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 _____	10/20/2020

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

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A 000	Initial Comments An unannounced complaint survey for complaint #2020016074 and #2020015979 was conducted on through at the Palms of Punta Gorda, an assisted living facility in Punta Gorda, Florida. Complaint #2020016074 and #2020015979 were substantiated at tag #0030 and tag #0152. A citation unrelated to the complaint was substantiated at tag #0055. The following is description of the deficiencies.	A 000		
A 030	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (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 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program,	A 030		

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A 030	Continued From page 1	A 030		

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 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident . . . . . , neglect, and , ;
6. Administrative and housekeeping schedules and requirements;
7. . . . . control, sanitation, and universal precautions; and,
8. The requirements for coordinating the delivery of services to residents by third party providers.
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone

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A 030	Continued From page 2 calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . . . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and 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	A 030		

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

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A 030	Continued From page 4	A 030		

facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.

(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

(2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the

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A 030	Continued From page 5 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 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by:	A 030		

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A 030	Continued From page 6 Based on resident and staff interview and observation, the facility failed to ensure that residents had access to the security code that allowed them to enter and exit the facility for 64 (Resident #1 - #64) out of 64 residents in the facility. Failure to promote a resident's right to move independently throughout the community allows for the arbitrary incarceration and denial of resident rights. Residents have the right to benefit from and to interact independently within their community. The facility failed to properly respond to resident grievances in relation to moving into another part of the facility. The facility failed to allow residents to use the pharmacy of their choice for 1 (Resident #4) out of 3 resident's pharmacy choice reviewed. The facility failed to provide a homelike environment. The findings included: Observation during an initial tour on at 9:20 a.m., found the dining room floor carpet area was stained by the #500 hallway. Observation of Resident #2 on at 9:40 a.m., found the resident's bed had no linens and the pillows were without pillowcases. The pillows were soiled. The room was full of clutter. At the time of observation Resident # 2 said the following: "They moved us here with out any notice. See, look at my bed. I have no linens. It's been like that for 4 days. I don't have any sheets. I don't have pillow cases. I have been sleeping in a bed without any sheets or pillow cases for days now. They don't do my bed. They don't help me. Look at me. I am in a scooter. I can't walk. So they don't help me to even do my bed. No I don't have the code to come in and out. You know what they	A 030		

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A 030	Continued From page 7 do? They change the codes all the time. They lock the front door at 5 p.m." Resident #3 said on at 10:05 a.m., "No they did not tell anyone that we are moving. She (implied the administrator) does not give us the code to go out. We are like prisoners here. They lock the front door at 5 p.m.,". Resident #3's room was full of clutter. No sheets and no pillow cases. Resident #4 said on at 10:30 a.m., "Here is the deal. Out of the blue they just took our staff and threw us here on the other side of the building. We don't have the code to go out. We just have the code to the smoking area. No we can not go out. She also locks the main door at 5:00 p.m. She (implied the administrator) came and told us we will switch to another pharmacy. I told her I don't want to switch to the other pharmacy. I did not fill out the form. I did not sign the consent. Then, I got a bill from the new pharmacy even though I never opt out to used them. That is a violation of resident rights. And as far as I know is a HIPAA violation. I am very upset about that. Because I made the mistake to complain she gave me a 45 days notice. If that is not retaliation I don't know what it is. Of course if you go and talk to her she will lie about everything. She has no consideration of any kind for any for us." Resident #4's room was cluttered with personal inventory. Resident #5 said on at 10:40 a.m.: "What can a say. They moved us without any notice. People were crying. Terrible. I don't have the code to go out. Only to the smoking area in the . And she (implied the administrator) is not allowing us to go out after 5:00 p.m. We used to go out. Not since she came in ."	A 030		

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A 030	Continued From page 8 Resident #6 said on . . . . . at 10:50 a.m.: "She (implied the administrator) did not give us the code. Before we used to go out all the time at the front. Now they have to open the door for us. After 5 p.m. there is no one here. You will knock and knock no one will open for you. She saying is for our safety. We have been here for years. We never had issues. Now it feels we are in prison." Resident #7 said on at 10 :59 a.m.: "She (implied the administrator) never listen to us. She just decided we needed to move. And here we go. No they did not tell us a thing. There was chaos. Residents were crying. No, I don't have the code to go out. And after 5:00 p.m.. Good luck. You wont be able to go out. Someone has to open the door for you. No one is there. The old good days we used to be out and about. We used to feed the rabbits and the birds. Not any more. She does not let us do that." During a confidential resident group interview on . . . . . at 11:00 a.m., multiple residents said they are intimidated by the administrator. They feel she does not want to listen to them. She is like a dictator. Out of fear of retaliation they do not say that much because she will give 45 day notice to who ever talks. She never listens to them. She never notified them of the move. She changed the codes. They are very upset they can not go out independently as they used to. They are not allowed to leave the facility after 5 p.m. and are locked in. Licensed Practical Nurse (LPN) A said on at 11:10 a.m., when asked if the residents had the code to go out said, "I don't think so, it changes all the time." "Maybe they do, I am not sure."	A 030		

