STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967791	10/22/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
A Banyan Residence	100 Base Ave East Venice, FL 34285	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0011 - 58a-5.0181(5) Fac - Admissions - Discharge S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= B
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D

Specific Tag Findings:
These are the results of the Biennial survey completed on . . . at A Banyon Residence an Assisted Living Facility (ALF) in Venice, FL.

The following is a description of non-compliance:

0010-Admissions - Continued Residency 58A-5.0181(4) FAC
Based on clinical record review and staff interview, it was determined that the facility failed to ensure that residents are appropriate for continued residency for 1 (Resident #7) of 2 residents reviewed. This is evidenced by the facility's failure to ensure that Resident #7 who had one (1) . on his right ankle that required the use of a . vacuum met the continued residency criteria

The findings include:

Observation made on . . . at 10:35 a.m. during the initial tour of the facility revealed that Resident #7 was in his . up in a chair. Further observation revealed that the resident had a . vac that was attached to his lateral right ankle. He stated that this was put on a few weeks back to help and heal the . that he has on his ankle.

Clinical record review revealed that Resident #7 had an AHCA Form 1823, . . . 2010 dated . . . Review of Section 1: Health Assessment Section C the resident was coded as not having any . , 3 or 4 pressure sores.

Review of fax dated . . . at 4:38 p.m. to Resident #7's primary care physician states "(name of resident) has an open area on his right ankle bulb; per the home health nurse he has now developed one plus selling and it is not healing with hydrocolloid and she thinks it may need more. Please advise." The physician's response was on . "These are hard to heal. Get . Doppler and culture . arrange for treatment at . . . care center at Health Park."

Review of . care progress notes dated . revealed that the area was debrided again " ... He says he can't sleep on his left side and he was told that there is no good way to offload that area. Review of the assessment and plan: " ... I would like to get a TCOM to assess for . . . ... If that shows he has good . . saturation to tissue, I will perform and additional . . . debriding to get rid of the undermining and then we will order a . VAC to place at the base of the . at that time ..."

Review of . care progress notes dated . . . "(name of resident) returns to . . . care center today for

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follow-up of his right lateral ankle . Today he had TCOMs done, which showed very high numbers in the 70s, especially around the area of the . They all had good response to , showing no signs of any significant . He has no other complaints. They have ordered a VAC. It is supposed to be delivered today, but as of yet that have not received it. Physical examination: The looks essentially the same and measure 0.9 x0.9 x0.6. There is still little bit undermining from 6 to 10 o'clock, 1-2 mm of undermining there. Otherwise, it looks healthy. There is no tissue present. Under Assessment and plan: " ... He will have his VAC changed with home health on Friday and I will him back to see me next week on Tuesday."

Review of care progress notes noted ." ... His right ankle is essentially unchanged at 0.9 x 0.9 x 0.5 cm, and has a thick amount of at the base that requires debridement, but no signs of at all." Under assessment and plan: "... We are going to go ahead and place VAC to area today, and I will see him next week in follow-up ..."

Review of care progress notes dated "(name of resident) returns to the care center today for the follow-up of his right lateral malleolus . He has had the VAC in place now for about a week" ..." It measure 0.8 x 0.8 x 0.5 cm.."

Facility record review revealed that Resident #7 is assisted with a shower on Monday Wednesday and Saturday. Clinical record review lacked documentation that Resident #7 had a on his right outer ankle.

Review of skilled nursing visit note dated ."SNV to perform care. No new wounds. outer ankle cleansed with SNS. has appointment with new MD and the clinic." Review of the assessment sheet revealed that the right outer ankle was pink in color, moderate drainage, no odors and measure 4.0 x 4.0 x 0.3.

Review of ALF Communication Form dated "... performed care to right ankle with profore lite. R/V sat for care. Not on abt at this time."

Review of skilled nursing note dated "outer measurements 3.0 x 3.0 inner 1.0 x 1.0 x 0.4. Scant drainage per sheet. was seen at (name of care clinic) and has new treatment order." Review of the care flow sheet dated revealed that the was classified as a

Review of ALF Communication Form dated care cleanse R ankle with NS .5 x.5 x.3. No drainage noted. Prism to bed cover with profore 4 layer wrap."

