Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967791	A. BUILDING: _____ B. WING _____	02/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A BANYAN RESIDENCE	100 BASE AVE EAST VENICE, FL 34285

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced complaint survey for complaint # 2019018575 & 2019018584 & 2019018587 was conducted through at A Banyan Residence, an assisted living facility in Venice, Florida. Complaint #2019018575 & 2019018584 & 2019018587 were substantiated at A0010 and A0025. The following is description of the deficiencies.	A 000		
A 010 SS=D	429.26(&9) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.	A 010		

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A 010	Continued From page 1	A 010		

(2) A physician, physician assistant, or nurse practitioner who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interest in the facility.
(9) A , ill resident who no longer meets the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met.

59A-36.006
(4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 59A-36.002, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are:
(a) The resident may be bedridden for no more than 7 consecutive days.
(b) A resident requiring care of a may be retained provided that:
1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services

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A 010	Continued From page 2 license and services are provided pursuant to a plan of care issued by a health care provider, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from the facility. (c) A [redacted] ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however,	A 010		

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A 010	Continued From page 3 staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure residents have a to medical examination by a health care provider after a significant change to determine the continued appropriateness of residents for 1 (Resident #18) of 1 resident reviewed with a The findings included: Record review of Resident #18's chart revealed a note from a Home Health agency dated that Resident #18 had a to the A nursing ALF communication to the Physician Assistant (PA) was found in the chart dated which indicated right lump opened and requested PA see Resident #18 for care orders to right Home Health notes were found in the chart indicating they were providing care to the right , but there was no staging of the in the documentation. On at 11:50 a.m., Staff A Licensed Practical Nurse (LPN) said Resident #18 had a on her right , but was unable to say what stage the was at. On at 12:44 p.m., the Administrator said Staff A did not have any documentation of the stage of the right and she was	A 010		

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A 010	Continued From page 4 contacting the Home Health agency to see if they had documentation of staging. The Administrator said there were no current residents in the building with , . On at 12:53 p.m., Staff A (LPN) said she did not know what stage the , had been. Staff A said home health would be who staged the and the only documentation on right , she found at that point was a note by the Physician Assistant on that the was and said the paperwork provided from the Home Health agency that had already been provided to this surveyor was the same as she herself had. On at 1:40 p.m., Staff A provided 2 skilled nursing visit notes for dates and which had been faxed over by the Home Health agency. Notes indicated they had been treating several to the right , including a , to the right , with an onset date of . Notes dated and indicated had a foul odor, a large amount of drainage and were 50 % . (indicates tissue) Progress note written by PA on indicated the right , had progressing . have channels that extend from a into and through tissue or . On at 11:10 a.m., in an interview, the PA said Resident #18 had been having , for about a month or so prior to entering Hospice services on . The PA said Resident #18 had become cachectic (wasting) and the right , had been progressing. The PA said he discussed with the family that the was (full thickness tissue loss) and the choices were to	A 010		

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A 010	Continued From page 5 move to a nursing home or enter hospice services. Record review of Resident #18's chart also indicated she had been admitted to Hospice services on . Hospice Care plan included a diagnosis of of right . Resident #18's Health Assessment Form 1823 provided by the Administrator was dated . This indicated Resident #18 did not have any , 3 or 4 , . On at 2:43 p.m., Staff A (LPN) said it was her responsibility to get the health assessments 1823 done. Staff A (LPN) said she does not use her license at the facility as they do not have a specialty license, so she relies on Home Health Agencies to do care and assessments. She said she was unaware that a constituted a significant change and that was why she did not have a new health assessment 1823 done when Resident #18 acquired the . Class III	A 010		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification	A 025		

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A 025	Continued From page 6 must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services.	A 025		

