STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964729	**02/07/2019**
NAME OF PROVIDER OR SUPPLIER **VILLAGE PLACE RETIREMENT**	STREET ADDRESS, CITY, STATE, ZIP CODE **18400 COCHRAN BLVD.** **PORT CHARLOTTE, FL 33948**	

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

0000 - Initial Comments

An unannounced relicensure, limited nursing service and emergency power plan monitoring survey was conducted through at Village Place Retirement Center, an assisted living facility (license #9249) in Port Charlotte, Florida.

The following is description of the deficiencies.

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

Based on record review and interview, the facility failed to offer personal supervision as appropriate to their needs for 2 (Residents #13 and #14) out of 3 Residents sampled for medication review. The facility failed to follow their facility policy regarding : "Medication Availability".

The findings included:

During an interview on at 1:00 p.m., the Wellness Director and Executive Director reported they were not aware there were 17 pages of "Awaiting Pharmacy" notations for residents receiving assistance with medication self-administration for the month of , and 4 pages for the month of , . The Wellness Director reported she was not informed by the med techs about the medications awaiting pharmacy delivery and the residents' providers and families were not notified regarding missed medications.

The facility policy for "Medication Availability" (review date) states: "The Wellness Director is overall responsible to ensure medications are available as prescribed by Physician. If a medication has not been received by the community and the supply is at 2 days or less: The med tech will contact the pharmacy for the status of the medication delivery and request an emergency supply of the medication. Notify the Wellness Director, licensed staff or Executive Director verbally or via phone if it is after hours or on a weekend. The Wellness Director will follow up with the pharmacy representative verbally to confirm medication delivery. Notify family and the physician and will document in the resident record. Notify the Executive Director of any missed medications or challenges receiving medications timely. The Wellness Director and or Licensed Nurse will conduct an audit on the medication carts monthly to ensure that prescribed medications are available."

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964729	02/07/2019
NAME OF PROVIDER OR SUPPLIER **VILLAGE PLACE RETIREMENT**	STREET ADDRESS, CITY, STATE, ZIP CODE **18400 COCHRAN BLVD.** **PORT CHARLOTTE, FL 33948**	

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

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

Based on Record Review and Interview, the facility failed to make a reasonable effort to ensure prescriptions for residents receiving assistance with self-administration of medications are filled or refilled in a timely manner for 2 (Residents #13 and #14) out of 3 residents sampled.

The findings included:

During Med Review on at 9:00 a.m., it was observed listed on the Medication Observation record (MOR) that Resident #13 was prescribed the medication: , , (medication) 5 mg tablet once daily. It was documented by med techs on the MOR as "Not available by pharmacy" on , , , and .

Resident #14 was prescribed medication: , 100 mg capsule by twice daily for . It was documented by med techs on MOR as "awaiting pharmacy" on dates: , at 8:00 a.m. and 4:00 p.m., at 8:00 a.m. and 4:00 p.m. and at 8:00 a.m.

During interview with Staff G on at 9:45 a.m., she reported the notation awaiting pharmacy means the medication is not available and is waiting for pharmacy to deliver to facility. She reported the med techs do not inform the Director of Wellness regarding medications that are awaiting pharmacy.

During interview on at 1:00 p.m., the Wellness Director and Executive Director reported they were not aware there were 17 pages of "Awaiting Pharmacy" notations for residents receiving assistance with medication self administration for the month of , and 4 pages for the month of , . The Wellness Director reported she was not informed by the med techs about the medications awaiting pharmacy delivery and the resident's providers and families were not notified regarding missed medications.

The facility policy for "Medication Availability" (review date) states: "The Wellness Director is overall responsible to ensure medications are available as prescribed by Physician. If a medication has not been received by the community and the supply is at 2 days or less: The med tech will contact the pharmacy for the status of the medication delivery and request an emergency supply of the medication. Notify the Wellness Director , licensed staff or Executive Director verbally or via phone if it is after hours or on a weekend. The Wellness Director will follow up with the pharmacy representative verbally to confirm medication delivery. Notify family and the physician and will document in the resident record. Notify the Executive Director of any missed medications or challenges receiving medications timely. The Wellness Director and or Licensed Nurse will conduct an audit on the medication carts monthly to

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964729	02/07/2019
NAME OF PROVIDER OR SUPPLIER **VILLAGE PLACE RETIREMENT**	STREET ADDRESS, CITY, STATE, ZIP CODE **18400 COCHRAN BLVD.** **PORT CHARLOTTE, FL 33948**	

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

ensure that prescribed medications are available."

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview, the facility failed to ensure that within 30 days of employment, newly hired staff submitted a written statement from a health care provider documenting the individual does not have any signs or symptoms of communicable . . . . . for 1 (Staff E) of 4 staff reviewed.

The findings included:

Staff E was hired as a medication technician on . . . . . Staff E's file contained no statement from a health care provider that they had no signs or symptoms of communicable .

On at 12:07 p.m., the Business Office Manager said they do not have a communicable statement for Staff E.

Class III

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

Based on record review and interview, the facility failed to ensure facility employees complete the in-service training required by Florida Administrative Code within 30 days of employment for 3 (Staff D, E, and F) of 3 employee files reviewed. The facility also failed to provide at least a 2 hour pre-service orientation prior to interacting with residents for 3 (Staff D, E, and F) of 3 staff reviewed hired after . . . . .

