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
	AL11969278	A. BUILDING: _____ B. WING _____	01/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL SEASONS IN NAPLES	15450 TAMIAMI TRL N NAPLES, FL 34110

(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 off-hours complaint survey for #2023006626 was conducted on Saturday [redacted] at All Seasons in Naples, an assisted living facility, in Naples, Florida Complaint #2023006626 was substantiated at A 025. The following is a description of the deficiencies.	A 000		
A 025 SS=C	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making [redacted] for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 (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. This Statute or Rule is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide the necessary supervision to prevent . . for 2 (Residents #1 and #2) of 2 residents reviewed for . The findings included: The facility policy (not dated), stated: "Should a resident experience a , staff will provide or arrange for necessary emergency care, and will	A 025		

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A 025	Continued From page 2 follow up with necessary service plan updates. The procedure included, "details of the are to be noted in the medical record, the Responsible Party will be notified of each during the shift of the ...and The Director of Assisted Living informs the physician of subsequent and instability. Medical intervention, , and/or gait analysis is arranged when residents remain at significant risk for ". The findings included: 1. Record review revealed Resident #1 was admitted to the facility on . The admission diagnoses included . The Health Assessment - Form 1823 dated indicated the resident had a , related to . Special precautions documented, "memory care unit due to poor safety awareness". Resident #1 was treated in the local hospital emergency department on after a and was diagnosed with a closed injury and closed of the bone, initial encounter. No service plan was provided for this resident. Resident #1's progress notes indicated on the resident was observed dragging a chair, writer attempted to grab chair to place , resident still had hold of chair, lost balance, started tumbling backwards and . Progress notes documented Resident #1 on at 8:15 p.m. Resident was observed lying in supine position outside on the lanai by the patio chairs and trying to sit up. Progress notes documented resident again on	A 025		

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A 025	Continued From page 3 . . . . . out of a chair in the dining room at approximately 8:53 p.m., Progress notes dated at 12:45 p.m., documented Resident #1 was observed "lying supine on the floor with her resting on a bag of towels, she was . . . . . from the . . . , upper , , and an area below the right , . The floor area was covered with a blue flooring glue due to the contractors replacing the old/soiled carpeting." Facility analysis stated resident walked through the kitchen area and upon exiting the resident tripped and . in the hallway that was under construction. This hallway was receiving a new floor. The corrective action identified was to contact construction personnel to ensure they were following the agreed upon contract to properly barricade all areas under construction. Progress notes dated . . . . , ... and documented resident evaluated s/p and walk with supervision on the memory care unit, resident is non-verbal, resident continues to ambulate with steady gait, remains non-verbal, and the unit continuously. "Educated resident about risk and the continued disruption of the contractors and the resident maintains a blank stare." Resident #1 was treated in the local emergency department again on after a and diagnosed with closed . . . . . of the . . . bone, initial encounter. Progress notes dated at 4:53 documented Resident #1 had . . . . The Assisted Living Director documented resident was laying on the ground in the dining room in front of a chair. Resident remains non-verbal and	A 025		

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A 025	Continued From page 4 unable to contribute any information to the situation ...Resident continues to stand and attempt to walk, the resident remains unaware of her environment and anything in the environments such as chairs, walkers, other residents are tripping hazards for the resident. Progress notes dated document Resident #1 was observed sitting on the patio floor. Progress notes dated at 12:15 p.m., document Resident #1 was observed in the hallway lying on the floor on her . She was assisted up. 2. Record review revealed Resident #2 was admitted to the facility on . The admission diagnoses included , The 1823 admission assessment indicated the resident had and only identified to self. Resident #2 required supervision with ambulation and assistance with bathing, , grooming and toileting. Resident #2 service plan dated indicated the resident has long term memory issues including severe , ; unable to remember or use information; may require repeated verbal prompts and/or direction. Resident #2's service plan noted she has a high potential. Facility incident tracking report and progress notes indicated Resident #2 had multiple including: On at 3:34 p.m., Resident #2 in the recreation area. On at 8:20 a.m. Resident #2 and was found in the hallway.	A 025		

