STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964729	03/18/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Village Place	18400 Cochran Blvd. Port Charlotte, FL 33948	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0082 - 58a-5.0191(3) Fac - Training - S-S= D
St - A - 0090 - 58a-5.0191(11) Fac - Training - S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D

Specific Tag Findings:
These are the results of an unannounced Biennial and Limited Nursing Service (LNS) survey conducted on through at Village Place an Assisted Living Facility (ALF).

The following is a description of non-compliance:

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observation, record review, and interview the facility failed to provide personal supervision for 11 of the 30 residents in the memory care unit. The facility failed to contact the resident's health care provider and the resident's family when a resident exhibited a significant change for 1 (Resident #1) of 2 records reviewed. The facility failed to update the written record as needed of any significant changes for 1 (Resident #1) of 2 residents sampled

The findings include:

1. On at 1:19 p.m., observation revealed 11 residents in the locked unit. Several of which were wandering aimlessly throughout the unit halls. No staff was observed to be in sight. At 1:27 p.m., a staff member came into the unit walked briskly around. She then proceeded to the door and let herself and the surveyor out again leaving the residents on the memory unit unsupervised.

On at 1:13 p.m., Employee D stated that there should be 3 staff in the memory unit at all times. She said that 3 staff allows for 1 staff member to toilet a resident and still have at least 1 staff member on the unit to supervise the other residents. She stated that those residents are especially at risk and need special supervision because they can't call for help. Employee D agreed that finding the residents for any amount of time unsupervised was not acceptable and could be dangerous.

2. On a review of Resident #1's record revealed on the resident weighed 92 pounds. On the resident weighed 80 pounds. Review of the Nursing Care Notes revealed no mention of notification to the physician or to the family of the weight loss. Review of the Physician Orders revealed no orders regarding the weight loss. Review of the Nursing Care Notes reveal an episode of and lasting several days in of this year. The Nursing Care Notes lack documentation of any communication with the family or the physician. Review of Resident #1's AHCA Health Assessment Form 1823 revealed that she was sent out to the hospital during this time. The Nursing Care Notes failed to document any communication between the facility and the physician regarding the transfer from the facility. The Physician Orders failed to document an order to

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transfer the resident to the hospital.

On . . . . at 12:57 p.m., Employee D stated that it was their policy to let the resident and the families know of any change in condition or medications. If orders come across the fax, we let everyone involved know. Employee D stated that the conversations are documented in the progress notes. She stated that Resident #1's Nursing Care Notes regarding the weights may have been thinned. She stated it was their policy to thin anything older than 6 months. She stated that she couldn't explain why the physician wasn't notified because that was before she was hired. Employee D said that Resident #1 did have an episode of . back in Employee D did look through Resident #1's Nursing Care Notes and agreed that there was no documentation of any communication with the family or the physician. Employee D also confirmed that there was no documentation of Resident #1 being sent out to the hospital.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation, record review, and interviews the facility failed to respond to resident complaints in reference to food services and failed to treat residents with personal dignity and individuality in reference to their food choices.

The findings include:

Menu record review revealed that on . . . . . the facility modified the lunch menu and did no longer include two choices. It was only one course. Further review revealed that as of . . . . . the facility went back to its old menu where two options were offered at lunch.

Surveyor asked Executive Director (ED) on . . at 1:40 p.m., whose decision it was for the menu to be modified from two choices to one. She said that it was a corporate office decision but residents were notified. She stated that a food council meeting is held every first Friday of the month. The surveyor requested a copy of the minutes. The Executive Director stated on . at 3:00 p.m., that they had no proof of minutes and it was an oversight of the office manager that she forgot to document the minutes.

The facility was able to provide minutes only for the following months:

On . . . . . residents complained that vegetables were not cooked enough, want more yogurt, fresh fruit, and cream of wheat, meat needs to be tender, serve toast with eggs.

Food minutes of resident counsel that took place on . . . at 9:30 a.m., revealed that residents were complaining that veggies and pork were tough. Wanted more fruit (bananas).

There was no evidence that residents were notified of change of lunch menu.

The only note found was after the change during the meeting that took placed on . . . . . At that meeting residents questioned that change in the menu.

