CORRECTIVE ACTIONS FOR THE DEFICIENCIES THAT WERE FOUND BY STATE SURVERY ON 11, 2015

0028 Resident Care– Actives of Daily Living

Resident coordinator will have in-service with all caregivers on the following topics

- Assisting and Cueing Residents
- Diets
- Washing hands
- Serving one table at a time
- Dinning
- Application of clothing protectors not to be called a bib and ask the Resident before assisting
- We have notified Hospice that an as tolerated diet is not appropriate for resident # 15
- Serving food in sanitary manner

0030 Resident Care – Rights and facility procedures

All Call lights have been fixed

¾ Side rail has been removed

Medication Administration

Resident coordinator will have in-service with all nurses RE: Policy of Medication administration

0081 Training & Staff in-service

Based on personal records reviewed facility failed to train 2 (staff A&B) of 4 employees in food handling within 30 days of new hire

*Administrations will set up in-service every 30 days to be compliant

0092 Food Service – General responsibilities

Resident number 15 - diet was as tolerated

*notified hospice that there is no such order

*in-service will also include diets that the Palms offers and the importance of correct diets for each and every resident

0093 Food Service – Dietary Standards

Will assign someone from the kitchen to make sure all 3 dining areas (menus) match the same week and/or if the meal is changed- substitution is put into place

Physical Plant Safe living environment

- Again side rails will be monitored plus measured by maintaince – loose side rails looked like 4 inches but surveyor alleged 6 inches. – was not measured at that time maintaince fixed and they now measure 2 ¾ inches

- Doors in 500 hall have been sanded and re painted
- All vents are cleaned
- Terminex spray monthly along with maintance man as needed
- door is cleaned

E.C.C

Resident # 10

Resident can walk and does walk with walker. Daughter requests resident to be in a wheelchair to prevent . Resident is non-compliant at times and walks with walker. Administrator was not sure at the time when asked if resident can propel herself in wheelchair. –Resident walks with walker. Daughter is in process of buying wheelchair. Resident uses ours at times

*Notified surveyor _____ Administrator felt there may be other resident that needed to be admitted to E.C.C Once our new E.C.C nurse starts which is taking E.C.C over on

-Resident has been on E.C.C service since

-service plan was mailed out previous surveyors stated we just needed to place stickie note on service plan that it was mailed and awaiting return. Dated family is aware as we have called then several times to mail back or come in to sign. No changes in service plan. –Never have been sited previously for service plan not being sent back signed in 2 months.

E.C.C Service plan

Interview with the nurse- She would not be aware as she only charts on E.C.C residents and she is a new nurse.

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Monthly nursing assessment on resident #11 was 1 day late as we had notified surveyors. We had no E.C.C nurse. Administrator was following through with assessments plus service plans. Assessment will be completed by administrator until E.C.C can be trained. E.C.C records are being documented daily in the ADL book. New nurse answered wrong documents shows in process notes. Assist XT 00B will do in-service on documenting ADL's in process notes as well as nursing daily documentation in E.C.C book but now the staff cant retrieve info state wants.

Page 7 of 8

E.C.C Records –

ADL's are being documented daily in ADL book. New nurse answered wrong. Nurses document daily assist XT 00B.

E.C.C will have in-service with nurses to document ADL's in progress notes and note that you communicated with family regarding service plans

Z815 Background Screening: Prohibited offense's

Employee A's personal record shows she did not have break in unemployment she came directly from another health care facility to here at The Palms

Employee C did have a break in unemployment and is in the process of completing another level 2; taken off schedule until completed

Employee D was hired . The level 2 background check became effective and renewed on ../.. employee D completed level 2 background ... 2011

Thank you for your review in keeping our facility in compliance under state guidelines

Sincerely

The Palms Of Punta Gorda

Holly Summers E.D

The Palms of Punta Gorda

2295 Shreve Street, Punta Gorda, FL 33950
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27 2015
By DIVISION OF HEALTH QUALITY

FAX

Date: 8/27/15

4 Number of Pages (including coversheet)

To: AHCA

From: Kelly Simmons ED

Title or Dept: Stevilee Heckscher

Title or Dept: Administration

Fax #: (239) 338-2372

Fax #: (941) 655-8585

Phone #: ( )

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Memo:

Survey corrections

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953279	08/11/2015
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 TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

This is the unannounced Biennial, Limited Nursing Services (LNS), and Extended Congregate Care (ECC) survey conducted on through / / at Palms of Punta Gorda, an Assisted Living Facility (ALF), located in Punta Gorda, Florida.

