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

Complaint investigations #20180033, #2018005148 and #2108007173 were conducted in conjunction with the re-licensure survey on . Palm Cottages of Rockledge license # 9987 had a deficiency at the time of the visit related to complaint investigation #2018003333.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

1. Based on observations record review and interview, the facility failed to honor the rights regarding termination of residency from the facility for 2 of 12 sampled residents (#17 and #18) by not accepting the residents back into the facility after hospital admission, to be treated with consideration and respect, due recognition of personal dignity & individuality and admitted 1 of 1 sampled alert and oriented resident (4) to the secure memory care unit because he needed more physical care not due to memory care issues, did not provide a discharge notice to 1 of 12 sampled residents (#18) and did not ensure the use of physical was limited to half bed rail for 2 of 12 sampled residents (#14 and 15).

Findings:

1. Record review for resident #18 revealed a resident health assessment form 1823 that was dated , the health care provider noted she required assistance with all of the activities of daily living and ambulation and transferring. Record review for resident #18 revealed a resident observation log that note on -at 9:25 AM called to cottage because resident was having chest pain and was short of breath. According to the observation log 911 was called at 9:26 am arrived at 9:30 AM and resident transported to hospital ER. resident remains at hospital. There was an order for hospice services that was dated . There was no documentation regarding the resident returning to the facility available for review.

On at 1 PM, the resident care director said the resident went to the hospital and she and the administrator went to the hospital to assess the resident and felt they could not meet her safety needs and did not accept the resident back to the facility after she was admitted into the hospital.

at 1:15 PM the administrator said the resident's daughter wanted the staff to get the resident up and walk her 10 times a day. The staff were afraid due to safety issues, the residents daughter would come in and make resident #18 walk with the walker and force her to walk when she could not, the resident would struggle to walk. The administrator said she called their consultant and was informed due to the safety concerns for the resident they could not meet her needs. She said the resident's individual needs could have been met, however the expectations of what the resident's daughter wanted the

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facility to provide could not be met due to safety reasons.

Further record review revealed there were no notes that documented the resident had declined since her hospital admission and required a higher level of care. In addition, there was no documentation regarding the expectations of the resident's daughter and the inability of the facility to meet those requests. There was no documentation that this had been discussed with the resident or her daughter nor was there any documentation of the request made of her daughter that were beyond those that could be met by the facility. There was no documentation to confirm the facility had provided the resident or her daughter a 45-day notice.

On at 4 PM, the administrator said she had spoken with the resident's daughter regarding her expectations, she said there was no documentation to confirm this and that the facility did not a 45-day notice of discharge.

2. Observations during the facility tour on at 6:20 AM noted the beds of resident 14 and 15 had hospital beds full bed rails. The full rails were not build in on the bed they were removable.

In an interview on at 9 AM with the Resident Care Director who identified both residents as being under the care of hospice.

Resident record review for resident #14 revealed a health assessment report dated that listed diagnoses of Parkinson's and . Continued review revealed no evidence to confirm that a healthcare provider's order for the use of half-bed rails only had been obtained.

In an interview on at 3:45 PM with the Resident Care Director, who said hospice supplied the hospital bed.

3. In an interview on at 9:15 AM with resident #4 who said regarding activities "I watch TV. That is about it. You are lucky if you know how to use the remote control, you watch TV". He added he needed to shower, to get out of bed, and to get dressed. He was able to toilet himself. He added he did not want to take his pills anymore because he had taken them for a very long time and they do not make him feel better. The mornings "are my worst, when you saw me. I really needed help and she came. I can put the , myself but can get help if I need".

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4. Review of the closed record for resident #17, revealed she was admitted to the facility on , and discharged on . Her initial health assessment (form 1823) was dated . The health assessment did not include any diagnoses, but documented the resident was independent with all Activities of Daily Living (ADLs). Resident #17 was admitted to hospice care on with a diagnosis of . The latest 1823 in the record was dated . The diagnosis section on the form stated, "see attached" but there was nothing attached to the assessment. She was noted to be , and all ADLs were documented as requiring "1 person assist."

Review of the nursing observation notes found an entry by the Resident Care Coordinator (RCC) dated , 2 pm documenting a call was placed to the resident's brother explaining resident now required "2-person assist" in a "1-person cottage and needs to transition to a memory care cottage, or would have to move out." The brother responded he was "unable to afford memory care." The RCC explained she "would be happy to contact hospice to assist with relocating his sister." A note entered on at 2pm by the ED and RCC documented they placed a follow-up call to the resident's brother and informed him a 45-day notice of discharge was mailed to him on . The note further stated they contacted hospice again who reported they had not been able to find a place within the brother's budget.

A letter dated was found in the record documenting the facility's 45-day notice of discharge due to being "unable to meet your sister's need for the level of care she requires nor for her safety at this time."

Review of the contract for admission to the facility dated was not found to contain any language stating if a resident's condition changed and required a 2-person assist, they would have to move to memory care or move out.

On at 4:30 PM the resident care coordinator stated it is their policy for residents who require a 2 person assist to transfer or for toileting to move them to the memory care cottages, regardless of their diagnoses, because those are the only cottages they staff with 2 caregivers.

On at 4:40 PM, the administrator agreed and said that is their policy and said they "would have to provide 2 caregivers in all cottages in order to meet potential needs and that would increase the cost for everyone." The administrator confirmed the language stating the resident were required to move to memory care if they needed a 2-person assist was not in the contract.

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4. Resident #15's record revealed a facility admission date of . A health assessment form 1823, dated on , indicated her diagnoses included , , , , and . She was hard of hearing, had , forgetfulness, , right eye and she received hospice services.

Resident #15's record did not contain an order from a health care provider for full side rails to her bed, which were .

On at 3:44 pm, the resident care director confirmed that resident #15 had full side rails on her bed and she said hospice supplied the bed and full rails without discussing it with her first.

5. Resident #4's record revealed a facility admission date of . A health assessment form 1823, dated on , indicated he had a diagnoses of , , , of his left lower leg, type 2, , below the knee amputations, , , and . He required assistance with ambulation, bathing, dressing, toileting, and transferring, supervision with , , and was independent with eating. He had , devices for his legs.

Facility notes indicated that on he arrived to the facility with his family. He was able to ambulate with a walker and the assistance of one person.

On , he was alert and oriented and able to verbalize his wants and needs. He was pleasant and .

During an interview with the resident care director on at 12 pm, she said resident #4 was moved from a was not in a memory care unit to one that was because the resident played the staff by acting, as he was unable to put on his , legs and assist during transfers. Therefore, he required two people to assist him with transferring so he was placed in a memory care unit where there were more staff.

During an interview with resident #4's daughter on at 3:30 pm, she said the facility staff phoned her a few weeks after her dad was admitted and said the staff were getting hurt while transferring him so

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he had to be moved to memory care where there were two caregivers as opposed to one caregiver in the assisted living unit he was initially admitted to. She said she was assured by the facility that there would be other residents on the memory care unit who would have the same level as her dad and they would be able to talk with him.

Class III