STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965658	05/22/2018
NAME OF PROVIDER OR SUPPLIER **PALM COTTAGES OF ROCKLEDGE**	STREET ADDRESS, CITY, STATE, ZIP CODE **3821 SUNNYSIDE COURT** **ROCKLEDGE, FL 32955**	

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

0000 - Initial Comments

The re-licensure survey with Extended Congregate Care (ECC) was conducted on , 2018. Palm Cottages of Rockledge, license #9987, had deficiencies at the time of the survey.

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

Based on observations, interviews and record review the facility retained 1 of 12 sampled residents (6) who exceeded assisted living facility continued residency, had an unstageable pressure and failed to obtain for 1 of 12 sampled residents (#13) a face-to-face medical examination by a health care provider at least every 3 years after the initial assessment.

Findings:

1. In an interview on at 9 AM with the Resident Care Director who identified resident # 6 as receiving home health care for care to a pressure on right foot.

Observations on at 8:45 AM note the resident sat in a wheelchair and fed himself. Was alert and oriented.

In an interview on at 10:45 AM resident # 6 said a nurse came to check on his foot and his was getting better. He was aware that he should shift his weight and take rests to relieve pressure.

Resident record review revealed resident # 6 was admitted on with diagnoses of pressure to and right heel , , and .

Facility note dated indicated he had a reddened area to and deep tissue injury to the right heel.

A health care provider's visit note dated indicated right heel and (pressure) . The resident was send to the hospital on because of right heel and penile phimosis; needed changed.

An updated health assessment report dated that listed diagnoses muscle , , and an unstageable , left heel and a to . Page 2 of the assessment indicate the resident had an unstageable , to the right heel and a pressure to the .

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Home health care nursing note dated indicated pressure to right heel unstageable and pressure to sacral region . The right heel was unstageable and measured 0.7 x 0.9 x 0.

Home health visit note dated indicated right heel pressure was unstageable.

In an interview on at approximately 3:30 PM with the Resident Care Director who confirm the resident had an unstageable pressure on the right heel.

In an interview on at approximately 4 PM with the administrator who said the resident had not been given notice of discharge.

2. Record review for resident #13 revealed the lasted resident health assessment form 1823 that was dated . Further record review revealed there was no updated health assessment form 1823 completed 3 years after this assessment.

On at 3 PM, the resident care director confirmed the findings.

Class III

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

Based on record reviews and interviews, the facility failed to notify a health care provider when 2 of 12 sampled residents (#13 and #19) refused medications and failed to follow an order from a health care provider for 1 of 12 sampled residents (#12).

Findings:

1. Resident #19's record revealed a facility admission date of . A health assessment form 1823, dated , indicated that her diagnoses included , left hip , and . She required assistance with self-administration of her medications.

The record contained an order from a health care provider, dated , for 40 milligrams (mg,) take 1 tablet by mouth twice a day at 6 am and 12 pm.

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Resident #19's ..... 2018 Medication Observation Record (MOR) contained an entry for the ..... The 12 pm dose was circled on , , - , , , and - . Documentation on the back of the MOR indicated that she refused the ..... on those dates. There was no documentation on the MOR or in the resident's record to indicate a health care provider was notified when she refused the .

On ..... at 3:36 pm, the resident care director confirmed the findings and said the caregivers who assisted the resident with her medications did not tell a nurse when she refused the .

2. Observations on at 6:15 AM, revealed staff P was in the resident #13 with a cup with a pill inside. Staff P asked resident#13 if she was going to take her morning medication and the resident said she was not going to take it. Staff P came out of the placed the pill in the garbage that was located on the side of the medication cart. Staff P said she had taken the medication out of the package after she had asked the resident if she was going to take it and when she returned to the give it to resident #13 she refused. She said she had learned in her medication training if a resident refused the medication to throw it away.

Review of the Medication Observation Record (MOR) for resident #13 revealed the following:
On -6 AM- , 50 mcg 1 daily at 6 AM the resident had refused the medication
-all 9 am "meds" refused
- , -Low 81 mg-refused at 9 AM; 500 mg refused;
at 5:45 AM-refused not given/thrown out
and /6 Am- , refused-not given

Further record review revealed there was no documentation that the health care provider was notified when the residents refused to take her medications.

3. Review of the and MOR for resident #12 revealed on certain days , 325 milligrams (mg) take two 650 mg twice a day for pain was marked as not given because the medication was not available as follows:

at 9 AM and 5 PM-noted, "Awaiting med" not given
at 5 PM--noted, "Awaiting med" not given
-no time-"waiting" not given

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-no time -noted, "Awaiting med" not given
-no time -noted, "Awaiting med" not given
, and each written twice without times noted "awaiting med" not given
written twice no time noted, "Waiting med" not given
written twice no time noted, "Awaiting med" not given
and both written twice with no times noted "not available" not given
and no time noted, "Awaiting med" not given

On , the resident care director said the nurse was not aware that resident#12 was refusing the . She requested from the pharmacy the history of , 325 mg that was sent to the facility. It was revealed that for , and , the medication was delivered to the facility, she did not know why the staff did not give the resident the medication and noted it was unavailable. She said the medication was in the medication cart.
The medication was located at the facility and the staff did not follow the physicians order to give the medications.

