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
	AL11910134	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE ON THE ISLE	930 SOUTH TAMIAMI TRAIL 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 These are the results of an unannounced Biennial survey conducted on at Southwest Florida Retirement Center at Village on the Isle, an Assisted Living Facility (ALF) with a licensed capacity of 100. The following is a description of non-compliance:	A 000		
A 010	58A-5.0181(4) FAC Admissions - Continued Residency (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (e) of this subsection, criteria for continued residency in any licensed facility shall be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a face-to-face medical examination by a licensed 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 58A-5.0131, 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. The form must be completed in accordance with that paragraph. After the effective date of this rule, providers shall have up to 12 months to comply with this requirement. (a) The resident may be bedridden for up to 7 consecutive days. (b) A resident requiring care of a stage sore be retained provided that: 1. The facility has a LNS license and services are provided pursuant to a plan of care issued by a licensed health care provider, or the resident contracts directly with a licensed home health agency or a nurse to provide care; 2. The condition is documented in the resident ' s	A 010		

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A 010	Continued From page 1 record; and 3. If the resident ' s condition fails to improve within 30 days, as documented by a licensed health care provider, the resident shall be discharged from the facility. (c) A 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 the services of a licensed hospice which coordinates and ensures the provision of any additional care and services that may be needed; 2. Continued residency is agreeable to the resident and the facility; 3. An interdisciplinary care plan is developed and implemented by a licensed hospice in consultation with the facility. Facility staff may provide any nursing service permitted under the facility ' s license and total help with the activities of daily living; and 4. Documentation of the requirements of this paragraph is maintained in the resident ' s file. (d) The administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility. (e) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C. (5) DISCHARGE. If the resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident ' s needs, as determined by the facility administrator or licensed health care provider, the resident shall be discharged in accordance with Section 429.28(1), F.S.	A 010		

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A 010	Continued From page 2	A 010		

This Statute or Rule is not met as evidenced by:
Based on observation, record review and interview, the facility failed to coordinate and ensure provision of care for pressure sores for a ill resident requiring hospice services for 1 (Resident #2) of 2 resident records reviewed. The facility failed to accurately assess, monitor and consistently provide treatment for the pressure sores and failed to assure documentation was maintained in the resident's record. The failure to accurately assess and implement timely interventions for care placed the resident at risk for worsening of the pressure sores.

The findings include:

1. Observation during the tour of the facility in the presence of the Executive Director (ED) on at 9:34 a.m., revealed Resident #2 seated in a recliner chair. The resident was very thin and frail looking in appearance. The ED stated the resident is receiving hospice services.

Review of the 1823 Health Assessment dated documents the resident with a diagnosis of . Further review of the record includes a past medical history of , and lupus.

Review of the hospice team care plan documents the resident was admitted to hospice services on for a diagnosis of , uncomplicated, as the resident was hospitalized in (2012) for and has had a rapid decline since. The resident's weight was 114 lbs. prior to hospitalization, 97 lbs. after hospitalization and

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A 010	Continued From page 3 current weight is 82 lbs. for a total weight loss of 32 lbs. Hospice notes dated .. .. documented the resident had a _ (pressure on the which "was now healed." Careplan interventions per hospice included a hospital bed with an alternating air pressure mattress. Notes by hospice on .. documents, "Open area on is healed at this time." Review of the nursing progress notes on .. by the ALF (Assisted Living Facility) nurse dated .. documents the following: "4 small open areas to observed hospice notified." There was no other documentation in the resident's record as to the coordination or provision of any additional care and services that may be needed in relation to the wounds. There was no evidence of an assessment of the wounds by the hospice nurse or an interdisciplinary plan of care between hospice and the ALF with regard to care. Interview with the ED, who is also an LPN (Licensed Practical Nurse), on .. at 2:00 p.m., revealed she was unaware of the wounds on the resident's and confirmed there was no documentation by the hospice nurse regarding his assessment of the wounds. At 3:00 p.m. on after surveyor intervention, the ED showed a copy of a physician's order faxed to the facility from hospice on which documented the following: "ALF staff reports that patient has four very small open areas around her Areas are not over boney prominences. Clean area and apply	A 010		