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A 030	Continued From page 9 The administrator interview took place on at 11:50 a.m. She said every single one of the residents on the #500 hallway were given a two week notice prior to moving to the new area in the facility. She said before she made the move she called the Agency for Healthcare Administration (AHCA) and spoke to the supervisor who advised her she needed to ensure residents are safe and supervised. She said she talked to all the residents. She said the president of the resident council was notified and he was aware of the issues. She said the president did not allow anyone to come in when they had the meeting so they did not have the minutes. She said she had notifications of the move in residents' records and also notified their power of attorneys (POAS). The administrator acknowledged the residents could not freely go out of the building even though they were not deemed as being an elopement risk. She said it was a safety issue. She said she notified resident's case manager at the Medicaid provider program. She proceed providing the phone number. She said the reason the residents complain is because they don't like her. She said every time she goes to see them they use foul language towards her. She said they are upset because she has rules they have to follow. "They wanted me to let them do what ever they wanted. Smoke, drink, do drugs." The administrator acknowledged there was an error with Resident #4's medications. She said the error was corrected and a reimbursement was given for the bill the resident received. A phone call was placed to the Medicaid provider case manager on at 1:15 p.m. She said the move took place on . None of her 16 residents in the facility were aware of the move. She said the facility did not notify the residents.	A 030		

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A 030	Continued From page 10 She was not notified either. Residents were upset of the move and for the fact that they can not go out freely. On [redacted] at 6:06 p.m., the surveyor returned to the facility. No receptionist was on duty. The bell was rang to be let in. Medication Technician (med tech) Staff G answered the door. No residents were seated outside the front doors. Staff G said the receptionist leaves at 5 p.m., after that residents have to find staff to let them out. She said only 4 residents are allowed to go out: Resident #5, #9, #7 and #2. Day two the surveyor arrived on [redacted] at 7:18 a.m., knocking on the door. There was no answer. No one was at the front desk. Finally at 7:30 a.m., Licensed Practical Nurse (LPN) Staff G opened the door. She said the receptionist comes in at 9:00 a.m. She said she is here from 9 a.m. to 5 p.m. No one is here after. If residents need to go out they have to find one of the staff to let them out. She said the residents do not have the code to go out. A tour of #500 hallway on [redacted] at 8:05 a.m., found no toilet paper and paper towels in the bathrooms. Observed Housekeeper Staff E vacuuming the hallway. She said she was at #500 hallway yesterday. She said she does not do beds. The aides have to do that. Resident Care Coordinator Staff F said on [redacted] at 8:30 a.m., "No the residents do not have the code. They are all upset especially the ones that smoke. They used to come smoking up front. They don't like the new administrator because she has structure and rules. She told them they have to smoke in the [redacted]. They are upset they moved. They did not like that. I know	A 030		

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A 030	Continued From page 11 they don't have the code to go out. The receptionist lets them out. She is here 9 a.m. to 5 p.m.. No they do not have the code." A grievance on record dated [redacted], indicated multiple residents complained of the move. Per note on record, residents spoke with the administrator and residents accepted the move. The grievance resolution was not in agreement with residents interviews. The administrator said on the follow-up interview on [redacted] at 11:00 a.m., all residents agreed at the time with the move. They are just lying now. They manipulate the situation. The grievance regarding Resident #4's pharmacy choice issue indicated issues brought to the administrator's attention. Per the grievance the issue was resolved. Per the grievance Resident #4's information was provided to the new pharmacy per the resident agreement which stated: "if do not use the company preferred provider, I also understand that I will have the responsibility for reordering mediations but in the event the medications are not delivered within two days prior to depletion of my medication stock, the Company will reorder my mediations with the preferred pharmacy to ensure no disruption takes place. I agree to pay for the mediation and any associated service charges." Record review of Resident #4's agreement found he did not sign a contract that included the paragraph mentioned above. During an interview on [redacted]/0 at 10:57 a.m., the administrator confirmed Resident #4's contract was old and did not include the new language. Also, acknowledged there was no addendum on record. Furthermore, she could not provide evidence as of how the resident's medication was	A 030		

