STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911767	**04/09/2014**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Gulf Coast Village Assisted Li	**1333 Santa Barbara Blvd Cape Coral, FL 33991**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0092 - 58a-5.020(1) Fac - Food Service - General Responsibilities S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - N277 - 58a-5.031(2) Fac - Lns - Resident Care Standards S-S= D
St - A - N278 - 58a-5.031(3) Fac - Lns - Records S-S= D

Specific Tag Findings:
These are the results of the Biennial with Limited Nursing (LNS) survey that took place on through at Gulf Coast Village an Assisted Living Facility (ALF).

The following is description of non-compliance.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on record review, the facility failed to obtain an complete Health Assessment for 1 (Resident #13) out 21 of sampled residents

The findings include:

Record review for Resident #13 found that she was admitted to the Assisted Living Facility (ALF) on Health Assessment review for Resident #13 found that the assessment on file did not state whether the residents needs can be met in the ALF or not, whether or not the resident needs assistance with self-administration of medication, and the date the assessment was completed.

Further review for the same resident found that there was an assessment dated The assessment was incomplete since it did not state whether or not the residents needs can be met in the ALF.

Record review for Resident #13 found that she was admitted to Hospice on with primary diagnosis listed as Neither Health Assessment indicated that resident was under Hospice care.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation, record review, and interview, the facility failed to have evidence of residents participation in menu planning and failed to treat resident with dignity and achieve the highest level of independence and autonomy in terms of their food services for resident that reside at Harbor unit and failed to ensure a safe environment by not securing an tank for Resident #17.

The findings include:

1. Meal observation on at 12:30 p.m., at Harbor unit, revealed that there were no butter knifes on the tables.

Interview with the food manager, present at time of observation on at 12:30 p.m., revealed that butter

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knifes were not utilized for safety reasons and servers were to pre- cut meat and butter the rolls prior to serving the residents.

Only 3 residents were observed that needed assistance with their meal. The remaining 14 residents were observed eating their meal independently. None of the 14 residents were observed utilizing butter knifes.

When the Manager was questioned on at 11:29 a.m., as of who's decision it was not to utilize butter knifes in the Harbor unit she stated, "Its a corporate decision, it's been like that for the time I work here. I wondered myself, there are knifes there."

The Manager stated on at 12:18 p.m., "I asked the food manager and she said that there are knifes available, they just have to ask and we will provide." The Manager was asked: Did you had a formal meeting to inform residents that they can have butter knifes or remind staff to ask residents if they want to use a knife? She stated, "No."

The Manager stated that residents that reside in the Harbor unit are not to participate in culinary food meeting that take place on a monthly basis at the facility's main building. She stated, "90% of the residents reside in that area have memory problems." However, surveyor was able to interview 4 residents out of 17 that were present, that represents 23.5 % of the population.

Resident #1 stated on at 10:30 a.m., "I eat everything; I like everything that is served here." Resident #1 was asked: Do you participate in menu planning or have any meeting about food choices? Resident #1 replied, "No."

Resident #2 stated during interview conducted on at 10:58 a.m., "I like shrimp but they do not provide that all the time. I used to have shrimp and sea food when I was in the independent side. I asked them to have more they know about it. Resident #2 was asked: Do you have any meeting where you discuss about food or menu planning? Resident #2 replied, "No."

Resident #3 stated on at 11:21 a.m., "I have 3 meals a day; my favorite is breakfast, the food it's not that great, but is ok. They don't have that much sea food here, but they know I want that." Resident #3 was asked: Do you have any food menu planning discussions or meetings? Resident #3 replied, "No."

Resident #5 stated on at 12:04 p.m. "We have 3 meals a day, lunch is my favorite, and food is ok." Resident #5 was asked: Do you ever have any discussions or meetings about food choices or meal planning? Resident #5 replied, "No."

2. During a tour of the facility with the Assistant Director of Nursing (ADON), on at 11:50 a.m., observed in of Resident #17 was 1 large unsecured tank in the living area.

