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 _____	**09/11/2020**

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement a care plan intervention related to fall prevention as written and determined by the facility's Interdisciplinary Team for one resident (#59) of four residents that required floor mats. Findings included: Record review of the Incident by Incident Type Log for March 9, 2020 to September 9, 2020 revealed Resident #59 had seven falls since April 2020. Four out of the seven falls were classified as unwitnessed. The unwitnessed falls occurred on 4/29/20, 5/2/20, 6/27/20, and 9/8/20. An observation on 9/9/20 at 2:54 p.m., revealed Resident #59 was lying in bed under the covers. His bed was in the lowest position with the handrails lifted. There were no floor mats observed on the floor beside the Resident's bed. Further observation revealed no floor mat availability within the room. Resident #59's Admission Record revealed an admission date of [DATE] with medical [DIAGNOSES REDACTED]. Resident #59's Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status of 5 that indicated severe impairment. The MDS Section G: Functional Status revealed Resident #59 required extensive assistance with one-person physical assist for bed mobility, transfer, and toilet use. Record review of Resident #59's active care plan revealed an initiated focus, dated 1/19/20, for, At risk for further falls related to: Decreased lower extremity strength, History of multiple falls, Poor safety awareness, Unsteady gait/balance, fatigue, sob (shortness of breath) with exertion, antidepressant. Interventions included ensuring appropriate footwear (initiated on 2/10/20), scheduled toileting every 2 hours while awake (initiated on 6/29/20) and ensuring floor mats are at bedside while in bed (initiated on 4/28/20). Progress Notes: Incident Note, dated 9/8/20, revealed, Started morning rounding at 7:10AM and heard resident's roommate calling out. Came to see resident laying on the floor. Asked resident what happened and he said I fell . After asking resident what happened, resident was assessed. Vital signs taken . Placed resident back in bed with assistance by other staff nurse. Denies pain . An interview was conducted on 09/09/20 at 3:10 p.m. and Staff A, Certified Nursing Assistant (CNA) stated that Resident #59 recently had a fall on 09/08/20 and the facility was going to re-evaluate Resident #59 for additional interventions, including possibly requiring floor mats while the resident was in bed. He stated that the resident was already sleeping in bed when he arrived on his shift, 3:00 p.m. to 11:00 p.m. Staff A, through observation, verified that the resident did not have floor mats beside the bed while sleeping, nor did the resident have floor mats inside of the room. During an interview on 09/09/20 at 3:16 p.m. the Assistant Director of Nursing (ADON) confirmed, through observation of Resident #59 sleeping in bed, there were no floor mats in place. The ADON stated that floor mats were deemed inappropriate for Resident #59 because the resident would get out of bed and sometimes the floor mats would cause him to become unsteady, increasing the risk of a fall. The resident is on scheduled toiletings every 2 hours. She said, That is our error, we have not updated his care plan to remove the floor mats. The ADON was unable to confirm after what fall floor mats for Resident #59 were deemed unsafe. She stated that she would need to speak with the Risk Manager to verify when it was decided to remove the floor mats. During an interview on 09/09/20 at 3:24 p.m. the ADON asked the Risk Manager after what fall was Resident #59 deemed unsafe to have floor mats. The Risk Manager stated that she would need to look through his record. Both the ADON and the Risk Manager proceeded to look on the computer for the documentation. During an interview on 09/09/20 at 3:38 p.m. the ADON stated they were unable to find documentation indicating floor mats were deemed unsafe for Resident #59 and the Risk Manager was currently in the process of finding floor mats to place by his bed side. An observation on 09/09/20 at 3:48 p.m. revealed the Director of Nursing (DON) walking onto Resident #59's unit carrying a floor mat. An interview on 09/09/20 at 3:55 p.m. with the DON and the Regional Nurse was conducted and the DON stated that if the care plan states floor mats should be present, then the floor mats should have been there. The Regional Nurse confirmed that Resident #59's care plan required floor mats to be present when he is in bed. Neither the DON nor the Regional Nurse could confirm when the floor mats stopped being placed at Resident #59's bed side. The DON stated earlier he was carrying the floor mat for Resident #59. In interview on 09/10/20 at 8:01 a.m. the DON provided documentation that a Fall Care Plan Validation occurred on 07/22/20 to validate safety devices were in place for fall risk residents. Record Review of the Midnight Census Report: Fall Care Plan Validation, dated 07/22/20, revealed confirmation that Resident #59 had floor mats. During an interview on 09/10/20 at 1:32 p.m. the Risk Manager stated that all falls are investigated. The Interdisciplinary Team meets every morning to review falls and update care plans accordingly. A review of the facility's policy titled, Risk Evaluation for Falls, revision date July 2017, stated the purpose was, To identify and address risk factors associated with resident falls, to determine the need for any special care, assistive device or equipment needs, assist with resident care planning needs and to confirm the continued accuracy of the evaluation. A review of the facility's policy titled, Nursing/Risk Management-PALM program, revision date June 2020, stated, Current Residents: 1. Following a fall, the resident will be re-evaluated using the Evaluation of Fall Risk in the electronic health record. *Note this evaluation will also be completed upon hospital return, quarterly and with significant change 2. The care plan will be updated following each fall with modification of interventions based on interdisciplinary team review and resident need 3. All residents experiencing a fall(s) will be reviewed at the next Standards of Care meeting following the fall(s) 4. The Interdisciplinary Team will determine which residents are to be included in the PALM program. A review of the facility policy titled, CH 4: CAA Process and Care Planning, revision date October 2019, stated, 4.7 The RAI and Care Planning: As required at 42 CFR 483.21(b), the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistence with each resident's written plan of care . The overall care plan should be oriented towards: 1. Assisting the resident in achieving his/her goals. 2. Individualized interventions that honor the resident's preferences. 3. Addressing ways to try to preserve and build upon resident strengths. 4. Preventing avoidable declines in functioning or functional levels or otherwise clarifying why another goal takes precedence. 5. Managing risk factors to the extent possible or indicating the limits of such interventions. 6. Applying current standards of practice in the care planning process. 7. Evaluating treatment of [REDACTED].