An email was received on from the resident care director who said she had conducted an investigation, the , 325 was delivered timely, and there was medication located in the overflow bin. She said there was medication in the medication cart and overflow bin at the time of the investigation and she did not know why the staff noted it was unavailable. She said if there was not any medication in the cart, the staff was to check the overflow bin for the medication.

Class III

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

Based on observations and interview the facility failed to ensure the unlicensed staff (F, L and P) who assisted residents (#4, #8, #13 and #16) with self-administration of medications followed the correct procedure.

Findings:

1. Observations on at 7 AM in # at the Sylvester House, noted staff F assisted resident #4 with self-administration of medications. She came out of the resident's a cup that had a pill inside. She said the resident refused the medication, so she threw the cup with the pill inside, in the garbage can by the cart. She said she always threw them way in the garbage if the resident refused.

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2. Continued observations noted the staff proceeded to assist resident #16 with her medications. The resident lived in # at Sylvester House. Staff F took the medication from the cart, put the pill in cup and brought it to resident who sat in the enclosed porch. She gave the cup and water to the resident and observed resident take the med.

In an interview on at 3:35 PM with the Director of Resident Care, who offered no comment.

3. Observation during an interview with resident #8 on at 9:45 AM revealed that staff L came into the resident's a small cup with pills in it and a glass of water. She apologized for the interruption and handed the cups to the resident without saying anything to the resident about the medications or asking if she wanted to take her medications. The resident took the small cup, put the pills in her mouth and then swallowed them with the water provided. Staff L said thank you and left the .

Record review for resident #8 revealed a health assessment dated . Diagnoses included , , , insufficiency, / . She required assistance with self-administration of medications.

On at 10:00 AM, staff L confirmed that she brought the medications to resident #8 already in the cup, did not bring the packaging to the resident and did not read the label to the resident. She stated this is how she always does it.

On at 3:00 PM, the Resident Care Coordinator, an LPN, confirmed this was the wrong procedure.

4. Observations on at 6:15 AM, revealed staff P was in the #13's a cup with a pill inside. Staff P asked resident#13 if she was going to take her morning medication and the resident said she was not going to take it. Staff P came out of the placed the pill in the garbage that was located on the side of the medication cart. Staff P said she had taken the medication out of the package after she had asked the resident if she was going to take it and when she returned to the give it to resident #13 she refused. She said she had learned in her medication training if a resident refused the medication to throw it away.

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Staff P did not follow the proper steps when she assisted with the residents medications, she did not in the presence of the resident, read the label, open the container, remove the prescribed amount of medication from the container after the resident agreed to take.

Class III

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

Based on personnel record reviews and interviews, the facility failed to ensure 2 of 5 sampled staff (B and E) received the required trainings within 30 days of employment.

Findings:

1. Caregiver B's personnel record revealed a hire date of . . . . . The record did not contain documentation to indicate she received in-service training that covered facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation, as required.

On . . . . . at 4:09 pm, the human resource director confirmed the findings.

2. Personnel record review for staff E, hired on and a Registered Nurse revealed a certificate dated . . . . . that indicated she attended an Internet in-service training regarding emergency preparedness for healthcare providers. However, there was no evidence to confirm she attended/received an hour in-service training regarding the facility's emergency procedures including chain-of-command and staff roles relating to emergency evacuations. There was no evidence to confirm she received an -in-service training regarding reporting major incidents.

In an interview with the human resources manager . . . . . at 3:30 PM, who confirmed the findings.

Class III

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

Based on personnel record review and interview the facility failed to ensure that 1 of 5 sampled staff (E) received an in-service craning regarding the facility's ( ).

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Findings:

Personnel record review revealed staff E was hired on [redacted] and was a Registered Nurse. There was no evidence to confirm she received an -in-service training regarding the facility's policies and procedures.

In an interview with the human resources manager [redacted] at 3:30 PM, who confirmed the findings.

Class III

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

Based on observation, dietary record review and interview, the facility failed to ensure 6 months of dated menus were kept on file.

Findings:

Observations found the current menu posted in each of the 8 cottages.

Review of the dietary records in the office of the dietary manger found no record of the menus served in the past 6 months.

On at 10:35 AM, she stated she was not aware she needed to keep a record of which menu was served each week. She said she rotates the menus through the 6 week cycle they use. She confirmed she did not have dated menus or a record of what was served in the past 6 months.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record reviews and interviews, the facility failed to maintain an accurate weight record for 1 of 12 sampled residents (#12).

Findings:

Review of the weight record for resident #12 revealed that on his weight was recorded as 127 pounds (lbs.,), on his weight was recorded as 100 lbs. and on his weight was recorded as

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120 lbs.

During an interview with the resident care director on . . . . at 3:30 PM, she said the resident did not have a weight loss as recorded, she said it was a recording error.

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 for 2 of 12 sampled residents (#5 and 12) contained all of the required information.

Findings:

Review of the facility's posted license on . . . . . revealed the facility held an Extended Congregate Care (ECC) specialty license.

Individual review of the contract for residents #5 and #12 revealed the contract did not contain a list of the specific ECC services to be provided by the facility and any associated charges.

In an interview on . . . . . at 4 PM with the administrator who said the information must have been overlooked.

Class