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A 010	Continued From page 4 Seni-care cream with each episode of incontinence and at bedtime." The ED stated the physician's order was written on , but never faxed to the facility until today ; 3 days after the wounds were identified. She stated the hospice nurse was the nurse recommending the orders to the wounds; however, she could not confirm whether the resident was receiving the recommended treatment to the affected areas. Interview with staff nurse "A" on at 3:10 p.m., who was providing oversight for the resident's care, revealed she was not the nurse who originally identified the open areas on and knew nothing about the resident requiring treatment to the wounds. She stated she was not made aware of the resident's wounds as it had not been passed on in report over the weekend. A telephone interview was conducted with the hospice nurse on at approximately 8:50 a.m. The hospice nurse stated he came in to the facility at the request of the staff nurse (staff nurse "B") to assess open areas on the resident's He stated she (staff nurse "B") said she saw 4 open areas; however, he saw only 3 areas which were not on a bony prominence, rather the "meaty portion" of her bottom. He was asked to provide the specific location of the open areas observed on the resident's "bottom." The hospice nurse stated he observed one open area on her and two open areas on the inside of her He did not feel these were pressure areas. He felt that barrier cream after each episode of incontinence should be applied. He stated his assessment of the areas was in the computer, not in the resident's record. He stated he never left notes, shared his assessment of the	A 010		

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A 010	Continued From page 5 wounds or provided treatment orders to the staff nurses at the facility. Interview with staff nurse "B" on [redacted] at 10:03 a.m., revealed she was not aware if the resident had the cream applied to her bottom. She stated on Friday [redacted] a CNA (Certified Nursing Assistant) reported open areas on the resident's bottom to her and she viewed 4 reddened areas on the inside of the resident's [redacted] She called hospice and notified the hospice nurse and he came out to the facility. He went to see the resident and came back to the nursing office after 3:00 p.m. which was after report, and he said that he saw "3" areas; however, she stated she told him she saw "4" areas and that "He would get a cream for her and possibly a cushion for her chair...and that was it." She stated she reported this from the day shift to the second shift. She was not at the facility over the weekend or yesterday [redacted] so is not aware whether the treatment had been done. Observation on [redacted] at 9:47 a.m., revealed staff nurse "A" and "B" entering Resident #2's [redacted] After donning a pair of gloves they walked over to the resident who was slouched in a recliner chair. The nurses assisted the resident to an upright position in the chair, and then to a standing position. The resident yelled, "OUCH! It's hurting me." Staff nurse "A" asked where it was hurting and the resident stated, "My whole ass is hurting me." The resident was observed to be sitting on top of a towel on the recliner chair and not a cushion. Staff nurse "B" stated she wasn't sure what happened to the idea of the cushion that was recommended by the hospice nurse. After assisting the resident from the [redacted], both	A 010		

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A 010	Continued From page 6	A 010		

nurses assisted the resident to a left side lying position on her bed. The nurses lowered a brief and exposed oozing stool. The resident's [illegible] were deep purple. A [illegible] pressure [illegible] was observed at the bottom of the resident's [illegible]. The [illegible] base at the 10:00 position presented with yellow tissue and the remaining base of the [illegible] was deep red. The peri [illegible] area was deep purple. Staff nurse "B" measured the [illegible] to be 1 c.m. in length x .5 c.m. in width and approximately .1 c.m. in depth. On the left mid [illegible] a small superficial round pinpoint open area approximately .1 c.m. in circumference was identified. Pink tissue was observed in the base of this area. The right [illegible] had an "orange peel" textured appearance. Staff nurse "B" stated the resident's [illegible] to the [illegible] area "looked worse than when I saw it on Friday (4 days earlier)."

On [illegible] at 11:07 a.m., the ED, staff nurse "B" and the hospice nurse provided a routine visit note by the hospice nurse for the date of [illegible]. The hospice nurse had printed his notes and brought them over to the facility.