An interview on at 11:50 a.m., with the ADON, when asked if she thought the large tank was okay to be where it was, she replied, "I'll remove it."

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Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on record review, observation and interview, the facility failed to properly store prescription and non-prescription medications for 1 (Resident #18) out of 21 residents.

The findings include:

During a tour of the facility on at 11:30 a.m., with Assistant Director of Nursing (ADON), a bottle of Ropinole 0.25 mg 1 tab po (by mouth) qhs (at bedtime); a bottle of Highlands - Restful Legs and a bottle of Highlands - Leg Cramps with 0.3% 1 gtt affected eye Q4h for 10 days start on was observed on a table in the resident's

During an interview with Resident #18 when asked about the medication observed on the table in her she responded "I don't know if I am going to keep take that one (Ropinole) and the eye drops is for my I 'm not sure if I am going to take these, they are for my legs. I have that restless leg."

During an interview on at 2:00 p.m., with ADON, when asked if Resident #18 has a physician order to self-administer for the medication observed on the table in her stated, "For the Ropinole, our pharmacy sent it, and the resident sent it back and said she was going to get it from her pharmacy, she didn't give it to us when she got it. It is on her Medication Administration Record (MAR), but no, have nothing to hide here, she doesn't have a physician order to self-administer the medication. She also doesn't have one for the 0.3% and it has been removed as well as the Highlands - Restful Legs and the Highlands - Leg Cramps with

A record review of Resident #18's physician orders revealed that they failed to document an order to self-administer the Ropinole, the Highlands, or the

Class III

0092-Food Service - General Responsibilities 58A-5.020(1) FAC
Based on observation, the facility failed to ensure the residents were served food in a safe, sanitary manor.

The findings include:

1. During the lunch service on at 12:00 p.m., Resident Aid J was observed touching lip of plate when serving lunch plate to the residents at the table. During the next round of serving plates the surveyor asked the nurse in the dining , Staff K, Licensed Practical Nurse (LPN) to observe J delivering plates to the resident tables. We both observed J, remove the lid on the plate then placing her thumbs on the edges of the resident's plate delivered it in front of the resident, placing it down on the table.

2. Observation on at 12:40 p.m.in the Harbor dining the lunch meal service revealed that Staff A was picking up drinking glasses and coffee cups on the top drinking surface of the cups.

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Staff A also was observed placing a resident in a wheel chair in the dining . . . . Staff A was not observed wearing gloves. Staff was not observed washing her hands or using hand sanitizer. After she placed the resident by the table, Staff A was observed carrying a lunch entree to a resident's table. She removed the cover and placed both thumbs on the plate when served the food to the resident. Staff repeated the same while serving a total of 3 residents.

Class III

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on record review and interview, the facility failed to have evidence of resident's participation in menu planning.

The findings include:

Culinary meeting review revealed that resident meetings were conducted on a monthly basis at the facility's main campus. Further review revealed no documentation of residents meeting at the Harbor memory unit.

The Manager stated on . . . . at 12:18 p.m., that residents that reside in the Harbor unit did not participate in the culinary food meeting that takes place on a monthly basis at the facility's main campus. She stated: "90% of the residents reside in that area have memory problems." However, the surveyor was able to interview 4 residents out of 17 that were present, that represent 23.5 % of the population

Resident #2 stated during interview conducted on . . . . at 10:58 a.m.: "I like shrimp but they do not provide that all the time. I used to have shrimp and sea food when I was in the independent side. I asked them to have more they know about it." Resident #2 was asked: Do you have any meeting where you discuss about food or menu planning? Resident #2 replied, "No."

Resident #3 stated on . . . . at 11:21 a.m., "I have 3 meals a day; my favorite is breakfast, the food it's not that great, but is ok. They don't have that much sea food here, but they know I want that." Resident #3 was asked: Do you have any food menu planning discussions or meetings? Resident #3 replied, "No."

Resident #5 stated on . . . . at 12:04 p.m., "We have 3 meals a day, lunch is my favorite, and food is ok." Resident #5 was asked: Do you ever have any discussions or meetings about food choices or meal planning? Resident #5 replied, "No."

