STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953279	09/19/2018
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

An unannounced complaint survey for CCR #2018013360 was conducted on at the Palms of Punta Gorda, an assisted living facility (license #8469) in Punta Gorda, Florida.

The complaint contained 3 allegations; 1 allegation was unsubstantiated, 1 allegation was substantiated without citation and 1 allegation was substantiated with citation.

The following is description of the deficiencies.

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 provide access safe environment related to use of bed rails, security of and personal /hallway esthetics for 10 (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, and #12) out of a sample of 83 resident observed.

The findings included:

The U.S. Consumer Product Safety Commission (CPSC) and Food and Drug Administration (FDA), http://www.cpsc.gov/PageFiles/133466/adult bedrail.pdf and http://www.fda.gov/cdrh/beds, identify safety concerns about bed rails: "Inspect and regularly check the mattress and bed rails for areas of possible entrapment, the bed rail and mattress should leave no gap wide enough to entrap a patient's head or body. The FDA is recommending a dimensional limit of less than 60 mm (2 3/8 inches - neck diameter) for the area between the inside surface of the rail and the compressed mattress. Be aware that not all bed side rails, mattresses, and bed frames are interchangeable and not all bed rails fit all beds. The agency (CPSC) received reports of 155 deaths and 5 injuries, related to portable bed rails, from 2003 to 2015. Of the deaths, 143 were related to rail entrapment." (updated 2017)

1. On at 10:40 a.m., observation of the bed used by Resident #1 revealed a 1/2 bed rail positioned in the middle of the bed. A space (gap) of approximately 5 inches was observed between the bed rail and the mattress, creating a high potential for head or bodily entrapment. The surveyor pulled on the bed rail and it easily moved to create a larger gap between the bed rail and mattress. The Maintenance Director was called to the resident's said the bed rail straps needed to be secured around the mattress. After this was done, the surveyor pulled on the bed rail and it easily moved again to create a 5 inch gap.

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On at 10:40 a.m., the Maintenance Director said there was no mechanism in place to regularly check the positioning of bed rails on resident beds and hospital beds. The Maintenance Director acknowledged that he would be unable to secure the bed rail, used for Resident #1, to prevent movement and eliminate any gap between the bed rail and bed.

2. Observation of 83 resident beds, between 10:40 a.m. and 12:30 p.m. on , revealed that Residents #2, #3, #4, #5, #6, #7 and #8 also had portable bed rails that were a safety hazard with gaps between the bed rail and mattress or had the potential for a gap due to unsecured bed rails.

3. Observation of Resident #9's , on at 1:00 p.m., revealed that she had a portable bed rail on top of her clothes chest. Although the bed rail was not on the resident's bed, there was no mechanism to secure the bed rail to the bed in the event it was used.

Observation also noted a small unsecured cylinder observed on top of the resident's dresser. The Director of Nursing, who was present at this time, acknowledged that the cylinder should have been in a rack to secure the integrity of this compressed gas and prevent potential injury.

4. Observation of the Resident #12, on at 12:05 noon, revealed a floor tile had a rip and missing portion. This tile area was next to the bed and represented a safety issue.
The Executive Director, present at this time, said they were remodeling.

5. The carpeting, in the facility back hallway, was observed on at 12:05 p.m. to be stained, worn and rippled.

Class III

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

Based on observation, and interview the facility failed to ensure a safe living environment maintained in good working order. Portable bed rails presented an entrapment hazard due to a gap between the bed rail and the mattress and/or the high potential for a gap to occur. This was evidenced on the beds of 8 (Resident #1, #2, #3, #4, #5, #6, #7, #8) out of a sample of 83 resident beds observed. The facility failed to ensure that an cylinder was appropriately secured for one (Resident #9) out of one resident sampled for use of . The facility failed to ensure the facility was maintained on good working order for 3 (Residents #10, #11 and #12) of 83 observed.

The findings included:

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1. On at 10:40 a.m., observation of the bed used by Resident #1 revealed a 1/2 bed rail positioned in the middle of the bed. A space (gap) of approximately 5 inches was observed between the bed rail and the mattress, creating a high potential for head or bodily entrapment. The surveyor pulled on the bed rail and it easily moved to create a larger gap between the bed rail and mattress. The Maintenance Director was called to the resident's said the bed rail straps needed to be secured around the mattress. After this was done, the surveyor pulled on the bed rail and it easily moved again to create a 5 inch gap.

On at 10:40 a.m., the Maintenance Director said there was no mechanism in place to regularly check the positioning of bed rails on resident beds and hospital beds. The Maintenance Director acknowledged that he would be unable to secure the bed rail, used for Resident #1, to prevent movement and eliminate any gap between the bed rail and bed.

Observation of 83 resident beds, between 10:40 a.m. and 12:30 p.m. on , revealed that Residents #2, #3, #4, #5, #6, #7 and #8 also had portable bed rails that were a safety hazard with gaps between the bed rail and mattress or had the potential for a gap due to unsecured bed rails.

Observation of Resident #9's , on at 1:00 p.m., revealed that she had a portable bed rail on top of her clothes chest. Although the bed rail was not on the resident's bed, there was no mechanism to secure the bed rail to the bed in the event it was used.

2. Observation of Resident #9's , on at 1:00 p.m., revealed a small unsecured cylinder observed on top of the resident's dresser.
The Director of Nursing, who was present at this time, acknowledged that the cylinder should have been in a rack to secure the integrity of this compressed gas and prevent potential injury.

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3. Observation on at 12:00 p.m. of the shared Residents #10 and # 11 revealed a distinct offensive odor and carpet in which was very worn and stained.
The Executive Director present at this time, said the had an odor and nothing could be done about it.

Observation on at 12:05 p.m. of Resident #12's a hole in the wall behind the entrance door that appeared to be the size of the door knob. In addition, a floor tile had a rip and missing portion. This tile was next to the bed and would be a safety hazard.
The Executive Director present at this time, said she was unaware of the hole.

On at 12:10 p.m., carpeting in the facility's back hallway was observed to be stained, worn and rippled. Rippled carpet has the potential to be a safety hazard.

Class III