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A 025	Continued From page 7 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide appropriate supervision for each resident and failed to maintain a written record of any significant changes, illnesses that result in medical attention, changes in method of medication administration or other changes that result in the provision of additional services for 4 (Residents #15, #16, #17, and #18) of 4 resident files reviewed. The findings included: 1. Record review of Resident #17's chart revealed hospital paperwork from a hospitalization in . . . . . Progress note from hospital paperwork dated indicated Resident #17 had a . . about 8 days prior to hospitalization when he was unattended on the toilet and had been admitted to the hospital with acute right and severe . . . . . Hospital paperwork indicated surgery was not recommended as Resident #17 was non-ambulatory and had advanced . . . . risk completed by facility on . . . . indicated Resident #17 had a in the past year, needed assistance of one, had . . . . . , used bathroom with assist, was on . . medications and had a . . . . . process. He was evaluated as a moderate risk for . On at 9:00 a.m., in an interview, the Administrator said Resident #17 had a . . on with no injury. The Administrator said Resident #17 had been seen in between the . . and the hospitalization on three times by home health and once by the Physician Assistant (PA). The Administrator said Resident #17 had	A 025		

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A 025	Continued From page 8 been on the toilet and became agitated and started swinging and when the caregiver stepped [illegible], Resident #17 [illegible] to floor. Facility progress note by Staff A, Licensed Practical Nurse (LPN) dated [illegible] stated: "Resident had an incident last evening, aggressive and combative with staff. Resident slipped from toilet to floor during transfer. No complaints of [illegible], no apparent injuries. Resident will be seen by Physician Assistant (PA) tomorrow for review of medications, behaviors and [illegible] risk. Responsible party notified." Review of PA progress note in Resident #17's chart dated [illegible] made no mention of a [illegible], rather the chief complaint indicated PA was seeing Resident #17 for positive [illegible], symptoms, [illegible] and a positive productive [illegible], for which he ordered an [illegible]. Review of Home Health notes on [illegible], [illegible], and [illegible] made no mention of a [illegible] or [illegible] assessment, rather the notes indicate Home Health was seeing the resident to monitor a [illegible] condition. On [illegible] at 9:28 a.m.., Staff A (LPN) said Resident #17 on [illegible] and on [illegible] she put him on the list for the PA to see. When Staff A was shown PA note for [illegible] made no mention of [illegible], injury, or [illegible] assessment, Staff A replied, "ok all I can say is if he didn't address it, he didn't address it. I put him on the list for a [illegible]." Staff A said she did not keep the lists of patients referred or the reason they were referred to the PA. Further review of facility progress notes following	A 025		

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A 025	Continued From page 9 the note on made no further mention of Resident #17 having had a , revealed no documentation of any post monitoring or any further assessments for , or change in condition. On at 12:51 p.m., Staff A (LPN) agreed there was no documentation regarding any follow up post and agreed they can't prove any follow up was done. Progress note by Staff A (LPN) dated at 11 a.m., indicated: PA in to see resident. Resident complaint of right , , . No injury noted. New orders received for , to right , and , along with a . Left detailed message with responsible party. Results are pending. Progress note by Staff A (LPN) dated at 1:45 p.m., indicated: positive , results received and reviewed by PA. Resident #17 sent to ER for evaluation. All care staff interviewed in length, going 5 days with no knowledge of any injury to the above Resident. The PA's progress note in Resident #17's chart dated indicated: resident had positive right , , and positive ( ). After , was received, an addendum was added by PA indicating right , status post , and sent to the hospital. Upon return from hospitalization Resident #17's Health Assessment Form 1823 dated indicated the resident was on Hospice and was a risk and non- , to the right lower extremity. Progress notes showed Resident #17 returned to	A 025		

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A 025	Continued From page 10 the facility on , was admitted to Hospice on , and he expired on . On at 12:30 p.m., in an interview, the Administrator said Incident reports were their documentation for and these weren't kept in resident charts. On at 12:53 p.m., Staff A said with they usually do an incident report and she would chart in the resident progress notes, notify the family, assess them and if there is a problem, she calls the PA. 2. Review of facility Grievance Reports indicated Resident #16's daughter had filed a grievance on that on a recent morning her father was found sitting on the ground nude and she was concerned he had . Record review of facility progress notes for Resident #16's entire stay (admitted and discharged to family on) revealed no documentation of a , post monitoring, or assessment for /change of condition following a . On at 11:55 a.m., in an interview, the Administrator said Resident #16 had an unwitnessed on that was reported by the family. The Administrator said he did an investigation and incident report on it and found that on at 6:40 a.m., the caregiver was doing nightly rounds and discovered Resident #16 seated on the ground leaning against the bed. The caregiver had not reported this and had been disciplined. The Administrator agreed there was nothing documented regarding the in the progress notes.	A 025		

