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 _____	09/16/2021

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 #2021010610 was conducted on [redacted] to [redacted] at The Palms of Punta Gorda, an assisted living facility in Punta Gorda, Florida. The survey was completed in conjunction with 3 revisits. The complaint contained 4 allegations of which 3 were substantiated. Deficiencies remain, refer to ASPENs M6E711, and M89D13. The following is a description of the deficiencies. .	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. 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 must notify the resident's representative or designee of the need for health care services and must assist in making [redacted] for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition.	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 59A-36.007 Resident Care Standards. 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 independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure staffing was maintained and services were provided as needed on the evening and night shifts for 3 (Resident #3, #17, and #18) of 4 residents	A 025		

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A 025	Continued From page 2	A 025		

interviewed; further the facility had no staff documentation of resident care or significant changes as the documentation software was changed and all notes were lost.
On . . . . , the facility was recommended to staff the facility to meet the needs of the residents. This deficiency was uncorrected from . . . .
The facility must immediately increase staff to a minimum of 3 care staff on the evening and night shift, 1 for each section of the building.

The findings included:

1. Observation on at 5:30 a.m., revealed no staff answered the door. Upon entry, no staff was observed in the Summit section of the building. 1 staff was observed in the Valley section of the building, assist in 1 resident to the bathroom while leaving the bathroom door open to the hallway. 1 staff was also observed in the Meadows Section, which is Memory Care.

On . . . at 6:29 a.m., Resident #17 said there should be a male care giver on all shifts. The resident said they require the assistance of 2 people to safely use the bathroom and sometimes the female staff can not handle it and they have had because the single staff could not safely assist. Resident #17 said they often do not have the staff. Sometimes they have to go in a brief so the girls can change them in bed, due to lack of able assistance.

On at 7:00 a.m., Resident #3 said staffing is an issue as other places pay more. Staff are not replaced if they call off. The Resident Care Coordinator does not come in to help when staff call off.

On at 8:45 a.m., Resident #18 said she

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A 025	Continued From page 3 had to use the bathroom, and has been pressing the call button repeatedly for 30 minutes and no one had come. After surveyor intervention, staff came to assist the resident. On , the Census was 79, 24 on Summit Unit, 22 on Valley Unit, and 17 on Meadow Unit (secured memory care unit). A review of the . Resident Counsel minutes revealed residents were asking why some staff answered the call button immediately, and some never answer. The Executive Director responded that a respectful response time is 10 to 15 minutes, If longer than 15 minutes put in a grievance, so she would know who may be being On at 2:30 p.m., the Executive Director said she had been trying to schedule at least 3 staff on the night shift. When shown the "Punch Report" (report showing the times personnel clocked in and out) had 18 evening shifts from through without adequate staff, and the night shift had 25 nights without adequate staff, and included 5 nights with only 1 staff in house on the night shift she said she did not realize the actual counts. 2. On , a review of the record for Resident #19 revealed the resident was admitted on . There were no notes and no discharge notice. During the review, the Executive Director said the resident had called and sent herself to the hospital. She said the resident was able to care for herself, but refused to do anything for herself. She said the Hospital called her, but the resident did not want to return. The Executive Director said she worked with the Hospital toward placement. She verified that there was no	A 025		

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A 025	Continued From page 4 documentation of the resident's refusal to care for herself or why the resident went to the hospital. On , a review of discharged Resident #20's record revealed the resident was admitted on , and discharged on . The record contained 3 incident reports for disruptive behaviors. Also in the record was 1 letter dated which highlighted the inappropriate behaviors of the resident. On , a 45-day Notice of termination was given to Resident #20 due to behaviors. There were no other progress notes or documentation of actions leading to the termination or of disruptions to others. There was no documentation of why the resident was discharged on rather than allowed the 45-days of the notice. On at 6:30 p.m., the Resident Care Director said they had little to no documentation by staff in the resident files. She said the former management company was changed and they had not printed the notes/progress reports for anyone before it was removed. She said that some staff occasionally made a note, but had not been recording notes about the residents since sometime in . On at 7:15 p.m., the Executive Director verified the system used by the former management company was pulled and their software was taken . She verified the staff had not printed the records before the software was removed. Class II	A 025		
A 030	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures	A 030		

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A 030	Continued From page 5 59A-36.007 (5) 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, 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;	A 030		

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A 030	Continued From page 6 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 standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (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 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. 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	A 030		

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A 030	Continued From page 7 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 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	A 030		

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A 030	Continued From page 8	A 030		

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 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

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A 030	Continued From page 9 of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state 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	A 030		