Interview with the hospice nurse at this time revealed he stated he saw "3" wounds (on [illegible], one on "each of the ischiums" and one on the [illegible]; however, review of his notes for this day showed a documented [illegible] pressure [illegible] to the resident's "sacrum" and "left side of [illegible]. There was no documentation regarding the wounds on the ischium(s). This assessment is in direct conflict with the conversation held earlier in the day with this same hospice nurse via telephone who stated and wrote orders for wounds that were not over "bony prominences." The [illegible] type according to the treatment orders dated [illegible] was in conflict with his

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A 010	Continued From page 7 assessment regarding documented in his notes on [redacted]. There was no accurate assessment of the resident's wounds and neither the hospice nurse or facility staff could confirm where the wounds were accurately located, whether or how they were being monitored or whether care was being consistently rendered. Orders were not received by the facility for the wounds until 3 days after the wounds were discovered and after surveyor intervention. When asked about his conflicting assessment and physician's orders, the hospice nurse stated he "Needed to make an amendment to his notes." He could not explain the conflicting information and documentation. He informed the facility he, "Dropped the ball." He stated he provided treatment to the wounds on [redacted] but never provided the order for treating the resident's wounds to nurses at the ALF and could not be sure the wounds were being treated consistently after his last visit Class III	A 010		
A 025	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, 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 individual.	A 025		

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A 025	Continued From page 8 (c) 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; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to contact 1 (Resident #2) of 2 residents' health care provider and responsible party regarding the development of pressure sores. The facility also failed to ensure physician orders for pressure sores were received and followed and failed to update the record with regard to changes in the resident's medical condition. The findings include: 1. Observation during the tour of the facility in the presence of the Executive Director (ED) on [redacted] at 9:34 a.m., revealed Resident #2 seated in a recliner chair. The resident was very thin and frail looking in appearance. The ED stated the resident is receiving hospice services.	A 025		

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A 025	Continued From page 9 Review of the 1823 Health Assessment dated documents the resident with a diagnosis of . Further review of the record includes a past medical history of , and lupus. Review of the hospice team care plan documents the resident was admitted to hospice services on for a diagnosis of , uncomplicated, as the resident was hospitalized in (2012) for and has had a rapid decline since. The resident's weight was 114 lbs. prior to hospitalization, 97 lbs. after hospitalization and current weight is 82 lbs. for a total weight loss of 32 lbs. Hospice notes dated documented the resident had a (pressure on the which "was now healed." Careplan interventions per hospice included a hospital bed with an alternating air pressure mattress. Notes by hospice on documents, "Open area on is healed at this time." Review of the nursing progress notes on by the ALF (Assisted Living Facility) nurse dated documents the following: "4 small open areas to observed hospice notified." There was no other documentation in the resident's record as to the coordination or provision of any additional care and services that may be needed in relation to the wounds. There was no evidence of an assessment of the wounds by the hospice nurse nor an interdisciplinary plan of care between hospice and the ALF with regard to care.	A 025		

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A 025	Continued From page 10 Interview with the ED, who is also an LPN (Licensed Practical Nurse), on at 2:00 p.m., revealed she was unaware of the wounds on the resident's and confirmed there was no documentation by the hospice nurse regarding his assessment of the wounds. At 3:00 p.m. on , after surveyor intervention, the ED showed a copy of a physician's order faxed to the facility from hospice on which documented the following: "ALF staff reports that patient has four very small open areas around her Areas are not over boney prominences. Clean area and apply Seni-care cream with each episode of incontinence and at bedtime." The ED stated the physician's order was written on but never faxed to the facility until today , 3 days after the wounds were identified. She stated the hospice nurse was the nurse recommending the orders to the wounds; however, she could not confirm whether the resident was receiving the recommended treatment to the affected areas. Interview with staff nurse "A" on at 3:10 p.m., who was providing oversight for the resident's care, revealed she was not the nurse who originally identified the open areas on and knew nothing about the resident requiring treatment to the wounds. She stated she was not made aware of the resident's wounds as it had not been passed on in report over the weekend. A telephone interview was conducted with the hospice nurse on at approximately 8:50 a.m. The hospice nurse stated he came in to the facility at the request of the staff nurse (staff nurse "B") to assess open areas on the resident's	A 025		

