STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105574	A. BUILDING _____ B. WING _____	**07/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PALM GARDEN OF LARGO	**10500 STARKEY RD LARGO, FL 33777**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observations, interview and record review, the facility failed to ensure that resident call lights were answered in a timely manner for 2 of 9 (#7, #8) sampled residents. Findings included: 1. During observations on 7/14/20 at 11:21 AM,a beeping sound could be heard upon entry onto Unit C through closed double doors onto the 200 hall (starting with room [ROOM NUMBER]). While touring Unit C, the beeping sound could be heard while stationed at the center of the wing which connects 4 halls in the center, which is where the nurses' station was located. The beeping sound could be heard louder from the nurses station. Observations of the unit revealed that 5-plus staff persons were passing meal trays from a meal cart which was parked at the corner of the center of the hall close to room [ROOM NUMBER], with one person checking trays before staff deliver. At 11:30 AM a second cart was delivered to the unit and parked next to the first cart. Staff continued to retrieve and deliver the meal trays. The one staff person continued to stand at the carts and check the meal trays before they were delivered. During this time, a green light was observed flashing above Resident #7's room door (which was located close to where the meal carts were parked). Continued observation of the unit revealed that there was a phone-like system located behind the nurses' station. It was noted that a light kept flashing in unison with the beeping sound. The light had the room number for Resident #7 written and flashing on the system. On 7/14/20 at 11:35 AM Resident #7's light was still noted to be flashing and the sound still beeping from the nurses' station. On 7/14/20 at 11:36 AM, Staff B identified herself as the Assistant Director of Nursing (ADON), and indicated that she was double-checking meal trays before they were distributed to the residents. It was noted that the light above Resident #7's door was still flashing. On 7/14/20 at 11:38 AM a staff person entered Resident #7's room and the light went out, some 18 minutes after it was originally observed flashing and sounding an alarm. Observations of Staff C, Certified Nursing Assistant (CNA), on 7/14/20 at 11:39 AM revealed that this staff person exited Resident #7's room. Interview with this staff person at this time revealed that she entered the room because the light above the door was flashing. She reported that the resident wanted her covers pulled up. Staff C reported that she just noted the light when she went into the room and did not know how long the light had been flashing. She reported that she did not hear any sounds that would let her know that the call light had been pressed. Interview with Resident #7 on 7/14/20 at 11:40 AM revealed that she had the call light on because she needed to be pulled up in the bed, and that her back was hurting her. She reported that she did not know how long she had waited for someone to help her, but reported that it's been a long time! Interview on 7/14/20 at 11:42 AM with Staff I, RN revealed that she was a float nurse and that call lights are answered right away by any staff. She reported that she did not see the call light flashing and did not hear the call light beeping at the nurses' station. Interview on 7/14/20 at 11:44 AM with Staff J, Central Supply, revealed that everyone answers call lights. He reported that he did not hear or see any call lights on. He reported that he was passing trays because everyone helps with passing trays. Interview with Staff B, ADON on 7/14/20 at 11:48 AM revealed that she was standing at the meal carts double-checking meals. She reported that during dining It's all hands on dining. She reported that not every unit has a person assigned to the nurses' station during meals, and that the only unit that has a specific person assigned to the desk is the rehab unit. She reported that all the other units and all the aides watch for lights. She reported that her expectation was that the response to call lights should be no longer than 5 minutes and that everyone can see the lights blinking at the room doors, and can hear the lights beeping. Review of Resident #7's record revealed that she was admitted to the facility on [DATE] and had a Brief Interview For Mental Status (BIMS) dated 6/7/20 with a score of 14. Interview with Staff B, ADON, on 7/14/20 at 12:55 PM revealed that she did not see the call light flashing above Resident #7's door and did not hear the call light beeping at the nurses' station. 2. Observations from the Unit A's nurses' station on 7/14/20 at 12:01 PM, identified a light was observed to go on above Resident #8's door, which started flashing then turned to a solid white light. At the same time a light illuminated on a wall-mounted peg board behind the nurses' station, and a beeping sound could be heard from the nurses' station that beeped in unison with the flashing light. During the observations, several staff persons were noted to be obtaining trays from a meal cart and distributing them to various resident rooms, while one staff person stayed at the cart and checked all trays prior to them being distributed. At 12:08 PM Staff K, CNA, was noted to go into Resident #8's room, turn off the call bell light, and speak to Resident #8. Interview on 7/14/20 at 12:09 PM with Staff K, CNA revealed that she went into the resident's room because the light was on. She reported that she knew that the light was on because she saw the light on above the resident room door and the light on above the nurses station, and that she could also hear the call light beeping. She reported that the light may have only been on 2-5 minutes. Interview on 7/14/20 at 12:11 PM with Resident #8 found that she had used the call light to get assistance. She reported that, Today they responded quick, only 8 minutes, compared to sometimes when I have to wait for up to 2 hours on the second and third shifts. She reported that there have been times when she needed to make a bowel movement. Resident #8 directed the surveyor to look at the clock on the wall across from her bed, and reported that the clock was not working and all it needed is a new battery and that she was told that she needed to put a work request in. When asked how she monitors time when the clock is not working, she pointed to a cell phone located on her over-bed table in front of her and she said with my cell phone. Interview on 7/14/20 at 12:15 PM with Staff L, Licensed Practical Nurse (LPN), who was standing at a medication cart that was parked at the nurses' station during the observation, found that there was no staff person assigned to monitor the nurses station or call lights during meal times. She reported that all staff respond to call lights, and that it was expected that lights are answered right away and that residents should not be waiting for more than 5 minutes for a response. She reported that she did not hear the call light beeping and did not see the call light blinking above Resident #8's room door. Review of Resident # 8's record revealed that this resident was admitted to the facility on [DATE], with a BIMS score dated 4/20/20 and a score of 14.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE