AGENCY FOR HEALTH CARE ADMINISTRATION

PRINTED: 02/16/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11953279	(X3) DATE SURVEY COMPLETED 02/12/2015
NAME OF PROVIDER OR SUPPLIER **Palms Of Punta Gorda (the)**	STREET ADDRESS, CITY, STATE, ZIP CODE **2295 Shreve Street Punta Gorda, FL 33950**	

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= G
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= G

Specific Tag Findings:
A complaint investigation survey CCR#2015001303 conducted on through at The Palms of Punta Gorda, an Assisted Living Facility, in Punta Gorda.

There were 4 allegations in this complaint 3 of which were substantiated. This resulted in Class II deficiencies at A0025 and A0030.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observation, record review and interview with staff and families, the facility failed to ensure supervision for 2 of the residents. (Residents #2 and 3). This lack of supervision resulted in resident on resident contact for 2 residents who lacked capacity to make this decision.

The findings include:

Resident #2 was admitted to the facility on . The health assessments dated document the resident's diagnoses include , Normal pressure (too much fluid in the causing pressure) with placement of with and , and the resident had a history of multiple . Resident #2 was noted to be alert and oriented with

The nurse noted in the admission noted dated , the resident was alert and oriented with . On , the progress note stated the resident was doing exit seek behaviors. On , the nurse noted the resident had learned the door code to the kitchen and was going into the kitchen to get snacks.

On , a note documented, "staff just found hiding in a female resident's the door with the door locked." On at 2 p.m., the nurse noted the resident "continues touching female resident and staff in inappropriate areas". The resident also verbalized inappropriate statements such as "Come to me baby", and "I want you to [expletive] me." Continuously redirected resident with no effect. This resident was noted to be sitting in the living , "touching himself inappropriately." The resident was sent to his

On at 1 p.m. the progress note stated the resident remained inappropriate around other residents and staff.

On at 12:30 p.m. The nurse noted "inappropriate behavior this AM with another female resident, kiss-while dancing. Resident told he is not allowed to kiss or touch other residents inappropriately. He said OK and then kissed the female resident again before leaving her."

On documentation noted the resident was observed opening an exit door (unit is a locked unit and required a key code to open any exit doors), pulling a female resident with him out the door. Staff were able to bring both residents back into the facility.

On 1:45 p.m., the staff reported to the nurse, the resident had a female resident in his , sitting on his bed. The female resident was crying and upset. (Staff A reported during interview on at 1:22 p.m. this was not unusual for this resident) Staff separated the 2 residents. Resident #2 was brought to the front and

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monitored and spoken to about inappropriate behavior.

On at 11:30 a.m. Resident #2 entered a female resident's . When staff went to check of them, and found both residents undressed (according to the nurse interview on at they were both nude). Resident #2 was removed from the female resident's (#2) . Staff put in the progress notes, "Resident just smirks at staff when he is told he CANNOT DO THAT"...

On at 2:15 p.m. the progress note documented, "resident in his female resident. Door locked. When caregiver opened door both residents were undressed. Was reported to nurses."

On at 11 a.m. the progress note stated "..resident was trying to be with female resident he was redirected multiple times but keeps going back to that behavior. Sent to another watch TV and monitor his behavior.

On 12 p.m. Resident redirected away from female companion. "Staff has maintained the whereabouts of the resident throughout shift..." The resident's daughter was notified of the resident's behaviors on at 10 a.m. The nurse also spoke with the daughter about having the resident discharged to a facility to better meet his needs. On 10:30 a.m. the resident was found dissembling the window in his . At 1 p.m., the resident was and transferred out of the facility.

On 1/15 at 1:15 p.m., interview with Staff D said they noticed Resident #3 had a bra up and out of place. Said the resident looked "spacey and distraught." She took the resident to the and she . When she wiped, the aide noted the toilet paper was pink. The in the toilet was yellow. She reported she had never seen any in the resident's . (Resident #3 has a long history of having . The resident was being treated for it 5-6 days prior to the incident). Staff D further reported the resident complained of pain in the area the next day during a shower as reported to her by another aide. When questioned about supervision of both of these residents, Staff D indicated the incident took place after lunch. She said they have 3 staff in that unit. Two of them were putting 3 residents, who required 2 person assistance to transfer, back to bed. That left 1 aide in the common area. She stated no additional staff was put in place for managing of the behaviors.