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A 025	Continued From page 11 He stated she (staff nurse "B") said she saw 4 open areas; however, he saw only 3 areas which were not on a bony prominence, rather the "meaty portion" of her bottom. He was asked to provide the specific location of the open areas observed on the resident's "bottom." The hospice nurse stated he observed one open area on her and two open areas on the inside of her . He did not feel these were pressure areas. He felt that barrier cream after each episode of incontinence should be applied. He stated his assessment of the areas was in the computer, not in the resident's record. He stated he never left notes, shared his assessment of the wounds or provided treatment orders to the staff nurses at the facility. Interview with staff nurse "B" on at 10:03 a.m., revealed she was not aware if the resident had the cream applied to her bottom. She stated on Friday a CNA (Certified Nursing Assistant) reported open areas on the resident's bottom to her and she viewed 4 reddened areas on the inside of the resident's . She called hospice and notified the hospice nurse and he came out to the facility. He went to see the resident and came back to the nursing office after 3:00 p.m. which was after report, and he said that he saw "3" areas; however, she stated she told him she saw "4" areas and that "He would get a cream for her and possibly a cushion for her chair...and that was it." She stated she reported this from the day shift to the second shift. She was not at the facility over the weekend or yesterday so is not aware whether the treatment had been done. Observation on at 9:47 a.m., revealed Staff nurse "A" and "B" entering Resident #2's . After donning a pair of gloves they walked	A 025		

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A 025	Continued From page 12	A 025		

over to the resident who was slouched in a recliner chair. The nurses assisted the resident to an upright position in the chair, and then to a standing position. The resident yelled, "OUCH! It's hurting me." Staff nurse "A" asked where it was hurting and the resident stated, "My whole ass is hurting me." The resident was observed to be sitting on top of a towel on the recliner chair and not a cushion.

Staff nurse "B" stated she wasn't sure what happened to the idea of the cushion that was recommended by the hospice nurse. After assisting the resident from the , both nurses assisted the resident to a left side lying position on her bed. The nurses lowered a brief and exposed oozing stool. The resident's were deep purple. A pressure was observed at the bottom of the resident's The base at the 10:00 position presented with yellow tissue and the remaining base of the was deep red. The peri area was deep purple. Staff nurse "B" measured the to be 1 c.m. in length x .5 c.m. in width and approximately .1 c.m. in depth. On the left mid , a small superficial round pinpoint open area approximately .1 c.m. in circumference was identified. Pink tissue was observed in the base of this area. The right had an "orange peel" textured appearance. Staff nurse "B" stated the resident's to the area "Looked worse than when I saw it on Friday (4 days earlier)."

On at 11:07 a.m., the ED, staff nurse "B" and the hospice nurse provided a routine visit note by the hospice nurse for the date of The hospice nurse had printed his notes and brought them over to the facility.

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A 025	Continued From page 13	A 025		

Interview with the hospice nurse at this time revealed he stated he saw "3" wounds (on one on "each of the ischiums" and one on the however, review of his notes for this day showed a documented pressure to the resident's "sacrum" and "left side of There was no documentation regarding the wounds on the ischium(s). This assessment is in direct conflict with the conversation held earlier in the day with this same hospice nurse via telephone who stated and wrote orders for wounds that were not over "bony prominences." The type according to the treatment orders dated was in conflict with his assessment regarding documented in his notes on There was no accurate assessment of the resident's wounds and neither the hospice nurse or facility staff could confirm where the wounds were accurately located, whether or how they were being monitored or whether care was being consistently rendered. Orders were not received by the facility for the wounds until 3 days after the wounds were discovered and after surveyor intervention.

When asked about his conflicting assessment and physician's orders, the hospice nurse stated he "Needed to make an amendment to his notes." He could not explain the conflicting information and documentation. He informed the facility he, "Dropped the ball." He stated he provided treatment to the wounds on but never provided the order for treating the resident's wounds to nurses at the ALF and could not be sure the wounds were being treated consistently after his last visit

The ED and staff nurse "B" were asked whether the resident's attending physician or responsible party were informed of Resident #2's pressure

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
	AL11910134	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE ON THE ISLE	930 SOUTH TAMIAMI TRAIL 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 sores. The ED stated it was their policy to inform hospice and then hospice would inform the family member and physician. The ED was unaware it was ultimately the responsibility of the ALF to ensure the resident's health care provider and other appropriate party was notified of the development of the pressure sores. Class III	A 025		

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Village On The Isle
930 South Tamiami Trail
Venice, FL 34285

Dear Administrator:

This letter reports the findings of a Biennial survey that was conducted on , 2013 by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after , 2013 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Harold D. Williams
Field Office Mananger

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Enclosure: State Form

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Tallahassee, FL 32308
http://ahca.myflorida.com

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