

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965335	(X3) DATE SURVEY COMPLETED 10/15/2017
NAME OF PROVIDER OR SUPPLIER BROOKDALE PALMER RANCH	STREET ADDRESS, CITY, STATE, ZIP CODE 5111 PALMER RANCH PARKWAY SARASOTA, FL 34238	

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

0000 - Initial Comments

An unannounced off-hours complaint survey for CCR# 2017008819 was conducted on _____ at Brookdale Palmer Ranch, an assisted living facility (license # 9737) in Sarasota, Florida.

The following is a description of the deficiencies.

0028 - Resident Care - Activities of Daily Living - 58A-5.0182(4) FAC

Based on observation, record review, and interview, the facility failed to provide appropriate supervision and assistance to toilet for 3 (Resident #1, #3, and #4) of 6 sampled residents. This resulted in the lack of care for _____ residents.

The findings included:

On _____, a review of the policy for Incontinence Care, dated _____ documented associates will assist with personal incontinence care as needed by the resident. This task will require much sensitivity. Associates will ask the resident how and what kind of assistance they need. Gather equipment before starting. Suggested guidelines include, wash hands and put on gloves, provide assistance for cleaning peri area, assist resident with handwashing, remove gloves and wash hands.

On _____, a review of the policy for Handwashing, dated _____ documented the purpose of handwashing is regarded as the single most important means of preventing the spread of _____. All associates should wash their hands to prevent the spread of _____ and _____ to other residents, other associates and visitors. A minimum of 20 seconds handwashing should be performed in situations including - not limited to: after offering incontinence care; after contact with _____, feces; after handling items potentially contaminated with any resident's excretions. The use of gloves does not replace handwashing.

On _____, a review of Resident #1, #3, and #4's health care assessment documented Resident #1 as independent for toilet and Resident #3 and #4 as requiring assistance. Residents #1, #3, and #4 reside on the Memory Care Unit.

On _____ at 10:00 a.m., Residents #1, #3, and #4, were observed sitting in the television _____ a music activity. At 11:40 a.m., Resident Assistants () Staff A and B escorted Residents #1, #3, and #4 to the dining _____ lunch. They were not checked for incontinence and not toileted before going to lunch. Resident #3 reeked of _____ when passing by him in the dining _____ his lunch. At 12:30 p.m., Residents #1, #3, and #4 were finished with lunch and returned to the television _____. At 1:15

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p.m., Residents #1, #3, and #4 were observed sitting in the same area. During this time 's Staff A and B were observed in the kitchen area of the dining At 1:25 p.m., Staff A toileted Resident #3 to check for incontinence. Resident Assistant Staff A and Staff B donned gloves and assisted him to the toilet. Resident #3 was wearing gray sweat pants and when he stood up, the seat and half of each pant leg was a darker color than rest of the pants, indicating the level of wetness. His wheelchair seat was also observed wet. Resident Assistant Staff A removed Resident #3's saturated brief and pants. Resident Assistant Staff A had to leave to search for a clean brief and on return applied the clean brief without washing off Resident #3. Resident Assistants Staff A and Staff B put clean pants on Resident #3 and returned him to his wheelchair, without cleaning it off. Resident Assistants Staff A and Staff B removed their gloves and without washing or sanitizing their hands, returned Resident #3 to the television . On at 10:45 a.m., Resident #1's wife said he uses briefs and is . She said she thought the staff take him to the toilet. She said while she is here, she does not see the staff checking his brief to see if it is wet or soiled and they do not offer to take him to the . She said it is not something he can do on his own. On at 1:35 p.m., Resident assistant Staff A went to take the lunch cart down to the first floor. Resident Assistant Staff B assisted Resident #1 to the toilet. Resident Assistant Staff B donned gloves to remove Resident #1's brief, which was saturated with . . . Resident Assistant Staff B radioed Resident assistant Staff A to bring her a clean brief, as there was none in his . Resident Assistant Staff A donned gloves. Resident Assistants Staff A and B applied a clean brief without washing his peri and areas. Resident Assistants Staff A and Staff B removed their gloves, and without washing or sanitizing their hands assisted him with his walker back to the television area. On at 1:45 p.m., Resident Assistant Staff A was observed assisting Resident #4 to the toilet. Resident #4's brief, which was saturated with , had a pungent odor of and had large bowel movement in it. Resident Assistant Staff A donned gloves, retrieved wipes and a clean brief from a the hall. Resident Assistant Staff A used a wipe with liquid soap on it to clean in between Resident #4's . . . and threw it in the trash. Using another wipe and liquid soap, Resident Assistant Staff A cleaned Resident #4's peri area and with the same wipe cleaned in between her again. Resident Assistant Staff A placed a clean brief on Resident #4, removed his gloves and did not wash/sanitize his hands. Resident Assistant Staff A took Resident #4 back to the television . On at 2:00 p.m., Resident Assistant Staff B said the residents needed to be changed every 2 hours. She stated, "Today they were not changed every 2 hours because I'm very busy today." Normally after lunch, they go into the television area. Staff B acknowledged Resident #1 was not cleaned when		