On at 1:22 p.m. an interview was conducted with Staff A. She identified the female resident who was found on as Resident #4. She said the resident was crying and upset, but this is the resident's pattern.

On the incident, she said she was unsure if any contact was made. However both residents were undressed. She was unsure when the residents were last seen by the staff prior to the incident. She said Resident #2 would go into the living there. She said she did not notify either Resident #2 or #3's families about the incident. She said they don't "usually notify the families about behaviors." They just redirect them.

An interview was conducted with the Administrator and the Resident Care Supervisor (RCS) on at 1:40 p.m. The RCS said she was on vacation, but staff called her on and she told them to put Resident #2 on 15 minute checks. The Administrator said he was aware of the incident, but said during a prior interview at 11:33 a.m., he felt it was not a "big deal" as neither resident was sent to the hospital. He said after the police came to the facility on he did a 24 hours adverse incident report about the incident. The Administrator also said he did not notify either family about the issue. He said the family of Resident #2, had been given an 45 day notice on for the exit seeking behaviors and taking other residents with him.

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An interview was conducted with the Marketing Director on /15 at 1:55 p.m. He said Resident #2 had resided in a skilled nursing facility prior to admission. While in that facility he had difficulty with in public and that facility had made a plan for privacy for the resident. He was to use his this activity with a sign in place to prevent interruptions.

On at 2:20 p.m., an interview was conducted with the Staff B, licensed practical nurse (LPN) who documented the incident on She said Residents #2 and #3 were both undressed, he below the waist, and she above the waist. She said she did attempt to determine from Resident #3 if anything happened, but stated the resident could not tell her about anything, and her body language did not show anything. As a result she figured nothing happened between the two residents. (Resident #3 lacks capacity to make a decision and has memory loss, and wandering) She also said Resident #3 is "flirty" with male residents.

At 3:30 p.m. on an interview was conducted with Staff C who found the residents. She said she knocked on the door which was locked. Resident #2 told her to "wait a minute." When he came to the door, Resident #2 had his shirt on, but was naked below the waist. She thinks both residents were getting dressed.

On at 9 a.m. an interview conducted with the RCS. She revealed she sometimes goes to evaluate residents prior to admission, but she did not do so for Resident#2. She said she was aware there were issues with the , but was told the resident would do this in the privacy of his She did not have any other plan in place for this resident. She said she was never told he was exhibiting this type of behaviors. The plan was never implemented. Further interview revealed the facility does not have a policy and procedure related residents with behavioral issues. When asked about providing 1 to 1 staffing to monitor Resident #2, she said they did put this into place on after the police came to the facility. She said at that time, Resident #2 admitted to having with Resident #3.

On at an interview with Resident #3's family indicated they were unaware of the incident until the police came to the facility.

Class II

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on review of resident records, interview with staff and administrative staff, and observation of residents, the facility failed to ensure there was a safe environment for 2 of the residents reviewed (Residents #2 and #3) Additionally, the facility failed to notify responsible parties of Resident #2's escalating behaviors and protect Resident #3 from his advances.

The findings include:

Resident #3 was observed in the dining lunch on at 12:05 p.m. She was drinking coffee and lemonade. She was able to say hello to the surveyor. When questioned about what she was drinking, she could not say it was lemonade. No behaviors where noted during the observation time. No other residents exhibited any behaviors during the lunch time observation.

All staff interviews throughout the on-site survey time on and revealed Residents #2 and #3 were preferential companions. However, when one or the other was out of the building, they would both express

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interest in other residents of the opposite . . . These residents reside in a locked unit of the assisted living facility.

Nurses notes on , , , , . . . and . . . document Residents #2's inappropriate behavior to female residents and staff.

On . . . . . Residents #2 and #3 were found behind locked doors disrobed. Neither Staff A, B, or C, when asked on , could provide a time when the residents were last seen, prior to being behind the locked door. Neither resident's responsible parties were notified of the incident at that time. The responsible parties were not notified of the behavior on . . . . . when Residents #2 and #3 were found in Resident #3's . . . . . .