The findings included:

Staff D was hired as a medication technician on . Staff D's file did not contain documentation of having completed a 2 hour pre-service orientation. Staff D's file did not contain documentation of having completed a 3 hour in-service in Activities of Daily Living and Behavioral needs. Staff D's file did not contain documentation of completing a 1 hour in-service training in reporting major incidents, reporting adverse incidents and facility emergency procedures including chain of command and staff roles relating to emergency evacuation. Staff D's file did not contain documentation of in-service training regarding the facilities resident elopement response policies and procedures. Staff D's file did not contain documentation of having completed a 1 hour incident report training. Staff D's file did not contain

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964729	02/07/2019
NAME OF PROVIDER OR SUPPLIER **VILLAGE PLACE RETIREMENT**	STREET ADDRESS, CITY, STATE, ZIP CODE **18400 COCHRAN BLVD.** **PORT CHARLOTTE, FL 33948**	

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

documentation of having completed a minimum 1 hour in-service in safe food handling practices.

Staff E was hired as a resident aide on . Staff E's file did not contain documentation of having completed a 2 hour pre-service orientation. Staff E's file did not contain documentation of having completed a 3 hour in-service in Activities of Daily Living and Behavioral needs. Staff E's file did not contain documentation of completing a 1 hour in-service training in major incidents, reporting adverse incidents and facility emergency procedures including chain of command and staff roles relating to emergency evacuation. Staff E's file did not contain documentation of in-service training regarding the facilities resident elopement response policies and procedures. Staff E's file did not contain documentation of having completed a 1 hour incident report training. Staff E's file did not contain documentation of having completed a minimum 1 hour in-service in safe reporting food handling practices. Staff E's file contained no documentation of having completed a 1 hour control training. Staff E's file contained no documentation of having completed a 1 hour in-service in Resident Rights and Recognizing and Reporting and Neglect.

Staff F was hired as a resident aide on . Staff F's file contained no documentation of having completed a 2 hour pre-service orientation.

On at 12:43 p.m., the Administrator said there had recently been a change in management companies and they took the files with them. The Administrator said they will redo the trainings and get the proper documentation in the files.

Class III

0082 - Training - / - 58A-5.0191(4) FAC

Based on record review and interview, the facility failed to ensure facility employees complete a one time education course on and (/) and maintain documentation of completion for 2 (Staff D and E) of 4 employee files reviewed.

The findings included:

Staff D was hired as a medication technician on . Staff D's employee file contained no documentation of having completed a course on / .

Staff E was hired as a Resident Aide on . Staff E's employee file contained no documentation

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964729	02/07/2019
NAME OF PROVIDER OR SUPPLIER **VILLAGE PLACE RETIREMENT**	STREET ADDRESS, CITY, STATE, ZIP CODE **18400 COCHRAN BLVD.** **PORT CHARLOTTE, FL 33948**	

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

of having completed a course on / .

On at 12:43 p.m., the Administrator said there had recently been a change in management companies and they took the files with them. The Administrator said they will re-do the trainings and get the proper documentation in the files.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on record review and interview, the facility failed to ensure facility employees complete at least one hour of training in the facility's policies and procedures regarding ( ) within 30 days after employment and maintain documentation of completion for 2 (Staff D and E) of 4 employee files reviewed.

The findings included:

Staff D was hired as a medication technician on . Staff D's file contained no documentation of having completed an in-service on .

Staff E was hired as a resident aide on . Staff E's file contained no documentation of having completed an in-service on .

On at 12:43 p.m., the Administrator said there had recently been a change in management companies and they took the files with them. The Administrator said they will redo the trainings and get the proper documentation in the files.

Class III

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

Based on record review and interview, the facility failed to issue and maintain training certificates in the facility's personnel files upon successful completion of trainings as required by Florida rule for 3 (Staff D, E, and F) of 4 employee files reviewed.

The findings included:

Staff D's employee file revealed a hire date of as a medication technician. Staff D's employee

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964729	**02/07/2019**
NAME OF PROVIDER OR SUPPLIER **VILLAGE PLACE RETIREMENT**	STREET ADDRESS, CITY, STATE, ZIP CODE **18400 COCHRAN BLVD.** **PORT CHARLOTTE, FL 33948**	

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

file was of multiple certificates documenting completion of trainings as required per Florida statute.

Staff E's employee file revealed a hire date of as a resident aide. Staff E's employee file was of multiple certificates documenting completion of trainings as required per Florida statute.

Staff F's employee file revealed a hire date of as a resident aide. Staff F's employee file was of multiple certificates documenting completion of trainings as required per Florida statute.

On at 12:43 p.m., the Administrator said there had recently been a change in management companies and they took the files with them. The Administrator said they will re-do the trainings and get the proper documentation in the files.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on interview and observation, the facility failed to store 72 hours of fuel on site required for a facility with a licensed capacity of 17 or more beds.

The findings included:

Observation of the fuel for the generator stored by the facility revealed there was not enough to run the generator for 72 hours.

On at 10:00 a.m., The Maintenance Director said there was enough fuel on site to run the generator for 48 hours. The Maintenance Director agreed there are more than 17 beds in the facility.

Class III