STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911942	01/19/2017
NAME OF PROVIDER OR SUPPLIER **ROYAL PALM RETIREMENT CENTRE**	STREET ADDRESS, CITY, STATE, ZIP CODE **2500 AARON STREET** **PORT CHARLOTTE, FL 33952**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on observation, record review, and interview, the failed to ensure medications ordered by a physician were acquired and available for 2 (Residents #12 and #20) of 2 resident medication reviews.

The findings included:

1. On / / at 9:34 a.m., Resident #12's daughter said when her mother returned to the facility on / / , the daughter gave all the medication instructions to the med tech and Licensed Practical Nurse (LPN) Staff C was there too. The daughter said when her mother asked the nurse about her iron pill, but the nurse said it wasn't on the list. The resident's daughter felt sure it was.
On / / at 9:34 a.m., Resident #12 confirmed she was not getting her iron pill. Resident #12 said she had a in the past and was supposed to be getting it.

A review of Resident #12's Resident Health Assessment (Form 1823) dated / / indicated the resident should be receiving supplemental iron ( ) 325 milligrams (mg) daily, famatodine (a stomach reducer) 20 mg every 12 hours, and 650 mg every 6 hours as needed for pain/temperature >100. Review of Resident #12's Medication Observation Record (MOR) also showed (a lowering medication) 20 mg daily.

On / at 11:45 a.m., Staff I checked medications on-hand in the med cart. Staff I said famatodine, , and ( ) were not on-hand for Resident #12.

On / at 12:05 p.m., the Director of Nursing (DON) said Resident #12 used to be self-medicating and her meds would have been delivered to the front desk; maybe they didn't know and they delivered them to her . She said she will investigate.

2. On / / at 2:45 p.m., Resident #20 said it had been 2 days without his pain medication; they had run out of it. Resident #20 said he told them 5 days ago it was running out, then told them 2 days ago it was running out, and now it is out. He said had to go down to tell them to order it, but they are supposed to pull the label and order the medication in advance. Resident #20 said it has happened 7 times in the past 11 months and it will be 5 or 6 days before they get them in. He said at first he talks to the med techs because he can see on the panel it is running out. When it gets to the dark side of the panel they should reorder. He said they were not ordered and he had to go down there today to tell them to order the medication.

On / at 3:04 p.m., the DON explained the process for refilling medications is to contact the pharmacy and they contact the doctor for hard scripts. This is done when they are close to being out,

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usually 14 or 7 days prior. The DON said Resident #20 has orders for oxy ( ) 10 mg twice daily as needed for pain and ER (, a long-acting pain reliever) 50 mg every 12 hours with meals. The DON went to medication cart to verify residents pain medications on-hand.
A review of the Log showed oxy 10 mg and a review of the medication card showed 39 were available which matched the log.
The Log for ER was not in the chart on the medication cart.
Staff K (a med tech) said was not on-hand in the medication cart and the log sheet for it was sent to the Resident Care office.
On the afternoon of / / , a review of that log indicated the last dose of ER was given / / at 8:00 a.m.
The DON then called the pharmacy on / / at 3:14 p.m. The DON reported the pharmacy said was last ordered on / . DON said she will see if they can "stat" (rush) it.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on record review and interview, the facility failed to ensure staff who provide assistance with self-administered medications obtain at least 2 hours of continuing education training on providing assistance and safe mediation practices for 1 (Staff E) of 3 staff reviewed.

The findings included:

A review of Staff E's personnel file revealed Staff E attended the 6-hour medication training on / / . There was no documentation Staff E attended a 2-hour continuing education training on providing assistance with self-medications and safe mediation practices in assisted living.

On / at 3:45 p.m., the Executive Director said she was aware Staff E needed the training. She said Staff E has been taken off the medication cart until it is completed.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the facility failed to provide a safe living environment, free of hazards, ensuring existing structures are in good working order and that each resident has a clean, comfortable bed.

The findings included:

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SUMMARY STATEMENT OF DEFICIENCIES
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On 1/17/17 at 9:45 a.m. during a tour of the facility, the following observations were noted:

Resident Room 344 had a freezer in the resident room was with thick ice.