Review of ALF Communication Form not dated "performed care to leg and applied profore lite, performed care and applied profore lite."

Review of ALF Communication Form dated "removed and reapplied VAC. lower leg 1.0 x 1.0 x 0.3 pink clean."

Review of ALF Communication Form dated called to see vac not working. Vac working fine.

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Nurse's notes dated states that resident has appointment with new doctor and clinic and The at that time was 4 x 4.

Nurse's notes dated stage the area to the right outer ankle as 3.0 x3.0 x 0.3 scant no odor, bed very pale 1 States that the wounds are staged. They are staged according to depth, bed appearance.

Nurse's notes date same treatment was being done to the same area.

Physician order dated reveals the location was right ankle (malleolus) every other day, 2 mepitel, 1 prisma and profore lite. The next visit was scheduled for

Physician order dated reveals the location was right lateral ankle "1 Iodosorb/Iodoflex 2 gauze profore lite." The next visit was scheduled on

Physician order dated revealed the location was right ankle lateral "1 Iodosorb/Iodoflex 2 gauze, kerlex. Under other orders given for surgical Please encourage use of EHOB at night." The next visit was scheduled on

Review of Resident #7's care and history and physical dated " ... He has home health doing care for the little that had gotten, and they noticed about a month ago that he had an open area over his right lateral malleolus. Reportedly they had been putting some dressing on it, but it seems to be healing, and so they advised that he come here for further assessment and treatment. He has never had any problems or or problems that he knows of. He is not Extremities: lower extremities, specifically the right lower extremity ... He does have 2+ pulses in both the dorsalis pedia and distributions. He has 2+ ankle on the lateral malleolus, he has an that is deep, with raised and rolled edges, and is completely around, that measures 0.7 x 0.8 x 0.4 cm. There is a thick amount of at the base, and there is likely or bone exposed at the base as well...

According the history and physical dated the area was debrided down to the fascia overlying the bone, and removed any tissue and The measurements after debriding were 1 cm x 1 cm x 0.5 cm.

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Review of care progress notes dated "... On physical exam, the is decreased in size 0.6 cm x0.5 cm x 0.4 cm. There is a mild 1-2 mm of undermining underneath; there is a thick amount of at the base... "

Review of care progress notes dated "... He says he can't sleep on his left side and he was told that there is no good way to offload that area. Review of the assessment and plan: "... I would like to get a TCOM to assess for

Review of care progress notes noted "... His right ankle is essentially unchanged at 0.9 x 0.9 x 0.5 cm, and has a thick amount of at the base that requires debridement, but no signs of at all." Under assessment and plan: "... We are going to go ahead and place VAC to area today, and I will see him next week in follow-up ..."

Review of care progress dated "(name of resident) returns to the care center today for the follow-up of his right lateral malleolus He has had the VAC in place now for about a week" ... "It measure 0.8 x 0.8 x 0.5 cm."

Physician order dated reveals the location was right ankle lateral to have vac changes at VRMC.WCC care on hold Monitor vac for placement and function only."

Review of skilled nursing visit note dated "SNV to perform care. No new wounds. outer ankle cleansed with SNS. has appointment with new MD and the clinic." Review of the assessment sheet revealed that the right outer ankle was pink in color, moderate drainage, no odors and measure 4.0 x 4.0 x 0.3.

During an interview conuducted on at 10:20 a.m. Resident#7's spouse stated he was admitted to the facility of this year. It was a little bump on the side of his ankle. He is on predinsone. This area began to appear in 2013. The home health nurse came around and was taking care of the and the area was not healing On of this year I was asked to take him to care center. I did not see due to the area always being covered by bandages and was surprised to see that the was a pretty bad looking spot. The nurse debried the area, measured the , and covered the back up. I was told I needed to bring him back once a week for 2 weeks. The area has remained the same. The vac was delivered to my house on . There was a delay due to to UPS not being able to find my house. Since that time he was to have the vac put on The home health nurse came into see my husband on and . The care center told me it was a pressure on his ankle.