The following is a description of the deficiencies:

0028 Resident Care - Activities of Daily Living

Based on observation, resident records reviewed and staff interview, the facility failed to provide 1 (Resident #15) of 4 residents with assistance with his lunch meal when he needed it.

The findings included:

Observation on / / at 12:00 p.m. showed Resident #15 trying to eat his soup but kept missing his mouth. Most of the soup was on the table and on his lap. The direct care staff moved his soup aside and gave him his lunch without offering him assistance with eating his soup. Resident #15 began eating his baked potato with his hands. The direct care staff approached his table and provided other residents at his table with assistance but the staff did not offer him assistance. He tried to eat his chicken with his fingers but he stopped. At 12:45 p.m. staff gave Resident #15 his dessert and took his meal away without offering assistance with more than 1/2 of his food on his plate. Resident #15 tried to eat his dessert with his spoon. However, most of the dessert was on his lap, table and floor. At 1:06 p.m. the staff took his cup of dessert away from him without offering assistance.

A review of Resident #15 health assessment dated / shows he requires assistance with eating but in the comments section it is written "needs to be fed."

An interview was conducted with the Licensed Practical Nurse (LPN) in the memory care unit at 2:00 p.m. on . She stated Resident #15 went to the hospital and when he came back he was but is fine now. Staff is supposed to provide assistance for all residents if they need help with eating their meals.

Class III

0030 Resident Care - Rights & Facility Procedures

Based on observation and interview, the facility failed to ensure all of the call bells in the memory care

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unit were working, failed to provide dignity to residents by the application of a bib with asking the resident, and failed to serve all of the residents at one table at one time.

The findings included:

1. Observation during lunch on at approximately 12:15 p.m., revealed the residents at the table (4) closest to the hallway were not served their meal together at one time.

2. Observation on / at 9:30 a.m., showed 3/4 side rail attached to Resident #12's bed. A review of a physician order dated showed an order for 1/2 bed rail.

An interview was conducted with the nurse in the memory care unit on / at 2:00 p.m. She stated Resident #12 cannot manipulate the 3/4 side rail on her bed independently. She is not aware why the rail on Resident #12's bed is 3/4 and not 1/2 side rail.

3. An interview was conducted with the nurse in the memory care unit on / at 9:20 a.m. She identified Resident #4, who lives in , oriented and is able to answer questions appropriately by the surveyors. Observation during the initial tour of the facility in the memory care unit on / at 9:30 a.m. showed in the call light was not working. An interview was conducted with Resident #4 at this time. He stated he did not know the call light was not working. Another tour of the memory care unit was conducted on / at 11:45 a.m. with the Administrator and Director of Operations. Observation of 's call light revealed it did not work. The Administrator stated it should work and she will get the maintenance worker to look at it and fix it. The tour continued showing 401 and 402 call lights not working. Both the administrator and Director of Operations confirmed these call lights are not working and will get them fixed.

4. Observation on / / at 12:05 p.m. Staff E went into laundry grabbed a clothing protector for Resident #19 placing the clothing protector without asking the resident if she wanted one or not. The resident is capable of feeding herself and was not observed to spill any food on her clothing.

Class III

0053 Medication - Administration

Based on observation and interview, the facility failed to ensure Resident #10 completed taking of medications.

The findings included:

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On / at 10:10 a.m. Resident #10 was observed in her , eating a cookie. There was a medication cup with 3-4 pills in it, sitting beside her on the arm of the recliner.

A review of the policy for administration of medication dated revealed: "Staff will exercise responsibility by observing the resident take the medication and watching for any subsequent reaction to the medication."

On / at 12:00 p.m., the Executive Director was informed about the observation. She stated she was upset about this as her staff knew they were to watch the residents take all of their medications prior to leaving the .

Class III

0081 Training - Staff In-Service

Based on personnel records reviewed and staff interview, the facility failed to train 2 (Staff A and B) of 4 employees in Nutritional and Safe Food Handling within their 30 days of hire.

The findings included:

1. A review of Staff A's personnel record showed she was hired on . A review of the certificate of this training showed she received the training on / . Staff is to receive this training within 30 days of their hire date.