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she and Resident Assistant Staff A changed his brief. She stated, "That happens a lot because they run out of wipes in their" Resident Assistant Staff B acknowledged they should have washed their hands and did not. On . . . at 2:40 p.m., Resident Assistant Staff A said there is no problem with getting briefs and wipes. He said he restocked the resident's . . . a couple of days ago. Resident Assistant Staff A said if the resident runs out of briefs and wipes, the RAs could get the supplies from the nurses' station. He said if there were no extra briefs and wipes, they would take it from somewhere to get a clean brief. Resident Assistant Staff A said he did not clean Resident #1 because he saw there were no wipes in the He said the handwashing policy is after every patient care; but many of the . . . do not have soap in it. He said most places have hand sanitizer, they do not. On . . . at 3:50 p.m., the Director of Nursing (DON) said the nurse is supposed to help care for residents as needed. She said Resident Assistants Staff A and Staff B should have washed their hands after removing the gloves and throwing out the trash before caring for another resident. She acknowledged the residents should have been washed clean of the . . . when changing their briefs. She said when Resident Assistant Staff A smelled any . . . when he served Resident #3 his lunch; he should not have given him his lunch and should have taken him to his . . . clean him up. The DON said Resident #1, #3, and #4 had briefs that were saturated, and then Resident Assistants were not able to meet the needs of the residents. On . . . at 4:50 p.m., the Executive Director said he wants the residents to get good care. He said the nurses should have helped out in the memory unit, not sitting in the nursing office. Class III **Photos taken** 0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS Based on observation, staff and family interviews, and record reviews, the facility failed to provide care and services, and personal dignity for incontinence for 3 (Resident #1, #3, and #4) out of 6 residents sampled. The facility failed to provide a decent living environment in the resident's dining . . . The findings included: 1. On . . . between 10:00 a.m. and 1:25 p.m., Residents #1, #3, and #4 were observed in the television . . . taken to the dining . . . lunch. After lunch they were returned to the television		

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being checked for incontinence or offered to go to the toilet. While Resident #3 was in the dining , the pungent odor of could be smelled when walking behind him. When Resident Assistants Staff A and Staff B did toilet Residents #1, #3 and #4, their briefs were found to be saturated with . Resident Assistants Staff A and B failed to provide care and services as to allow for Residents #1, #3, and #4 personal dignity for incontinence care. 2. On at 10:00 a.m., the dining was observed to have pieces of bread and cereal from the breakfast meal. At 11:20 a.m., the floor was observed to be in the same condition while the residents were brought in for lunch. At 1:20 p.m., the dining was observed to have several areas with food debris from breakfast and lunch. On at 10:15 a.m., Housekeeper Staff C said she does not clean the dining and has no idea who does it. On at 11:30 a.m., Maintenance Worker Staff F said the housekeeper is the one who cleans the dining . On at 12:25 p.m., Resident #5's daughter said the carpet in the hallway has had stains on it for months and no one has bothered to get a carpet cleaner to clean it. She said she has told the staff about it several times. She said even the activity person has tried to clean it, but it needs to be cleaned with a carpet cleaner. On /7 at 2:00 p.m., Resident Assistant Staff B said she does not know who is supposed to clean the floor in the resident dining . On at 2:40 p.m., Resident Assistant Staff A said maintenance [Staff F] sweeps and mops the floor in the dining . He said Staff F did not do it today. On at 3:50 p.m., the Director of Nursing (DON) acknowledged the multiple stains on the carpets in the memory unit outside of . 204 and 209. She said she was unaware of them and will have them cleaned. She said the Resident Assistants are supposed to clean the dining after every meal. Class III 0079 - Staffing Standards - Levels - 58A-5.019(3) FAC Based on observation and staff interviews, the facility failed to appropriately staff the facility in order to		

