STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963788	**02/07/2018**
NAME OF PROVIDER OR SUPPLIER **PANORAMA LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **1030 BALMY BEACH DRIVE** **APOPKA, FL 32703**	

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

0000 - Initial Comments

The re-licensure survey with and an initial licensure for Limited Nursing Services was conducted on . . . Panorama Living Assisted Living Facility, License #8705 had deficiencies at the time of the visit.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record reviews and interview, the facility failed to ensure a health assessment form 1823 was complete for 2 of 2 sampled residents (#1 and #3).

Findings:

1. Review of the record for resident #3 revealed an admission health assessment form 1823 that was dated . The question on the form that pertained to how much assistance resident #3 required with transfers was not answered.
2. Record review for resident #1 revealed a resident health assessment form 1823 dated , the section that indicated the type of assistance she required with toileting and transfers were left blank.

On . . . at 2:30 PM, the administrator confirmed the findings.

Class III

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observation, record review and interview, the administrator failed to monitor the continued appropriateness of placement for 1 of 3 sampled residents (#1) and retained the resident who required total care with all activities of Daily living (ADL's) and could not transfer and ambulate which exceeded the continued residency criteria.

Findings:

Observations on at 10 AM revealed a staff member was pushing Resident #1 in her wheelchair. The staff was instructing her to lift her feet while she pushed the wheelchair and the resident was having a hard time understanding that she needed to lift her feet while being pushed.

On at 10 AM, staff A said resident #2 could not do anything for herself, she said the staff had to

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totally dress and toilet her, she said sometimes she could assist with removing a blouse over her head. She said it took two people to transfer the resident because she could not walk

Record review for resident #1 revealed a resident health assessment form 1823 dated , the section that indicated the type of assistance she required with toileting and transfers were left blank. The health care provider noted she required assistance with ambulation, dressing, bathing and .

On at 1 PM staff D, said resident #3 could not ambulate and transfer and required total assistance with dressing, bathing and .

On at 3:15 PM, the administrator was informed the staff confirmed the resident was total care with her activities of daily living (ADL's) and could not ambulate or transfer. The administrator disagreed.

On at 3:15 PM observations, revealed resident #1 was in bed. The staff placed a wheel chair and walker next to her bed and asked the resident to stand and use the walker to transfer to the wheelchair, the administrator and staff A had to continue to coach the resident to sit up. Once the resident sat up, she had to be coached to stand and hold onto the walker. The resident struggled to stand using the walker. When the resident stood, she sat on the bed rails and staff A was observed holding a belt loop in her pants to assist her when she was ready to transfer. The administrator and staff A had to coach the resident continually to stand. When she did stand staff a used the belt loop to help slide the resident from the bed rail to the wheel chair, the resident did not bear weight on her feet at all to assist with the transfer.

The administrator said at the time she could transfer if she wanted, it was dependent upon her mood at the time.

Review of the physical notes dated that noted the resident was chair fast, unable to ambulate and unable to wheel self. She was discharged on because she met her maximum potential and she was discharged due to lack of progress. She did not tolerate well due to verbal agitation possible in regards to new living arrangements in same ALF.

Class III

0026 - Resident Care - Social & Leisure Activities - 58A-5.0182(2) FAC

Based on the activity calendar, observations and interviews the facility failed to provide an ongoing activities program 12 hours a week, 6 days a week that provided diversified individual and group

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activities in keeping with each resident's needs, abilities, and interests.

Findings:

Observations on at 9 AM revealed the facility consisted of two buildings. There was no activity calendar posted in a common area where the residents congregated in either building.

During interviews with the residents throughout the survey it was revealed that the facility did not have a variety of activities the residents were interested in, all they would do was to sit around and watch television all day. The only activities they were offered at times were dominoes and karaoke. The residents said they did not have meetings with the administrator or staff to discuss their interest in activities.