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A 030	Continued From page 12 depleted to two days since the resident was self-administering medications and they did not track his medication intake. She said the medications were filled out in error and the resident care coordinator contacted the pharmacy for the refund. A health assessment record review for all residents residing at the #500 hallway found that none of the residents were identified as elopement risk. Class II	A 030		
A 055	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for	A 055		

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	AL11953279	A. BUILDING: _____ B. WING _____	10/20/2020

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

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A 055	Continued From page 13 whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it	A 055		

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A 055	Continued From page 14 is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure medications are kept in a locked cabinet, locked cart or other locked storage area at all times. The findings included: On at 12:33 p.m., a medication cart was observed to be unattended and unlocked outside the nurse's station in the common area near the #200 hall. No staff was observed in sight of the medication cart. Licensed Practical Nurse Staff A was found inside the nurses station, she offered no explanation as to why the cart was left	A 055		

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A 055	Continued From page 15 unlocked and unattended. (photographic evidence obtained) On at 1:00 p.m., the Administrator said she would talk with the staff about locking the medication carts. Class III	A 055		
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate	A 152		

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A 152	Continued From page 16 keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe environment for residents in the facility by not providing a safe way for residents to enter or exit the facility independently. Failure to provide a safe and a secure environment for residents has a high likelihood of serious injury or harm. The findings included: During a resident group interview on at 11:00 a.m., with multiple residents from the 500 hallway at the smoking area, residents said they they were very upset they can not go out independently as they used too. They are not allowed to leave the facility after 5 p.m. The administrator's interview took place on at 11:50 am. She said she called the Agency for Healthcare Administration (AHCA) and spoke to the supervisor who advised her she needed to ensure residents are safe and supervised. She said the supervisor told her she did not have to give the residents the code in order to freely leave the premises. The administrator acknowledged the residents could not freely go out of the building even though they were not deemed as being an elopement risk.	A 152		

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A 152	Continued From page 17 She said it was a safety issue. She said the reason the residents complained is because they don't like her. She said every time she goes ... to see them they use foul language towards her. She said they are upset because she has rules they have to follow. She stated: "They wanted me to let them do what ever they wanted. Smoke, drink, do drugs." A phone call was placed to the Agency's area 8 office on ..... at 11:30 a.m. Supervisors said they never told the administrator not to give residents the code. They said absolutely no. They told her she must provide the residents the code in order for them to be able to independently go out. The administrator called the area 8 office again on ..... at 11:56 a.m., and told supervisors she had an alternative exit for all residents from the ... of the facility. The information was not provided to the surveyors during the course of the two day survey. The surveyors followed the administrator to the of the facility in the smoking area by hallway #500. She said that was the assigned exit for the residents. The following observation took place on ..... at noon. There was a ramp leading to a gravel/rocky area on one side and a ditch grassed area on the other side. No lighting was observed. The area was leading to a chain gate that was leading to the ... road of the old building's parking lot. The maintenance director the distance from the lanai to the front entrance to be about 1000 yards. The ramp bar was observed to be loose. The maintenance director acknowledged at the time of observation the ramp was loose and the door was supposed to be locked, but was found to be opened.	A 152		

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A 152	Continued From page 18 The administrator said they will expand the ramp and remove the gravel/rocks. In an interview with Resident #3 on at 12:10 p.m., about the administration's plans on expanding the ramp so they can use the exit as a way of leaving the facility, she stated: "Are you crazy? Who in the right mind will go that way. I will in a minute. There are rocks there and the ground is uneven." In an interview with Resident #4 on 12:15 p.m., Resident #4 stated, "Absolutely no. I am on a chair. I will and break my ." Resident #7 stated on at 12:19 p.m., "Let me ask you something. If you are in your house and you want to go out, how do you go out? Front door isn't it? This is my home. What makes you believe I want to go out that way? Don't you see the rocks?" Resident #6 stated on at 12:35 p.m., "Who's idea is this? We are old people here. We hardly can walk. No way. Absolutely not. That is my home. I live here. That's not fair. I have the right to go out. I am not in prison. I refuse to go out the way. It is not safe." Resident #8 stated on at 12:39 p.m., "No I am not going out that way. I am on a chair. I don't want to ." Class II	A 152		