he would rather continue to go out when he drinks. She said the facility has not had a formal meeting with the resident about his drinking and operating his power chair while intoxicated and injuries he has sustained while doing so. She said the resident has not received a 45 day discharge notice. The interim administrator said there has been no conversations with the resident about alternative plans until today when she asked the resident if the doctor allowed him to have drinks in the facility, would he stop drinking and driving and he said he does not want that. 7. On at 5:10 p.m., in an interview with the director of nursing, she said she is aware of Resident #2's drinking off property and being injured while operating his electric power chair and forth to where he drinks. She said the resident has been talked to by his sister about his behavior of driving his power chair when he is drinking off property. She also said the mental health social worker has talked to the resident about his drinking and his behavior while operating his power chair while intoxicated. She said the facility has not been able to control this behavior. She acknowledged Resident #2 has also been known to take other residents off property. Class II	A 025		