Class III

N277-LNS - Resident Care Standards 58A-5.031(2) FAC
Based on observation and interview, the facility failed to meet the standard of nursing practice in the nursing community for 1 (Resident #9) out of 21 sampled residents.

The findings include:

During an observation on . . . . at 2:30 p.m., of Staff K, Licensed Practical Nurse (LPN) performing a dressing

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changes on Resident #9 sitting in the [redacted] the lid on the toilet seat. Staff K, washed her hands, donned gloves and removed the old bandage from the area to the right of the right eye of Resident #9. Wearing the same gloves and without washing her hands and/or sanitizing her hands; Staff K used a gauze [redacted] with [redacted] soap and water to clean the area where there are several stitches. She then used a second gauze, wearing the same gloves, to clean off the soap. She then, with the same gloves on, applied polysporin ointment and covered the area with a bandage. She removed the gloves to retrieve a second [redacted] aid from her medication cart. She returned, donned a new pair gloves and applied the second [redacted] aid with paper tape. She removed the gloves.

During an interview on [redacted] at 2:00 p.m., with Staff M, Registered Nurse (RN) and Limited Nursing Service (LNS) Supervisor when discussing how to perform a dressing change she stated, "The nurse should wash her hands before she starts and change her gloves during the dressing change." Staff M was asked: Like between removing a dirty bandage and cleaning [redacted]' Staff M responded, "Yes." The surveyor informed Staff M that Staff K, failed to change her gloves and/or wash her hands while performing the dressing change on Resident #9 the previous day and she responded, "I guess I have some teaching to do."

Class III

N278-LNS - Records 58A-5.031(3) FAC
Based on record review and interview, the facility failed to maintain accurate records and monthly nursing assessments their for residents receiving Limited Nursing Services (LNS).

The findings include:

During the Entrance Conference on [redacted] at 9:00 a.m., the Manager was asked how many residents were on LNS and for what reason; she responded "We don't have any." Shortly thereafter the facility's Manager returned with the requested Alpha List of residents and stated "There are 3 residents on LNS, I was wrong."

A review of the LNS Log on [redacted] documents there are 2 residents receiving LNS; Resident #8 [redacted] and Resident #9 [redacted] care). Only Resident #9 was on the list provided earlier by the Manager. The LNS Log in the Harbor (Memory Care Unit is up to date).

An observation on [redacted] at 10:00 a.m., while on tour of the facility with the Assistant Director of Nursing (ADON), revealed there were 3 residents receiving LNS in the Manor and 2 residents receiving LNS in the Harbor (Memory Care Unit). Three of the LNS residents were receiving [redacted] none of the resident's doors had signs on their doors indicating the use of [redacted].

During an interview on [redacted] at 4:00 p.m., with the Limited Nursing Supervisor, Staff M Registered Nurse (RN) was asked if she is responsible for the LNS Nursing Assessments and how does she know who is receiving LNS services she responded, "I would say yes, I am responsible for doing the monthly nursing assessments. I asked them today who is on LNS and Staff M said nobody. I asked her if there is anything I need to review and sign and she said no. When I ask, I think it's a simple question and I am embarrassed that they don't even have a sign

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up for the residents who are on . I think I need to come over here and straighten things out over here."

As of he following residents were receiving LNS: Resident #9 l care); Resident #8 care); Resident #7 Resident #13 i and Resident #21

A review of Resident #7's section in the LNS log revealed there have been no Monthly Nursing Assessments completed; Residents #13 and #21 Monthly Nursing Assessments were completed on the 2nd day of survey.

A record review on of Resident #8's LNS Monthly Nursing Assessments revealed he had one completed on , and 3/8 14. Resident #8 has been receiving LNS since . Resident #8 is missing several LNS Monthly Nursing Assessments.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

Administrator
Gulf Coast Village Assisted Living Facility
1333 Santa Barbara Blvd
Cape Coral, FL 33991

Dear Administrator:

This letter reports the findings of a Biennial and Limited Nursing Service (LNS) survey that was conducted on . 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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