Memory Care hallway walls had dried spills throughout, missing paint, and scuffs on walls; and the carpeting was stained.

Memory Care activity/dining tile missing from top of wall divider; theer was plaster missing, scuff marks, and dried spilled liquid on the walls of divider. Two separate walls next to two separate tables with plaster at table level, tables with scuffed surfaces. Spilled liquid remained on the floor for 45 minutes following breakfast. There was dried spilled liquid on several walls, a freezer with frozen spilled food and uncovered/undated food.

Resident had laminate missing from the cupboard housing the refrigerator;

Resident had scuffed and stained baseboard and door frame, stained wall stained, and missing paint. There was an exposed electrical outlet with no cover plate.

Resident had large chunk of laminate missing from the floor.

Resident had scuffed, missing paint, scraped door and walls.

Resident had baseboard separated from drywall by the window, cracks in plaster, paint missing from a wall, brownish black substance on the wall by the window, and a strong foul odor in the .

On / at 10:18 a.m., Staff D agreed there was a strong odor of in Resident #19's . She said the resident is and she changed the resident, the sheets, everything but she couldn't get rid of the smell. The resident was in the said the bed was wet. Staff D said she had put a plastic bag on the bed and proceeded to pull back the fitted sheet to reveal a large, clear plastic garbage bag laid over the mattress with the fitted sheet placed over it. Yellow staining could be seen below the plastic bag.

On / / at 12:56 p.m., Executive Director (ED) said she would get Resident #19 a new mattress right away. The ED said she would be hiring an environmental hygienist to evaluate the entire structure. The ED said she would get started right away.

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Photos on file

Class III

0000 - Initial Comments

An unannounced relicensure survey was conducted 1/17/17 through 1/19/17 at Royal Palm Retirement Center, an assisted living facility (license #3915) in Port Charlotte, Florida.
This relicensure survey was conducted in conjunction with a revisit and a complaint survey.

The following is description of the deficiencies found during the visit.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review, observation and interview, the facility failed to provide care and services appropriate to the needs of residents accepted for admission to the facility for 2 (Residents #11 and #17) of 3 residents reviewed. The facility failed to monitor for two residents with orders for supplemental .

The findings included:

1. Review of the Limited Nursing Service (LNS) file for Resident #11 revealed an order dated / to admit to LNS for management. at 2 liters (L) via nasal cannula (n/c) continuous for diagnosis of hypoxemia.

On / / at 11:39 a.m., Resident #11 was observed in the dining no supplemental . Resident #11 said he doesn't wear it when he's eating, only when he's upstairs.

On / at 12:17 p.m., Resident #11 was observed lying in bed in his , still with no on.

On / at 8:07 a.m., Resident #11 was observed walking in the 4th floor hallway with no on.

On / / at 11:57 a.m., Resident #11 was observed walking in the first floor hallway with no on.

Daily nursing progress notes for Resident #11 document at 2 L via n/c. There was no documentation of Resident #11 refusing, removing, or not using the . Monthly progress notes by ARNP make no documentation of Resident #11 refusing or taking off.

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On 1/18/17 at 8:53 a.m., the Director of Nursing DON said the nurses are supposed to monitor is on. They are supposed to put it on in the morning. Resident #11 takes it on and off and his family is aware he does this. The DON said the issue is the same with Resident #17. DON asked, how are you supposed to supervise that? DON said it has to clarified with the physician what they want to do with that.

2. Review of the LNS file for Resident #17 revealed an order dated to admit to LNS for administration.

On at 12:44 p.m., Resident #17 was observed lying in bed, no on, tubing hanging over headboard.

On at 8:10 a.m., Resident #17 was observed at the dining table on the memory care unit with no on.

On at 3:20 p.m., Resident #17 was observed at the dining table on the memory care unit with no on.

Daily nursing progress notes for Resident #17 document at 2 L via n/c. There was no documentation of Resident #17 refusing, removing, or not using the . Monthly progress notes by ARNP make no documentation of resident refusing or taking off.