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	AL11964729	**03/18/2014**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Village Place	**18400 Cochran Blvd. Port Charlotte, FL 33948**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Twenty four residents and 3 family members participated in that meeting. Census in the facility is 94 residents. The ED stated that usually about 20 residents participate at this meeting and they are informed of all changes that will take in effect. Twenty residents in a facility of 94 residents represents only 18.8% of the whole population.

The Administrator stated on at 3:10 p.m., that that they utilized a food satisfaction survey that was given to all residents prior to the change. Only 24 residents responded to the survey. Scale utilized was 1 (does not like) up to 5 (love it). She said that the results of the survey were sent out to the main corporate office.

The surveyor randomly selected and reviewed the following surveys:

Resident #9 stated that her satisfaction with food was a 2.

Resident #11 was asked how satisfied are you with the food variety?: 1 (does not like) How is your overall food experience? 1, (does not like) also stated that there is no bread on lunch.

Resident #12 was asked how satisfied are you with the food? Rating: 2. How satisfied you are with the food variety: 2. How is your overall food experience: 1 (does not like). Same resident wrote that chicken is tough and most food is not fresh but frozen or defrosted.

Resident #13 answered all 3 questions: 1 (does not like).

Resident #5 was asked how satisfied are you with the food variety ?: 1 (does not like).

Anonymous resident answered 1 to all questions.

An interview with Food Manager (Staff D) on at 2:00 p.m., revealed that he was told by the corporate office that menu was to be modified to only one choice. He also stated that the facility had an alternative menu that included a total of 6 choices and residents were aware that if they did not like the main course they can ask someone in the kitchen to prepare one of the 6 alternative choices. He also stated that when the change was to take place he explained to them that this kind of menu it was not going to work for his residents. The menu was modified back to what it used to be on since residents complained about it.

During a lunch observation on at 12:02 p.m., surveyor heard a resident that did not want to identify himself saying out loud, "Are they giving us choices today because the state is here? Good."

A resident stated during a confidential interview on at 9:59 a.m., "food is not that great. My favorite meal is meatloaf and it's served only once since I came in, I think the food is worst since the new owner. They don't give choices for lunch anymore."

A resident stated during confidential interview on at 10:50 a.m., "We used to have choices for lunch but it's not the case anymore. The new Owner changed that."

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Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observation and interviews the facility failed to observe the resident take the medication for 1 (Resident #1) of 10 residents sampled.

The findings include

On ..... at 10:14 a.m., an observation was made in Resident #1's ..... Six pills were observed in a medicine cup sitting on the night stand next to her bed.

On ..... at 10:14 a.m., Resident #1 stated she didn't know what pills were on her night stand. She sated that she took her morning medications already.

At this time, Employee D stated that the pills should not have been in Resident #1's ..... Employee D said their policy states that the med tech should have waited and observed the resident swallow and take all of the pills. The pills should not have been left on the bedside table.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observation and interview the facility failed to keep medications in a locked cabinet, locked cart, or other locked storage receptacle ..... area at all times

The findings include

On ..... at 10:54 a.m., the door to the wellness center was observed to be unlocked and opened. In the wellness center on the wall was a bin for pharmacy returns. The bin was observed to contain multiple pill cards for multiple residents. Located next to the bin were 3 L bags of ..... fluids. The wellness center was empty and contained no staff. This same observation was made multiple times throughout the day.

On ..... at 9:35 a.m., the door to the wellness center was observed to be unlocked and opened. In the wellness center on the wall was a bin for pharmacy returns. The bin was observed to contain ..... fluids.

On ..... at 9:35 a.m., Employee D stated that yes, the medications in the bin should be secured. She stated that the pharmacy didn't pick them up. She promptly locked them in the refrigerator.

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC
Based on record review and interview the facility failed to obtain the required in-service trainings within 30 days of employment for 1 (Staff C) of 4 sampled employees.

The findings include:

Record review for Staff C (caregiver hired ..... found no evidence of the following in service trainings:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964729	03/18/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Village Place	18400 Cochran Blvd. Port Charlotte, FL 33948	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

reporting major incidents; reporting adverse incidents; the facility's emergency procedure including chain of command and staff roles relating to emergency evacuation; resident rights in an Assisted Living Facility; recognizing and reporting resident , neglect, and resident behavior and needs; providing assistance with Activities of Daily Living; resident elopement response policies and procedures; and a minimum of 1 hour in-service training in control, including universal precautions, and facility sanitation procedures before providing personal care to residents.