2. A review of Staff B's personnel record showed he was hired on . There was no documentation in his record showing he had this training.

3. An interview was conducted with the Business Office Manager on / at 10:00 a.m. She stated she was not able to find Staff B's training.

Class III

0092 Food Service - General Responsibilities

Based on observation and staff interview, the staff in charge of food service failed to ensure food was served in a sanitary manner. Furthermore, the facility failed to provide the correct therapeutic diet to Resident #15 who was on a pureed diet.

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The findings included:
1. Observation on / at 11:58 a.m., in the new dining E was observed touching the shoulders and the back of the chair of Resident #18. Staff E did not wash or sanitize her hands before passing bowls of soup and plates containing the residents lunch. This same staff member was observed touching the lips of the plates and on the rim of the bowls of soup during the entire meal service delivery.
2. Observation on at 12:09 p.m., Staff F was observed touching the lips of the plates and on the rim of the bowls of soup with her bare hands while passing during the entire meal service delivery.
3. Observation on / at 12:00 p.m., showed Resident #15 in the dining , being served his lunch. The food on his plate showed it was a regular diet and his water was thin liquid. A review of his health assessment dated showed the physician ordered a pureed diet with nectar thickened liquids.
An interview was conducted with the nurse assigned to the memory care unit on at 2:00 p.m. She reviewed the health assessment dated /. She stated Resident #15 was when he came back from the hospital but he is now fine. She was not aware of the physician order for the pureed diet. She stated Resident #15 was on nectar thick liquids when he was discharged from the hospital but is able to drink thin liquids and he eats a regular diet now. Further review of Resident #15's record shows there is no diet order written after showing he is to have regular diet and thin liquid.
4. On / at 12:15 p.m., Staff G was observed passing food in the front dining . During the food pass, the staff member was observed picking bowels up from the top and touching the rim of the bowls. When utensils were needed, then went to the bin to obtain them and touched all surfaces of the silverware.

Class III

0093 Food Service - Dietary Standards

Based on observation, staff interview and review of the facility's approved 5 week menu the facility failed to follow their approved menu, failed to post the correct menu and failed to document substitutions when made to the menu.
The findings included:
1. Observation on at 12:18 p.m., the menu was not posted in the new dining . Interview with Executive Director said the dietary department must have taken the menu from the bulletin board to give to the survey team. She said the menu is usually on the bulletin board outside the dining .
Review of the facility approved 5 week menus cycle revealed the menu was not the correct one.
2. Review of the facility approved week 5 menus revealed the residents were to receive roast turkey with bread stuffing, green beans, dinner roll, margarine and cherry top pound cake. Instead the residents received baked chicken with orange gravy, carrots, baked potato and cherry top pound cake with whipped topping.

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3. Review of substitution log on / / at 12:15 p.m., revealed the last substitution was dated when tilapia was substituted for pork chops due to being out of pork chops. The facility failed to document the substitution of chicken with orange gravy for the roast turkey.

4. During an interview on / / at 9:08 a.m. the kitchen manager said that the substitutions are supposed to be documented at the time of the substitution. He was not aware that the menu posted in the new dining the wrong week cycle and the menu was not followed by the dietary staff.
Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observation and staff interview, the facility failed to provide the memory care unit a clean and safe environment.

The findings include:

1. Observation during the initial tour of the memory care unit on / at 9:30 a.m. showed Resident #16's side rails are loose on his bed which makes a gap of approximately 6 inches between the side rail and his bed. At 1:00 p.m. the maintenance man was notified of this side rail. At 3:00 p.m., Resident #16's side rail was observed. The side rail was loose and had approximately 6 inches between the side rail and his bed. Another observation was conducted on / / at 11:45 p.m. with the Administrator and Director of Operations. Resident #16's side rail was loose on his bed showing a gap of approximately 6 inches between the side rail and the bed. At this time the Administrator stated she will contact the maintenance man to get this fixed.

2. Observation during the initial tour of the memory care unit on / / at 9:30 a.m. showed in several resident in the back area of this unit paint peeling off the inside of their . In several resident there were dust and debris coated on their air vents. The dining and chairs showed many gouges and scratches. The edges of each table showed they were worn down by the varnish gone and the edges were jagged. Another tour of the unit was conducted on / / at 11:45 a.m. with the Administrator and Director of Operations. The Administrator confirmed the observations of the resident peeling paint and dust and debris in the air vents.

