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
	AL11969144	A. BUILDING: _____ B. WING _____	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALM VIEW AT GULF COAST VILLAGE	1433 SANTA BARBARA BLVD CAPE CORAL, FL 33991

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A 000	Initial Comments An unannounced complaint survey for #2023017429 was conducted on [redacted] at Palm View at Gulf Coast Village, an assisted living facility in Cape Coral, Florida. Complaint #2023017429 was substantiated at A 031 and A 076. The following is a description of the deficiencies.	A 000		
A 031 SS=D	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, [redacted], and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the [redacted] resident's needs.	A 031		

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A 031	Continued From page 1 (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition and response to treatment or services ordered by the physician which may impact the resident's appropriateness for continued residency in the facility; 2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and 3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition. 4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3. (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection.	A 031		

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A 031	Continued From page 2 This Statute or Rule is not met as evidenced by: Based on interview, and record review, the facility failed to coordinate with Hospice staff to ensure two residents (Resident #1 and #2) of three residents surveyed with a illness and receiving hospice services and their representatives were properly informed of their rights and were able to self-determine and ensure a properly executed was in place according to the residents/representatives wishes. The failure of the facility to coordinate advanced directive choices of resident caused Resident #1 who had a form 1896 signed by her representative and her physician to have initiated after she had expired. The lack of coordination of advanced directive care caused Resident #2's court appointed guardian to not be informed of Resident #2's condition and his right as the health care surrogate to sign and initiate a for the resident. Findings included: 1. According to the facility policy " ( )" effective , "(b) On admission the Assisted Living Nurse Manager/Designee reviews with the resident their Code status Preferences. If the resident chooses to be a the DH form 1896 is completed and a copy is placed in the front of the resident's chart". The current policy does not address when residents are admitted to Hospice services and are diagnosed with a illness. There is no current policy on who is responsible to ensure a properly executed Form 1896 is on the resident's chart per the resident/representatives wishes.	A 031		

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A 031	Continued From page 3 A witness statement written by Licensed Practical Nurse, Staff A dated at 9:15 a.m. shows that on at approximately 2:45 p.m. Resident #1 was found "unresponsive". The statement shows Staff A called her supervisor Registered Nurse Staff C. The statement documents there was a copy of a DH Form 1896 on Resident #1's chart that was blank. Staff A documents Resident #1 was moved to the floor and was started. Staff A does not document when Emergency Medical Services ( ) were notified, but her statement shows did arrive at the facility. On at 11:15 p.m., the Executive Director (ED) stated Resident #1 was found unresponsive and pulseless. She stated Resident #1 had a that had been signed by the resident's representative and the Hospice physician. The ED stated when Hospice services were initiated on for the resident, her Hospice Nurse had assisted the resident in obtaining a . According to the ED, a copy of the was never given to facility staff. The ED verified there had been no contact with Hospice staff regarding the DRNO status of Resident #1. 2. On at 11:25 a.m., the ED stated Resident #2 was receiving Hospice Services but was not a . The ED stated Resident #2 had been deemed , and had a court appointed guardian. The ED said the guardian had to go through the court to be able to sign Resident #2's . The ED verified at that time the guardian was Resident #2's health care surrogate and able to sign for the resident's Hospice services. The ED stated there had been no discussion from the facility with Hospice staff or the resident regarding his status.	A 031		

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A 031	Continued From page 4 On . . . . . at 12:50 p.m., the Hospice Social Worker said she had personally spoken with Resident #2's court appointed guardian and he had told her he could not sign the resident's . . without going through the court first. On . . . . . at 12:59 p.m. Resident #2's court appointed guardian was asked if he understood Resident #2 had a . . . . illness. He stated he was not aware Resident #2 had a medical diagnosis that made him . . . . The guardian said he was not aware that residents could not receive services from Hospice unless the resident had a 6-month expected illness. The Guardian said he was never shown the . form 1896 that had a check off box for the court appointed guardian to sign. When asked what his wishes for Resident #2 would be if the resident stopped breathing, the guardian responded he would want Resident #2 to be a .	A 031		
A 076 SS=D	59A-36.009 FAC . . . . . ( ) (1) POLICIES AND PROCEDURES. (a) Each assisted living facility must have written policies and procedures that explain its implementation of state laws and rules relative to ( ). An assisted living facility may not require execution of a as a condition of admission or treatment. The assisted living facility must provide the following to each resident, or resident's representative, at the time of admission: 1. Form SCHS- , "Health Care Advance Directives - The Patient's Right to Decide," , . . . , or with a copy of some other substantially	A 076		