3. On at 1:35 p.m., the DON agreed there was no documentation in the LNS nursing progress notes indicating that either Residents #11 or #17 had a history of taking off or refusing to wear it, and there was no documentation that the ARNP or doctor was made aware if this is occurring.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation and interview, the facility failed to ensure staff members followed appropriate procedures to maintain control, sanitation and universal precautions.

The findings included:

On at 3:34 p.m., Staff G was observed pouring juice and water at the dining before dinner. Staff G was wearing gloves and touching tables, glasses, pitchers and the rolling cart. With

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same gloved hands Staff G picked 3 glasses up off the tables by inserting her fingers and thumb inside the glasses to carry 3 at a time to the cart. Staff G would then fill the glasses with ice using the ice scoop. Staff G was observed putting same gloved hands inside glass to remove excess ice cubes and tossing those cubes back into the ice bin. Staff G was also observed filling the glasses with juice and then reaching with gloved hand into ice bin to add more ice to glass without using ice scoop.

On / / at 3:40 p.m., Staff H was observed in the dining out drinks for dinner. Staff H was wearing gloves and touching tables and various objects. Staff H was observed using same gloved hands to pick up glasses from table by inserting fingers and thumb inside glasses to pick up multiple glasses at once.

On / at 4:22 p.m., Staff G was observed assisting on tray line. Staff G was wearing gloves and was observed touching apron, cardboard box, shelf, papers on which residents had indicated their dinner choices, and various objects in the tray line area. With same gloved hands Staff G was observed putting hand into grated cheese to sprinkle it on top of the spaghetti and meatballs with her hands. A spoon was available for use to scoop the cheese. Staff G was also observed with thumbs on the edges of plates. Staff G's thumb was observed touching the pineapple inside a dish.

On / at 9:55 a.m., Chef Staff J said the staff were trained by him, the sous chef and/or the lead server. When told of the findings of the dinner observation Staff J said, "That is embarrassing; that is not how it is supposed to be done." Staff J said recently had a meeting with them about that and they should know better. Staff J said he would talk with his staff.

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on record review, observation and interview, the facility failed to provide assistance with self-administration of medication and report suspected reactions or non-compliance to the residents' health care provider for 2 (Residents #12 and #14) of 2 residents observed for medication assistance.

The findings included:

1. On / / at 8:34 a.m., Staff I was assisting Resident #14 with medications. Resident #14 has been refusing DS (an), ordered milligrams (mg), one tablet by mouth twice daily for 7 days. Resident #14 said it was too many milligrams because it makes her sick and gives her . Resident #14 had not had this medication since Sunday, / / . Staff I said she hasn't told

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the nurse yet. She said there are no meetings, so you just need to catch the nurse when you can.

On 1/18/17 at 8:59 a.m., the Director of Nursing (DON) said the med tech usually lets them know if a resident is refusing a medication and then they notify the doctor. The DON said she just notified the Nurse Practitioner that morning regarding Resident #14 and had not heard anything back. The DON said the medication was for a type illness and agreed it had been 3-4 days since receiving the ordered .

2. On / / at 11:45 a.m., while checking medications on hand for Resident #12, Staff I found a card of (an) 300 mg capsules in the medication cart. Directions noted 1 cap every 12 hours for 15 doses. Staff I said this medication was not entered on the Medication Observation Record (MOR). Staff I said she worked the previous day (/ /) also and had not given this medication as she did not see it on the MOR and thought maybe it was for another shift.

Review of form 1823 for Resident #12 dated / / showed 300 mg one capsule every 12 hours (last dose to be given / / at 9:00 p.m.).

On / at 12:05 p.m., DON said she did not know why the medication was not on the MOR and she would call the physician to see if he wants her to take the .

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

, 2017

Administrator
Royal Palm Retirement Centre
2500 Aaron Street
Port Charlotte, FL 33952

RE: Relicensure survey

Dear Administrator:

This letter reports the findings of a state relicensure survey that was completed on , 2017 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 a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2017.** 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, RN
Field Office Manager

JS/arb
Enclosure State (5000-3547) Form
XG90

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