The only training on file was dated (two years after staff worked in the facility). The training did not include instructor's information. Therefore, the training could not be verified.

The Executive Director acknowledged on at 4:45 p.m. that Staff C lacked all of the in-service trainings mentioned above.

Class III

0082-Training - 58A-5.0191(3) FAC
Based on record reviewed and interview the facility failed to obtain training for 1 (Staff C) of 4 sampled employees.

The findings include:

Record review for Staff C, hired , found no evidence of training. The only training on file was dated , but lacked instructors information.

The Executive Director acknowledged on at 3:45 p.m., that Staff C lacked the training.

Class III

0090-Training - 58A-5.0191(11) FAC
Based on record review and interview the facility failed to provide evidence of a training in the facility's policy and procedures regarding Do Not Resesitate Order within 30 days after employment for 1 (Staff C) of 4 sampled staff.

The findings include:

Record review for staff C (caregiver hired on found no documentation of training. The only training on file was dated and did not have the instructors information.

Executive Director acknowledged on at 3:50 p.m. that staff C lacked of training.

Class III

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on observation, record review, and interview the facility failed to offer variety of foods adapted to resident food habits and preferences.

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	AL11964729	**03/18/2014**
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Village Place	**18400 Cochran Blvd. Port Charlotte, FL 33948**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

The findings include:

Menu record review revealed that on . the facility modified the lunch menu and no longer include two choices. It was only one course. Further review revealed that as of . . . . . the facility went back to its old menu where two options were offered at lunch.

The Surveyor asked the Executive Director (ED) on . at 1:40 p.m. whose decision it was for the menu to be modified from two choices to one. She said that it was a corporate office decision but residents were notified. She stated that a food council meeting is held every first Friday of the month. The Surveyor requested copy of minutes.

The ED stated on . at 3:00 p.m., that they had no proof of minutes and it was an oversight of the Office Manager that she forgot to document the minutes.

The Facility was able to provide minutes only for the following months:

On . residents complained that vegetables not cooked enough, want more yogurt, fresh fruit, and cream of wheat, meet needs to be tender, serve toast with eggs.

Food minutes review of resident counsel that took place on . . . . . at 9:30 a.m., revealed that residents were complaining that veggies and pork were tough. Wanted more fruit (bananas).

There was no evidence that residents were notified of change of lunch menu.

The only note found was after the change during the meeting that took placed on . At that meeting residents questioned that change in the menu.

Twenty four residents and 3 family members participated in that meeting. Census in the facility is 94 residents. The ED stated that usually about 20 residents participate at this meeting and they are informed of all changes that will take in effect. Twenty residents in a facility of 94 residents represent only 18.8% of the whole population.

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Resident #11 was asked how satisfied are you with the food variety? Rating: 1 (does not like). How is your overall food experience? 1 (does not like) also stated that there is no bread on lunch.

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and most food is not fresh but frozen or defrosted.

Resident #13 answered at all 3 questions: Rating 1 (does not like).

Resident #5 was asked how satisfied are you with the food variety? Rating: 1 (does not like).

Anonymous resident answered 1 to all 3 questions.

An interview with Food Manager (Staff D) on at 2:00 p.m., revealed that he was told by the corporate office that menu was to be modified to only one choice. He also stated that facility had an alternative menu that included a total of 6 choices and residents were aware that if they did not like the main course they can ask someone in the kitchen to prepare one of the 6 alternative choices. He also stated that when the change was to take place he explained to them that this kind of menu it was not going to work for his residents. Menu was modified back to what it used to be on since residents complained about it.

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A resident stated during confidential interview on at 10:50 a.m., "We used to have choices for lunch but it's not the case anymore. The new Owner changed that."

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Village Place
18400 Cochran Blvd.
Port Charlotte, FL 33948

Dear Administrator:

This letter reports the findings of a Biennial and Limited Nursing Service (LNS) survey that was completed on . . . . . 18, 2014 by representatives of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after , 2014 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyors. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

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Enclosure: State Form

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Tallahassee, FL 32308
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