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A 076	Continued From page 5 similar document, which incorporates information regarding advance directives included in chapter 765, F.S. Form SCHS- . . . . is available from the Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 34, Tallahassee, FL 32308 or the agency's website at: http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/HC_Advance_Directives/docs/adv_dir.pdf; and, 2. DH Form 1896, Florida . . . . Form, ... , 2004, which is hereby incorporated by reference. This form may be obtained by calling the Department of Health's toll free number 1(800)226-1911, extension 2780 or online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04005. (b) There must be documentation in the resident's record indicating whether a DH Form 1896 has been executed. If a DH Form 1896 has been executed, a yellow copy of that document must be made a part of the resident's record. If the assisted living facility does not receive a copy of a resident's executed DH Form 1896, the assisted living facility must document in the resident's record that it has requested a copy. (c) The executed DH Form 1896 must be readily available to medical staff in the event of an emergency. (2) LICENSE REVOCATION. An assisted living facility's license is subject to revocation pursuant to section 408.815, F.S., if, as a condition of treatment or admission, the facility requires an individual to execute or waive DH Form 1896. (3) . . . . PROCEDURES. Pursuant to section 429.255, F.S., an assisted living facility must honor a properly executed DH Form 1896 as follows: (a) In the event a resident experiences . . . . . or	A 076		

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A 076	Continued From page 6 , staff trained in , ( ) or a health care provider present in the facility, may withhold (and). (b) In the event a resident is receiving hospice services and experiences or , , facility staff must immediately contact hospice staff. The hospice procedures take precedence over those of the assisted living facility. This Statute or Rule is not met as evidenced by: Based on interview, and record review, the facility failed to ensure staff responsible were educated in the facility policy to immediately contact hospice staff when a resident experienced while receiving hospice services. The failure of the facility to contact hospice staff caused one resident of one residents surveyed (Resident #1) to not have a honored as per the patient/representative's wishes. Findings included: 1. According to the facility policy: " (.)" effective , "(b) Procedures: ...(b) In the event a resident experiences or , , our agency, community will immediately contact hospice staff. The hospice procedures take precedence over those of [the facility]". A witness statement written by Licensed Practical Nurse Staff A dated at 9:15 a.m. shows on at approximately 2:45 p.m. Resident #1 was found "nonresponsive". The statement shows Staff A called her supervisor Registered	A 076		

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A 076	Continued From page 7 Nurse Staff C. The statement documents there was a copy of a DH Form 1896 on Resident #1's chart that was blank. Staff A documents Resident #1 was moved to the floor and , , was started. Staff A does not document when Emergency Medical Services ( ) were notified, but her statement shows did arrive at the facility. On at 11:15 p.m., the Executive Director (ED) stated Resident #1 was found unresponsive and pulseless. She stated Resident #1 had a that had been signed by the resident's representative and the Hospice physician. The ED stated when Hospice services were initiated on for the resident the Hospice Nurse had assisted the resident in obtaining a . According to the ED, a copy of the was never given to facility staff. The ED verified there had been no contact with Hospice staff regarding the DRNO status of Resident #2. On at 11:36 a.m., Licensed Practical Nurse Staff A verified that on 11/27/23 at approximately 2:45 p.m. she found Resident #1 unresponsive and in . Staff A said she immediately called the supervisor who responded in 2 to 3 minutes, and they initiated on Resident #1 when they could not find a copy of the in the resident's chart. Staff A verified she was aware Resident #1 was receiving hospice services. Staff A said she was not aware of the facility policy to call hospice staff immediately when a hospice resident is found in . On at 12:00 p.m., Unit Supervisor Staff C verified she was called to Resident #1's room on at approximately 2:45 p.m. and found Resident #1 unresponsive and pulseless. There	A 076		

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A 076	Continued From page 8 was no DRNO on the chart. They called 911 and started . Staff C said she was aware at the time Resident #1 was receiving hospice services. She stated she was not aware of the policy to contact hospice services immediately when a hospice resident is found in . On at 12:15 p.m., Licensed Practical Nurse Staff D said she had been working as a nurse at the facility since 2017. She stated she had heard about the incident with Resident #1. Staff D said she was aware Resident #1 was receiving hospice services at the time she was found unresponsive. Staff D said she was not aware of the facility policy to call hospice immediately when a hospice resident was found in . Staff D verified there had not been any in-services for facility staff regarding the incident that had occurred with Resident #1. On at 3:15 p.m., the Executive Director and the Clinical Manager verified facility staff had not received any in-services regarding facility policy for since the incident occurred on	A 076		