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A 030	Continued From page 10 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: Based on record review, and interview, the facility failed to give 45 day notice, or immediate notice of discharge for 2 (Residents #19, and #20) of 3 residents reviewed for discharge. Failure to give the required notice of discharge results in a violation of resident rights and has denied Resident #19 her belongings. The findings included: 1. Resident # 19 was admitted to the facility on . On , she presented at the Hospital Emergency Department (ED) with , and diffuse . After work-up in the ED, she was "stable for transfer to her facility, although facility states they will not take the patient ." The patient was admitted to the	A 030		

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A 030	Continued From page 11 hospital until . . . . . , after case management located a facility to accept her. On at approximately 1:00 p.m., the Executive Director said Resident #19 wanted a , pill and when she could not get one she called 911. She verified she did not accept Resident #19 as she felt the resident's behaviors and refusal to do anything for herself made her inappropriate for the facility. She verified she had 1 conversation with the case manager, she did not provide a written 45-day or lesser notice, no physician had determined she needed a higher level of care, and the resident's belongings remained at the facility from . . . . . to . 2. Resident #20 was admitted to the facility on . . . . . Resident #20 was given a 45-day discharge notice on (to) due to repeated inappropriate behaviors. Resident #20 was on . On , the Executive Director said she would not allow him to return to the facility. The ED verified the 45-day notice had not expired yet, and further she had not given an immediate notice upon on . . . . or since. Class III	A 030		
A 079	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week	A 079		

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A 079	Continued From page 12	A 079		

0-5 168
212
16-25 253
26-35 294
36-45 335
46-55 375
56-65 416
66-75 457
76-85 498
86-95 539

For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week.
2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours.
3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.
4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night.
5. A staff member who has completed courses in First Aid and , , ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times.
a. Documentation of attendance at First Aid or courses pursuant to subsection

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A 079	Continued From page 13 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and [illegible]. 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least [illegible] must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled	A 079		

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	AL11953279	A. BUILDING: _____ B. WING _____	09/16/2021

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A 079	Continued From page 14 service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the	A 079		

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A 079	Continued From page 15 agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure staffing was maintained and services were provided as needed on the evening and night shifts for 3 (Residents #3, #17, and #18) of 4 residents interviewed. On . . . . . the facility was recommended to staff the facility to meet the needs of the residents. This deficiency was uncorrected from . The facility must immediately increase staff to a minimum of 3 care staff on the evening and night shift, 1 for each section of the building. The findings included: Observation on . . . at 5:30 a.m., revealed no staff answered the door. Upon entry, no staff was observed in the Summit section of the building. 1 staff was observed in the Valley section of the building, assist in 1 resident to the bathroom while leaving the bathroom door open to the	A 079		

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A 079	Continued From page 16	A 079		

hallway. 1 staff was also observed in the Meadows Section, which is Memory Care.

On at 6:29 a.m., Resident #17 said there should be a male care giver on all shifts. The resident said they require the assistance of 2 people to safely use the bathroom and sometimes the female staff can not handle it and they have had . . because the single staff could not safely assist. Resident #17 said they often do not have the staff. Sometimes they have to go in a brief so the girls can change them in bed, due to lack of able assistance.

On . . at 7:00 a.m., Resident #3 said staffing is an issue as other places pay more. Staff are not replaced if they call off. The Resident Care Coordinator does not come in to help when staff call off.

On . . . . at 8:45 a.m., Resident #18 said she had to use the bathroom, and has been pressing the call button repeatedly for 30 minutes and no one had come. After surveyor intervention, staff came to assist the resident.
Record review of the staffing schedule and "Punch Report" (report of the times personnel clocked in and out for the period of /21) revealed.

Evening shift from 3:00 p.m. to 11:00 p.m. revealed:
. . . . . - 1 staff on full shift, and 1 staff from 4:15 p.m. to 9:10 p.m., there was not 1 caregiver for each of the 3 sections. No male on shift.
- 1 staff on full shift, and 1 staff from 5:00 p.m. to 9:05 p.m., there was not 1 caregiver for each of the 3 sections. No male on shift.
. . . . . - 2 staff on full shift, there was not 1 caregiver for each of the 3 sections. No male on