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) Based on observations, record review, and interviews the facility: 1. failed to provide a permanently affixed compartment for storage of controlled drugs in three medication storage room refrigerators (A-Wing, C-Wing and Rehab Unit) of 3 refrigerators, and 2. failed to ensure that an opened insulin pen was labeled with the date opened in one medication storage room refrigerator (Rehab Unit) of three medication storage room refrigerators. Findings included: 1. On 09/09/2020 at 8:55 a.m. the Assistant Director of Nursing (ADON) accommodated the observation of the locked storage room on the C-Wing located behind the nurse's station. The refrigerator in the room was locked and contained a locked plastic box that was not permanently affixed and was easily removed from the refrigerator. The plastic box contained a closed small plastic box with plastic tie wraps that contained three vials of [MEDICATION NAME] 2 mg/ml (milligrams/milliliters), a Schedule IV medication. (Photographic Evidence Obtained) On 09/09/2020 at 9:10 a.m. The ADON then accommodated the observation of the locked storage room on the A Wing located behind the nurse's station. The refrigerator was locked and contained a locked plastic box that was not permanently affixed and was easily removed from the refrigerator. The plastic box contained a closed small plastic box with plastic tie wraps that contained two vials of [MEDICATION NAME] 2 mg/ml, and one bottle of an oral solution, [MEDICATION NAME] 2 mg/ml, both Schedule IV medications, and two cards of Dronabinol 2.5 mg capsules, a Schedule III medication. One card contained five capsules and the other card contained 30 capsules. (Photographic Evidence Obtained) Immediately following the observations, the ADON was then asked if she was aware that Schedule II-V medications were to be stored in a permanently affixed compartment in the refrigerator, and she replied no. On 09/09/2020 at 9:20 a.m. Staff C, Registered Nurse (RN) accommodated the observation of the locked storage room on the Rehabilitation Unit. The refrigerator was locked and contained a locked plastic box that was not permanently affixed and was easily removed from the refrigerator. The box was identified as Employee Health. The plastic box contained a small closed plastic box with plastic tie wraps that contained two vials of [MEDICATION NAME] 2 mg/ml, a Schedule IV medication. (Photographic Evidence Obtained) 2. Additionally, during the observation of the contents in the refrigerator on the Rehab Unit on 09/09/20 at 9:20 a.m. with Staff C, RN, a [MEDICATION NAME] FlexTouch insulin pen was noted to have been opened and not dated as to when the pen was opened. (Photographic Evidence Obtained) Staff C, RN confirmed that the insulin pen was opened and not dated with an open date. She stated that it should have been dated when opened, and she did not know why the pen was not dated. A review of the facility's policy titled, 6.0 General Dose Preparation and Medication Administration, with an effective date of 12/01/07 last revised 01/01/13, Section 3.11 on page 1 of 3 stated, Facility staff should enter the date opened on the label of medications with shortened expiration dates (e.g., insulins, irrigation solutions, etc.). On 09/11/20 at 2:56 p.m. a telephone interview with the Consulting Pharmacist revealed that he was aware that the controlled substances need to be in a permanently affixed container and that includes [MEDICATION NAME] ([MEDICATION NAME]) and [MEDICATION NAME] (Dronabinol). He also stated that the pharmacy provides stickers and instructs the nurses to write the opened date on the provided sticker when an insulin pen is opened. He stated that the facilities are given a list that includes all the medications that need to be dated when opened and that insulin pens would be on that list. A review of the facility's policy titled, 5.3 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles, with an effective date of 12/01/07 and last revised on 10/28/19, stated in Section 3.1.1, Store all drugs and biologicals in locked compartments, including the storage of Schedule II-V medications in separately locked, permanently affixed compartments, permitting only authorized personnel to have access.