Review of the activities calendar that was posted in the building called station 2 in a small corner next to the printer and computer, revealed the following activities, the time of the activities were not noted:

-Sunday- walk around the pool (0.5) arts and crafts (0.5), Sunday service (1.0),
-Monday- Walk around the pool (0.5), gardening (0.5), Karaoke (1.0), arts and crafts (0.5),
-Tuesday-Walk around the pool (0.5), gardening (0.5), bible study (1.0), arts and crafts (0.5),
-Wednesday-Walk around the pool (0.5), gardening (0.5), Domino (1.0), arts and crafts (0.5),
-Thursday-Walk around the pool (0.5), gardening (0.5), bingo (1.0), arts and crafts (0.5),
-Friday-Walk around the pool (0.5), gardening (0.5), Dancing with the stars (1.0), arts and crafts (0.5),
-Saturday-Walk around the pool (0.5), gardening (0.5), arm and leg exercise (1.0), arts and crafts (0.5).

Further review of the schedule revealed the same activities scheduled for each week for the month of , as above.

There were residents at the facility who were alert and oriented. The type of activities the facility scheduled were not appropriate for those residents. There were residents who were not capable of walking around the pool, playing bingo or dominoes. The planned activities were not diversified, individualized and group activities that kept up with each resident's needs, abilities and interest.

At approximately 2 PM, the staff were observed doing Karaoke with 4 residents, there were 4 residents sitting at the table playing dominoes together. The residents in station 1 location were not participating. The residents said they were asked, but did not want to participate.

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On at 2:30 PM, the staff was asked to provide the items used for arts and craft, the staff provided two coloring books that could be used for young children and a box of crayon. She also provided sheets of papers that had stickers on them. This was not appropriate for the residents who resided in the facility.

On at 3 PM, the administrator said the residents did not want to participate in activities. She was informed that the residents did not like what was offered. She confirmed she did not have meetings to discuss the type of activities the residents would like.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on record review, medication observation record (MOR) review and interviews, the facility failed to ensure a licensed nurse provided medication administration for 1 of 3 sampled residents (#2).

Findings:

Record review for Resident #2 revealed a health care assessment form 1823 dated . The health care provider noted she needed medication administration (nurse to provide).

Interview with staff D who said the unlicensed staff gave resident #2 her medication.

Staff A said the unlicensed staff would have to put the medication in the resident's hand and bring her hand to her mouth to take the medication.

Review of the MOR revealed there were unlicensed staff (non-nurses) initials indicating they were assisting with medication.

Observations on at 2 PM revealed the resident was in bed. She was not able to speak due to her . Her hands were contracted and were covered with socks.

On at 3 PM, the administrator who is a nurse said, the resident received hospice services and she thought the unlicensed staff could give her medications to her.

Class III

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0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on personnel record reviews and interview, the facility failed to ensure that 2 of 2 sampled staff (A and B) received the required in-service training within 30 days of hire.

Findings:

Personnel record review for staff A, a caregiver, revealed a hire date of .

Personnel record review for staff B, a caregiver, revealed a hire date of .

The records for staff A and staff B did not contain documented evidence to indicate either staff member received training on the facility's resident elopement policy and procedure, as required.

On at 2:45 pm, the administrator confirmed the findings.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observations and interview, the facility did not conspicuously post the planned menus nor was the menus easily available to residents and did not encourage the residents to participate in the menu planning.

Findings:

Observations on at 9 AM revealed the facility consisted of two buildings. There was no menu posted anywhere in station 2.

On during interviews with residents of the facility, it was revealed they were not encourage to participate in the menu planning. The residents said they would make suggestions and they were told the dietitian made the menus. A resident said bacon was suggested because they do not have meat every day for breakfast, and it was not included on the menu.

On at 4 PM, the administrator said the menu was posted in station 1, inside of the kitchen and not in station 2 for the residents who resided on that side. She further said she did not have a meeting to discuss the menu, she said bacon was not served because it was not good for the residents to eat every

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day. She was informed that the residents did not want bacon every day, but on occasion.

Class III

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

Based on observations and interview, the facility failed to ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances were maintained in good working order.

Findings:

Observations made on at 3 pm revealed a , which was used by residents, was located in a hallway and across from . The seat on the toilet was loose.

On at 3:05 pm, the administrator confirmed the finding.

Class III

0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS

Based on record reviews and interview, the facility failed to ensure a residency contract contained all of the required information for 1 of 2 sampled residents (#2).

Findings:

Review of the facility's renewal application revealed the facility applied for a Limited Nursing Service license.

Review of the residency contract for resident #2 revealed it did not contain a list of Limited Nursing Services to be provided by the facility, as required.

On at 3:45 pm, the administrator confirmed the finding.

Class