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meet the needs of 4 (Residents #1, #3, #4, and #5) out of 6 sampled residents. The findings included: On at 10:00 a.m., there were no Resident Assistants observed on the Memory Unit. At 10:35 a.m., Resident Assistant () Staff A was observed exiting the elevator drinking a can of soda and said Staff B is on the third floor helping someone. He attempted to contact Staff B by radio and was unsuccessful. At 10:39 a.m., Resident Assistant Staff B was observed exiting another elevator with a cup of coffee. She said she was down on the first floor and is assigned to this floor unless someone calls her for help. On between 10:00 a.m. and 1:25 p.m., Residents #1, #3, and #4 were observed in the television were taken to the dining lunch. After lunch, they were returned to the television being checked for incontinence or offered to go to the toilet. While Resident #3 was in the dining , the pungent odor of could be smelled when walking behind him. When Resident Assistants Staff A and Staff B did toilet Residents #1, #3, and #4, their briefs were found to be saturated with . Resident Assistants Staff A and B failed to provide care and services as to allow for Residents #1, #3, and #4 personal dignity for inconstancies care. On at 11:06 a.m., there were no Resident Assistants observed on the third floor. The Housekeeper said Resident Assistant Staff D is assigned to the floor. On at 11:18 a.m., Resident Assistant Staff D was observed on the first floor exiting the building. She said she was just running out to her car for a moment. She said she is assigned the first and third floors by herself. On at 10:00 a.m., the dining was observed to have pieces of bread and cereal from the breakfast meal. At 11:20 a.m., the floor was observed to be in the same condition as the residents were brought in for lunch. At 1:20 p.m., the dining was observed to have several areas with food debris from breakfast and lunch. On at 2:05 p.m., during an interview, Resident Assistant Staff D said she sometimes finds covering first and third floors a little much, but Medication Technician Staff E helps her out. She said the Resident Assistants frequently work short staffed, especially if someone calls out and they cannot get it covered. On at 10:45 a.m., during an interview, Resident #1's daughter said she has no idea of the		

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staffing and thinks weekends are harder. She said she thinks it is very frustrating for management because it is hard to get good help. She said on the weekends they are understaffed. She said while she is here she does not see the staff checking his brief to see if it is wet or soiled and they do not offer to take him to the She said it is not something he can do on his own. On . . . at 11:35 a.m., during an interview, the Director of Nursing said she is responsible for staffing. She said there are two Resident Assistants and two nurses on the Memory Unit. She said there is one Resident Assistant for the first and third floors, and there is a Medication Technician that can help her. She said the nurse is supposed to help care for residents when needed. She acknowledged the residents should have been washed of the . . . when changing their briefs. She acknowledged the staff today were not able to meet the needs of the residents. On . . . at 12:06 p.m., during an interview, Resident #2's daughter said she visits every day. She said she understands management has had problems with staffing; it is difficult to get good help. She thinks they can use more staff, especially on the weekends. She said her mother has a call button pendent and when pushed it does not go anywhere. She said her dad was sick one time in the . . . no one answered his call button. She said it is usually one nurse and two RAs (Resident Assistants) on the weekends. She said at night when her mom uses the pendent, no one comes so Resident #2 calls her. The daughter said she will call the facility and no one answers the phone, so she has to drive over. She said sometimes her mom calls her because she is in pain and wants a pain medicine. She said it can be very frustrating, like the time her dad was sick in the . . . he used his call button pendent and no one came. She said she thinks the residents could benefit from having more staff because they need so much attention. On . . . at 12:25 p.m., during an interview, Resident #5's daughter said there are many times when there are residents in the television . . . there is no staff around. She said she thinks they need more help. On . . . at 1:20 p.m., Resident Assistant Staff A was observed walking past Resident #6's . . . Residence #6 could be heard yelling very loudly, "help, help me!" Resident Assistant Staff A continued to walk past Resident #6's . . . stated, "he doesn't need help, he calls out all day long." Upon entering Resident #6's . . . , he was observed reclined in the recliner without pants on and his brief appeared wet. Class III		