3. Observation during medication pass on / / at 9:30 a.m. revealed had black fluffy material on the edges of the door on the upper half. There was also noted many ants crawling about the . On / / at 1:30 p.m. it was communicated with the Executive Director about the ants noted in . She was unaware of any issues with insects, as they have pest Control Company.

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Class III

E204 ECC - Admissions & Continued Residency

Based on observation, comprehensive record reviews and interview with administrative staff, the facility failed to place 1 (Resident #10) of 2 employees who required the services on Extended Congregate Care (ECC).

The findings included:

Resident#10's record revealed a health assessment dated which stated the resident required assistance with ambulation, bathing, and dressing. The resident has declined in physical abilities and no longer can walk without falling. The facility now has the resident in a wheelchair for transportation.

On at 10:30 a.m., an interview with the Executive Director revealed the resident cannot self-propel and needs total assistance with wheelchair use. Further interview said the resident should "probably be" on ECC, but is not. She said she has 4-5 other residents who should be on ECC and are not as yet.

Class III

E206 ECC - Service Plans

Based on one of one resident record review and staff interview, the facility failed to provide 1 (Resident #11) of 1 resident responsible party with the Extended Congregate Care (ECC) service plan dated

The findings included:

A review of Resident #11's service plan dated showed the ECC supervisor and Resident Care Coordinator signed this plan. However, there was no signature of Resident #11's responsible party and no indication Resident #11's responsible party was part of the development and was in agreement with the service plan.

An interview was conducted with the nurse in the memory care unit on at 11:50 a.m. She stated she is not aware if Resident #11's responsible party was part of this service plan or was given a copy.

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Class

E207 ECC - Services

Based on one of one resident record review and staff interview, the facility failed to do a monthly nursing assessment for Resident #11.

The findings included:

An interview was conducted with the Administrator on at 10:30 a.m. She stated her Extended Congregate Care (ECC) nurse left the facility and is in the process of hiring a new ECC nurse

A review of Resident #11's ECC notes showed she was admitted to ECC in 2013. A review of the monthly assessments showed the last one completed by a registered nurse was / .

An interview was conducted with the nurse in the memory care unit on / at 11:15 a.m. She stated the ECC nurse left the facility 2 months ago and does not think anyone has been doing the monthly assessments for the residents who are receiving ECC services.

Class III

E208 ECC - Records

Based on resident record review and staff interview, the facility failed to provide progress notes for 1 (Resident #11) of1 resident specific to her Extended Congregate Care (ECC) needs.

The findings included:

A review of Resident #11's ECC record showed she requires total care with all of the Activities of Daily Living (ADLs). A review of her daily progress notes showed the nurses are documenting she is getting out of bed daily and is fed by staff. The nurses are assessing her pain level and her skin. There was no documentation of Resident #11 receiving total care with her ADLs.

An interview was conducted with the nurse on / at 11:50 a.m. She stated the nurses write the progress notes for each resident who is receiving ECC services. She reviewed Resident #11's progress notes and confirmed there was no daily documentation of Resident #11 receiving total care with her ADLs.

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Class III

Z815 Background Screening: Prohibited Offenses

Based on personnel records reviewed and staff interview, the facility failed to have current Level II background screenings done on 3 (Staff A, C, and D) of 4 records reviewed. manner.

The findings included:

1. A review of Employee A's personnel record showed a hire date of . The Level II screening was completed on . A review of her application shows she had been unemployed for more than 90 days prior to her hire date.

2. A review of Employee C's personnel record showed a hire date of . The level II screening was completed on . A review of the application showed he been unemployed for greater than 90 days prior to being hired.

3. A review of Employee D's personnel record showed a hire date of and a Level II background screening completed on . A review of the application showed there was more than 90 days of unemployment prior to his hire date.

4. On at 10:00 a.m. an interview was conducted with the Business Officer Manager. She reviewed these personnel files and confirmed these three employees had a break in service and the facility did not have another level II background screening once they were hired at the facility.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

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

Dear Administrator:

This letter reports the findings of a state licensure survey that was completed on , 2015 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. **Please attach your corrective action and any additional documentation to support correction of identified deficiencies and send to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form

XG90

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