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A 025	Continued From page 5 On at 1:00 p.m. Resident #2 in the dining room and was called for a injury. On at 11:30 a.m. Resident #2 in the courtyard. The progress notes said the resident had an unwitnessed and was found in the garden, laying on her on the stones next to the memory care patio. On at 11:03 a.m., progress notes said the resident had a witnessed in the memory care unit hallway. On at 8:45 a.m., progress notes documented Resident #2 was found in the common area, lost her balance, and to the floor. On at 4:15 p.m., progress notes documented Resident #2 was found on the floor in the hallway. Progress notes said Resident #2 lost her balance and in the hallway. On at 1:39 p.m., progress notes documented Resident #2's husband went to visit his wife and discovered she had a black . Progress notes said he was concerned about the black and why he was not made aware. On at 1:05 p.m., Facility caregiver Staff C said she is responsible for Resident #2 today. She said she is supposed to check her residents every hours. She said there is no specific increased supervision or checks for Resident #2. On at 2:36 p.m. during a telephone interview, the memory care director said she was responsible for staff training. She said residents	A 025		

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A 025	Continued From page 6 in the memory care unit should be checked every hours. If someone is , we just have to keep on them. The process is for the staff to call me, the nurse, and 911 if needed, every time the resident hits the floor. After that I ensure the family is informed. If a resident has an 1823 with supervised ambulation the staff have to pretty much provide 1:1 if possible, ask the family if they are willing to hire private duty. On at 3:34 p.m., the Memory Care Director said she started an investigation into the resident when staff reported Resident #2 had a black on . Resident #2 had on the right and right . The Memory Care Director said she did not have any information as to how the black occurred, just that something happened between and . The Memory Care Director verified the service plan for Resident #2 was last updated on . No new or changed interventions were identified. She had no information to provide regarding Resident #1's . She said after a staff are to keep an on the person, try to check more on the resident. The Memory Care Director said the resident should not be out of the sight of a staff member. The Memory are Director said, "I can see the staff need training".	A 025		
A 034 SS=C	59A-36.007(9) ASSISTIVE DEVICES (9) ASSISTIVE DEVICES. Facilities are responsible for ensuring the safe usage of a resident's assistive devices. (a) The facility must have policies and procedures that include the requirements and methods for assessing the physical condition of assistive	A 034		

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A 034	Continued From page 7 devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. (b) Documentation of each assistive device a resident uses must be included in the resident's record. (c) Direct care staff using assistive devices while rendering personal services to residents must know how to operate and utilize the equipment. (d) All assistive devices must be clean, in good repair, and free of hazards. (e) The facility must encourage and allow the resident to function with independence when using the assistive device. This Statute or Rule is not met as evidenced by: Based on observation, staff interview and record review the facility failed to have documentation of each assistive device being used as bed rails for 1 (Resident #2) of 1 resident reviewed for assistive devices. The findings included: Resident #2 was admitted to the facility on . The admission diagnoses included . The 1823 admission assessment indicated the resident had and only identified to self. Resident #2 required supervision with ambulation and assistance with bathing, , grooming and toileting. Resident #2's service plan indicated the resident has long term memory issues including severe , ; unable to remember or use information; may require repeated verbal prompts and/or direction. No assistive devices or side rails were identified on Resident #2 service plan.	A 034		

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A 034	Continued From page 8 On . . . . . at 1:05 p.m., Staff C stated she was assigned to Resident #2. She assisted Resident #2 to bed with both side rails up. When she opened Resident #2's door, the resident was observed walking in the room, the side rails remained up. (photographic evidence obtained). On at 3:34 p.m., the Memory Care Director said, "I have to put the consent in place for the side rails". Both the Memory Care Director and Wellness Nurse said there was no consent and no service plan for the assistive side rails on Resident #2's bed.	A 034		