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A 079	Continued From page 17 shift. - 2 staff on full shift and 1 staff on 5:00 p.m. to 9:00 p.m., there was not 1 caregiver for each of the 3 sections. No male on shift. - 2 staff on full shift, and 1 staff from 3:00 p.m. to 7:00 p.m. and another staff from 3:00 p.m. to 9:00 p.m., there was not 1 caregiver for each of the 3 sections after 9:00 p.m. - 2 staff on full shift, and 1 staff from 5:00 p.m. to 9:00 p.m., there was not 1 caregiver for each of the 3 sections. No male on shift. - 2 staff on full shift, and 1 staff from 3:00 p.m. to 7:00 p.m. and another staff from 5:00 p.m. to 9:00 p.m., there was not 1 caregiver for each of the 3 sections after 9:00 p.m. - 1 staff on full shift, and 1 staff from 3:00 p.m. to 7:00 p.m. and 1 other staff from 5:00 p.m. to 9:05 p.m., there was not 1 caregiver for each of the 3 sections. No male on shift. - 2 staff on full shift, and 1 staff from 3:00 p.m. to 8:30 p.m., there was not 1 caregiver for each of the 3 sections after 8:30 p.m. - 2 staff on full shift, and 1 staff from 5:00 p.m. to 9:00 p.m., there was not 1 caregiver for each of the 3 sections. - 2 staff on full shift, and 1 staff from 5:00 p.m. to 9:00 p.m., there was not 1 caregiver for each of the 3 sections. No male on shift. - 2 staff on full shift and 1 staff on 3:00 p.m. to 7:36 p.m., there was not 1 caregiver for each of the 3 sections after 7:36 .m. No male on shift. - 2 staff on full shift and 1 staff on 5:00 p.m. to 9:13 p.m., there was not 1 caregiver for each of the 3 sections after 9:13 p.m. - 2 staff on full shift and 1 staff on 5:00 p.m. to 9:28 p.m., there was not 1 caregiver for each of the 3 sections after 9:28 p.m. - 2 staff on full shift and 1 staff on 5:00 p.m. to 9:32 p.m., there was not 1 caregiver for	A 079		

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A 079	Continued From page 18 each of the 3 sections after 9:32 p.m. No male on shift. . . . . . - 2 staff on full shift, there was not 1 caregiver for each of the 3 sections. No male on shift. - 2 staff on full shift and 1 staff on 5:00 p.m. to 9:00 p.m., there was not 1 caregiver for each of the 3 sections after 9:00 p.m. . . . . . - 2 staff on full shift and 1 staff on 5:00 p.m. to 9:00 p.m., there was not 1 caregiver for each of the 3 sections after 9:00 p.m. - 2 staff on full shift and 1 staff on 5:00 p.m. to 9:00 p.m., there was not 1 caregiver for each of the 3 sections after 9:00 p.m. No male on shift. - 2 staff on full shift and 1 staff on 5:00 p.m. to 9:00 p.m., there was not 1 caregiver for each of the 3 sections after 9:00 p.m. No male on shift. Night shift from 11:00 p.m. to 7:00 a.m. revealed: . . . . . - 1 staff on full shift, there was not 1 caregiver for each of the 3 sections. No male on shift. - 2 staff on full shift, there was not 1 caregiver for each of the 3 sections. - 1 staff on full shift, there was not 1 caregiver for each of the 3 sections. - 1 staff on full shift, there was not 1 caregiver for each of the 3 sections. - 2 staff on full shift, there was not 1 caregiver for each of the 3 sections. No male on shift. . . . . . - 1 staff on full shift, there was not 1 caregiver for each of the 3 sections. . . . . . - 1 staff on full shift, there was not 1 caregiver for each of the 3 sections. . . . . . - 2 staff on full shift, there was not 1 caregiver for each of the 3 sections.	A 079		

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A 079	Continued From page 19 . . . . . - 2 staff on full shift, there was not 1 caregiver for each of the 3 sections. . . . . . - 2 staff on full shift, there was not 1 caregiver for each of the 3 sections. . . . . . - 2 staff on full shift, there was not 1 caregiver for each of the 3 sections. . . . . . - 2 staff on full shift, there was not 1 caregiver for each of the 3 sections. No male on shift. . . . . . - 2 staff on full shift, there was not 1 caregiver for each of the 3 sections. . . . . . - 2 staff on full shift, there was not 1 caregiver for each of the 3 sections. . . . . . - 2 staff on full shift, there was not 1 caregiver for each of the 3 sections. No male on shift. . . . . . - 2 staff on full shift, there was not 1 caregiver for each of the 3 sections. . . . . . - 2 staff on full shift, there was not 1 caregiver for each of the 3 sections. . . . . . - 2 staff on full shift, there was not 1 caregiver for each of the 3 sections. . . . . . - 2 staff on full shift, there was not 1 caregiver for each of the 3 sections. No male on shift. . . . . . - 2 staff on full shift, there was not 1 caregiver for each of the 3 sections. . . . . . - 2 staff on full shift, there was not 1 caregiver for each of the 3 sections. . . . . . - 2 staff on full shift, there was not 1 caregiver for each of the 3 sections. No male on shift	A 079		