On at 1:40 p.m. it was confirmed with the Administrator and the Resident Care Supervisor (RCS), they were aware Resident #2 had the behavior issue of , but said the skilled nursing facility told them it was not a problem since the resident was trained to put a sign on his door for private time. They agreed they had no plan in place prior to the incident on . . . . . to ensure the protection of female residents. They did say they had given Resident #2's family a 45 day notice on The stated reason on the 45 day notice letter indicated the resident is more aggressive with the women in the facility and "he seems to laugh it off." There was no documentation in the record or discovered through interviews, of interventions to ensure the safety of the female residents of the unit.

Resident #3 lacked the ability to consent for any . . . . activity due to her . . . . Resident #2 appeared to be alert and oriented, but according to the evaluation dated, "has poor insight and judgement." No interventions were performed or documented prior to . . . .

After the incident on . . . . when both Residents #2 and #3 were found undressed in a locked the staff was supposed to perform every 15 minute checks on Resident #2. When questioned, the staff provided the surveyor with 4 pieces of paper. At the top of page one it listed as every 15 minutes. One of the pages has Resident #3's name on it. None of the pages had Resident #2's name on it to document the monitoring. On the left side of the page is listed the time of day in 15 minute increments. Along the top line is listed the dates, but staff have written over the type written dates so it is not possible to always read the dates. When these were showed to one of the LPN's (licensed practical nurse) she stated they were "just crap."

The police and a worker from the Department of Children's and Family services came to the facility on . . . . to perform an investigation of the incident. The facility placed Resident #2 on 1 to 1 supervision through the weekend on . Resident #2 was removed from the facility on . . . . . via . . . . . .

Class II

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Palms Of Punta Gorda (the)
2295 Shreve Street
Punta Gorda, FL 33950

RE: CCR #2015001303

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2015 by representative 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 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 surveyor. Should you have any questions please call this office at 239-335-1315.

Sincerely,

Jon Seehawer, RN
Acting Field Office Manager

JS
Enclosure: State Form

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RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2015

Administrator
Palms Of Punta Gorda (the)
2295 Shreve Street
Punta Gorda, FL 33950

RE: CCR #2015001303

Dear Administrator:

This letter requires the facility to comply with a Directed Plan of Correction as a result of a complaint inspection survey conducted on , 2015 by a representative of the Agency for Health Care Administration (Agency). The provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection was faxed to you on . 2015. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC).

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0025 - 429.26(7) Fs; 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= G

Directed Corrective Actions:

1. The Assisted Living Facility is required to assess all residents in the facility for continued residency as well as for abnormal behavioral issues, including aggression and hyper- activity. These assessments are to be completed within 48 hours by a Registered Nurse or the Resident's primary physician. These assessments will be retained in each resident's file and be updated when the resident experiences a significant change.

2. The Assisted Living Facility is required to assess all new admissions for abnormal behavioral issues, including aggression and hyper- activity, before admittance to the facility.

3. The Assisted Living Facility is required to provide training within 48 hours to all staff on dealing with persons with and related as well as dealing with persons who exhibit aggressive behaviors, including hyper- activity.

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4. The Assisted Living Facility is required to increase staffing on each shift in all areas of the facility where residents who were identified as having abnormal behavioral issues, including aggression and hyper- activity, reside. This staff increase must be at a level to ensure that a dedicated staff person is available in each area to provide continuous line of sight monitoring of each resident identified as having behavioral issues. This staffing increase will take place no later than 48 hours after residents having these behavioral issues are identified and/or before any new residents identified as having these behavioral issues are admitted. The facility administrative staff will provide onsite monitoring to ensure that additional staff is present and line of site supervision is taking place. This monitoring will take place on all shifts.

5. The Assisted Living Facility is required to develop policies and procedures on dealing with residents who display behaviors which are disruptive to the safe operation of the facility. The facility will also develop policies and procedures on dealing with and investigating allegations of , including resident to resident . These policies and procedures will be developed by no later than 2015.

6. The Assisted Living Facility is required to train all facility staff will on the above developed policies and procedures within 48 hours after they are developed. Training on these policies and procedures will also be included in the facility's training for all new employees.

7. The Assisted Living Facility is required to contact the Charlotte County Center for and Emergencies (Phone: 941-639-5499) and establish a schedule for facility staff training. This contact and establishment of a training schedule will take place within 2 weeks of receipt of this report.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact Laura Manville, Survey and Certification Support Branch, at (727) 552-1955.

Sincerely,

for:
Jon Seehawer, RN
Field Office Manager