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A 025	Continued From page 11 Review of facility progress notes revealed a note on at 10 a.m., indicating Resident #16 was and slow to respond and was sent to hospital via ambulance for evaluation. Resident #16 did not return to facility. Progress note dated indicated resident was discharged from the hospital and discharged from the facility with family. On at 12:53 p.m., in an interview, Staff A (LPN) said the Administrator did the incident report. Staff A said it should have been documented in the nurse's progress notes and agreed there was no documentation of any or assessment post . Staff A said it wasn't even put on the list for the PA to see because she hadn't known about it. Staff A said she was supposed to be notified of all . Staff A said the last time the PA saw Resident #16 was on . Staff A said with they usually do an incident report and she will chart in the resident progress notes, notify the family, assess them and if there is a problem, she calls the PA. On at 12:30 p.m., the Administrator said the Incident report is our documentation of the . 3. Record review of Resident #18's chart revealed Home Health was providing care to the right , . There was no staging of the in the documentation. On at 11:50 a.m., Staff A (LPN) said Resident #18 had a , on her right , , but Staff A said she was unaware of what stage the , had been. On at 12:44 p.m., the Administrator said Staff A did not have any documentation of the	A 025		

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A 025	Continued From page 12 stage of the right , and had contacted the Home Health agency to see if they had documentation of staging. The Administrator said there were no current residents in the building with , . On at 12:53 p.m., Staff A (LPN) said she did not know what stage the , had been. Staff A said home health would be who staged the and the only documentation on the right , she found at that point was a note by the Physician Assistant on that the was and said the paperwork provided from the Home Health agency that was currently at the facility did not indicate staging. On at 1:40 p.m., Staff A provided 2 skilled nursing visit notes for dates and which had been faxed over by the Home Health agency. The notes indicated they had been treating several to the right , including a , to the right , with an onset date of . The notes dated and indicated had a foul odor, a large amount of drainage and was 50 % . (indicates tissue) A progress note written by the PA on indicated the right , had progressing (have channels that extend from a into and through tissue or). On at 11:10 a.m., in an interview, the PA said Resident #18 had been having , about a month or so prior to entering Hospice services on . The PA said Resident #18 had become cachectic and the right , had been progressing. The PA said he discussed with the family that the was (full thickness tissue loss) and the choices were to	A 025		

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A 025	Continued From page 13 move to a nursing home or enter hospice services. Record review of Resident #18's chart also indicated she had been admitted to Hospice services on . Hospice Care plan included a diagnosis of of right . On at 2:43 p.m., Staff A (LPN) said she was unaware of the regulation for a significant change included a . Staff A said she does not use her license at the facility as they do not have a specialty license, so she relies on Home Health Agencies to do care and assessments. 4. Record review of Resident #15's chart revealed an order from the PA for: Deconoate 50 g/ml Intra Muscular every month. (is an medication). Record review of facility progress notes for entire stay at facility (admitted and discharged to family on) reveal no behaviors or behavioral problems were documented by facility staff for Resident #15. On at 10:46 a.m., the PA said the facility staff reported to him they were having problems giving Resident #15 her medications, having outbreaks and disruptive behaviors. The PA said the shot was given to calm her down. On at 12:39 p.m., in an interview, Staff A said Resident #15 was having behaviors such as , and agitation. Staff A said this information was relayed to the PA. Staff A said Resident #15 had behaviors the whole time she was at the facility. Staff A said, "I guess the behaviors	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967791	A. BUILDING: _____ B. WING _____	02/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A BANYAN RESIDENCE	100 BASE AVE EAST VENICE, FL 34285

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 14 weren't charted, I didn't put them in the progress notes." Staff A explained she attaches a sticky note to the list of patients the PA is seeing that day to let him know what issues the resident is having. Staff A said she does not keep this documentation. Staff A said she does review the documentation left by third party providers ie: PA, Home Health agencies and if they don't address what she brought to their attention she assumes there is no problem. Class II	A 025		