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A 079	Continued From page 20 On .. . . . , the Census was 79, 24 on Summit Unit, 22 on Valley Unit, and 17 on Meadow Unit (secured memory care unit). A review of the . . . . . Resident Counsel minutes revealed residents were asking why some staff answered the call button immediately, and some never answer. The Executive Director responded that a respectful response time is 10 to 15 minutes, If longer than 15 minutes put in a grievance, so she would know who may be being . , . . Under Miscellaneous Announcements a) Reminder - Between the hours of 5pm and 9am, the time the front desk is not staffed, if you need assistance you can call (941) - 833 - 6891. On at 2:30 p.m., the Executive Director said she had been trying to schedule at least 3 staff on the night shift. When shown the "Punch Report" had 18 evening shifts from . . . through without adequate staff, and the night shift had 25 nights without adequate staff, and included 5 nights with only 1 staff in house on the night shift she said she did not realize the actual counts. Class II	A 079		
A 093	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No	A 093		

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A 093	Continued From page 21 =Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the	A 093		

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A 093	Continued From page 22 seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of _____ the time between meals. (g) Food must be served attractively at safe and	A 093		

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A 093	Continued From page 23 palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . . . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on . . at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the food was served attractively at safe and palatable temperatures for 2 of 2 meals observed. The findings included: 1. On at 6:29 a.m., Resident #17 said the food is terrible. Scalloped potatoes are not cooked through, fries not baked through and . Food is not cut up when it is supposed to be. Toasted is not toasted and you are lucky to get butter on it. Breakfast is eggs and pancakes. There have been a lot of sandwiches lately and not hot meals. Also getting a lot of plain rice with nothing on it. We do not get condiments as they (facility staff) are saying you need to have your own condiments for any food. On at 7:00 a.m., Resident #3 said the food is reasonable but the Culinary Director does not	A 093		

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A 093	Continued From page 24 cook vegetables well. He over cooks them. Resident #3 said it is a quality of food issue most of the time. Resident #3 said he asked the Culinary Director about overcooking the vegetables, and the response was that the Culinary Director "likes mushy vegetables." Resident #3 said, "Staff do not eat meals here. I think that says a lot." 2. On at 8:05 a.m., the last of the food was being plated into white Styrofoam containers for delivery. A test meal was requested. The last 5 meals were passed at 8:14 a.m. The test tray was sampled at 8:15 a.m. and revealed the scrambled eggs were 98 degrees and were not warm, the sausage was 114 degrees, slightly warm to taste. and the oatmeal was 105 degrees, slightly warm with warm milk." Hot food is to be served at 145 degrees and should drop no lower that 135 at service. On at lunch, the closed hot cart left the kitchen at 12:00 p.m. It arrived at the Valley Unit activity area at 12:01 p.m.. The hot cart was not plugged into a socket to continue the warming. The drink cart arrived at 12:09 p.m. At 12:10 p.m., 15 covered plates and 1 test tray were removed from the hot cart and taken to Meadow Unit memory care. Memory Care census was 17 residents, 2 meals were missed. At 12:36 p.m., all resident were served, but the 2 waiting for the missed meals. The test tray revealed the breaded meat patty was 122 degrees, and warm with good flavor. The noodles were 119 degrees, over cooked with hard edges, and rubbery to taste. The green beans were 122 degrees, barely warm, very mushy, and falling apart.	A 093		

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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 093	Continued From page 25 On .. ... at 12:38 p.m. in the Valley dining room, 14 meals had been served, 5 meals refused by residents; the cart had 2 extra plates on it. By 12:57 p.m. the last person came to the dining room to be served. The test tray revealed the breaded meat was 120 degrees, barely warm with good flavor, the noodles were 122 degrees, barley warm with hard edges and tasted very bland. Green beans were 129 degrees, warm but very mushy and falling apart. The juice was 54 degrees, and cool not ... . On .. ... at 1:14 p.m., the temperatures were reviewed with the Culinary Director and the Executive Director. The Culinary Director said there is no where to plug the hot box in and they would have to have a plug wired to support the hot box. He verified the plates were covered but lacked any heat source to maintain temperatures. The Culinary Director supplied a temperature log which showed the temperatures for the lunch items were above 170 degrees when cooked. 3. A review of the Resident Council minutes for ... revealed, "Breakfast carts are not keeping food at serving temperatures. A: [answer] Old issue. Ordered a special plug for the hot box and will have to rewire a wall socket." The need for the hot box to maintain temperatures was discussed 90 days prior to the complaint survey and had still not been obtained and installed. Resident Counsel minutes for .... revealed, "e. Culinary Services i) People buy their own food and drinks. Was in hospital for three months, and food was never ." Class III .	A 093		