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 _____	

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	A 000		

This is the report for A Banyan Residence, an Assisted Living Facility (ALF), for a Complaint Survey, CCR# 2013004890 initiated on . . . . . and completed on . . . . . An exit for this complaint was held by telephone on .

There were 2 allegations in this complaint. One of these allegations was confirmed and there was a deficiency cited as a result at A025.

The following is a description of non-compliance:

A 025	58A-5.0182(1) FAC Resident Care - Supervision	A 025	

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.
(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

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A 025	Continued From page 1	A 025		

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 a review of resident records, observations and interviews with both administrative and clinical staff, the facility failed to ensure staff was aware and interactive with resident behaviors for 3 (Residents #1, #2 and #3) of 3 residents reviewed.

The findings include:

1. A tour of the facility was performed on [redacted] at 1:45 p.m. During the tour one of the residents (Resident #3) was observed to have a large [redacted] with scabbed area about the size of a dime located on the forehead. There was also purple [redacted] located on the left side of the forehead around the resident's left eye and left cheek area. In response to questioning the resident stated, "I was sitting and the couch, they picked me up and dropped me."

A review of the record revealed a note on the resident observation log dated on [redacted] There was no time on the note. It stated the resident had a [redacted] the previous day around 4:30 p.m. The resident's head was hit and as a result the resident's daughter took the resident to the emergency [redacted] A review of the incident report for this incident revealed the resident tripped over her own feet and [redacted] on her left side. For steps to taken to prevent recurrence, it stated "Remind her to ask for help."

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A 025	Continued From page 2	A 025		

This facility is equipped with video cameras. A review of the tape dated at 4:06 p.m., showed the resident sitting on a chair in a courtyard area in building C zone D. There was 2 staff that was also present in the area caring for another resident. Also there was another staff that was setting up a small table. None of the staff seemed to be supervising or observing this resident. Further observation of the tape revealed the resident was becoming restless, made a few attempts to get out of the chair. None of the staff reacted to her behavior. The resident then stood up hanging onto her walker, walked about three steps, she then stopped, and began to back up. At that time, the resident lost her balance and fell with the walker to the concrete patio. Staff then arrived to care for the resident. None of the staff recognized the attempts to stand prior to the fall.

2. Resident #1 had arrived to the facility on with diagnoses including and The resident was eventually admitted to the memory unit, a locked unit, but it is unclear when the resident moved there or if the resident was admitted directly into this unit.

Interview with staff on revealed Resident #1 had behavioral issues, wandered about the facility, was aggressive to staff and other residents. There was no documentation about any of these issues in the record.

An interview with the Administrator on at 2:15 p.m., revealed Resident #1 touching, fondling and kissing Resident #2. She stated a review of the camera film for this day was done as the staff was complaining of Resident #2's behaviors. The resident was also walking into

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A 025	Continued From page 3	A 025		

stripping the bed and manipulating all of the belongings of whomever lived in that . The incident occurred on , during the evening hours. The only documentation in Resident #2's record about the incident stated the resident "Touched and kissed another resident. I report this to Dr____ and the resident's wife and daughter." In fact, this is the only documentation in the resident's record.

On , the resident was [illegible] because of behaviors and was transferred to a receiving facility.

Interview with a Care Coordinator on at 3:15 p.m., stated the staff had been complaining about Resident #1's behavior so she pulled the tape to observe it. This is the only reason they were aware the resident had fondled and kissed Resident #2. She admitted the resident's behavior was worsening in response to questioning.

The staff did not recognize the resident's behavior was worsening and did not intervene for a possible medication adjustment for this resident.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
A Banyan Residence
100 Base Ave East
Venice, FL 34285

Re: CCR # 2013004890

Dear Administrator:

This letter reports the findings of a Complaint survey that was conducted on , 2013 by representatives 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 surveyors. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

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Enclosure: State Form

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
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2295 Victoria Avenue,
Fort Myers, FL 33901
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