During an interview conducted on at 11:22 a.m., the Administrator and Resident Care Corridinator stated that the resident was admitted to the facility requiring the use of a wheelchair. Then (name of home health agency) was requested by the family for his that he had upon admission to the facility. I believe that (name of the home health agency) had previoiusly worked with the resident in the past. The family member

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deceded to go with (name of doctor) at time of admission to follow the resident. was ordered to included OT and then he got out of his wheelchair and begain ambulating with a walker. Then all we know is the were being treated. The first time I was aware that there was a on his ankle when I faxed (name of doctor) on We were informed by the spouse that she was leaving for vacation. I told her about the order and the need to schedule appointment for care. The spouse wanted care appointment scheduled before she left. The appointment was scheduled on There was a case conference with the owners of facility on where all of the residents who were receiving home health were discussed to check on the resident's progress. The Administator told the spouse that the facility would need information about the staging size of the The resident was seen by the care center on and the Resident Care Corridinator called over to care center to determine the stage of the as well as what the treatment plan would be. The care center faxed the report over on The spouse was informed that the have to be treated or the resident would not be able to stay at the facility. The condition of the right ankle was first brought to the facility's attenton after discussion with the home health nurse on

During an interview conducted on at 12:05 p.m., the Home Health RN Clinical Supervisor stated our start of care date was There was no other encounter with this resident since his admission to the facility. Our referral was for assessment and measurements and report findings back to the resident's primary care physician. The assessment dated there were 8 sites identified 4 were and 4 were dry scabbed areas. There were no areas noted to his right lower ankle. care was ordered on and treatment was performed to include 1 week 1 for initial visit. The order was written for 2 weeks twice a week. On the nurse documents 3 wounds. One on the right thigh and to lower extremities. No ankle was identified. She stated that she recalls the resident becoming ambulatory and kept bumping self. Notes dated on do not mention the right lower ankle. On nurses noted a scabbed on the right ankle was scabbed measuring 1 x 1 on the anterior right ankle. On nurses notes still present and scabbed measuring .8 x .5. Nurses noted on scabbed .5 x .5.

During an interview conducted on at 1:35 p.m., the Home Health RN stated she has been coming to the facility to treat the resident for In the cupboard at the facility is where the home health charts are kept. Every time the resident is seen I will write a note in the resident's chart. There should be a note in the chart when I had notice the area on the resident's ankle. I speak to the Resident Care Director and tell her about my visit before I leave. When I first saw the on his right ankle. I did not know what it was. It was underneath his sock. That is the first time I saw the area. She asked the resident what had happened and he indicated that he was hitting it against the wheel of the walker. I spoke to the resident's previous physician and he ordered hydrocolloid to be applied to the area. Shortly after the resident was being followed by another doctor, the resident was referred to the care center. The care center took over the care after that. When the resident goes to the clinic the clinic takes care of all of the care. The resident would be seen twice a week at the care and I would see the resident once a week. The resident has some short term memory problems and does not always recall what has happened.

During a telephone interview conducted on at 3:21 p.m., the LPN at the care center stateed the type of that that the resident had on the first visit to the care center on suggests that it is a due the location of the being on a boney prominence. The depth of the at the time of the visit was 0.04 and was classified as a The most recent measurements taken on were 0.5 and the area remains a

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During a telephone interview conducted on at 10:20 a.m., Resident #7's care doctor stated the first time the resident went to the care center was on and the area on the resident's ankle suggests the may be pressure related due the resident favoring his right side when sleeping. She stated that she ordered some test to rule out if the was caused by a lack of flow to the area. She states that the area to the resident's ankle was classified as a on after the testing to the area came back within normal limits. The area remains a and the resident is scheduled to return to care today.

Class III

0011-Admissions - Discharge 58A-5.0181(5) FAC
Based on observation, clinical record review and staff and family interview, the facility failed to ensure that if the resident no longer meets the criteria for continued residency the resident shall be discharged. This is evidenced by the facility's failure to ensure that Resident #7 who had one (1) on his right ankle that required the use of a vacuum met the continued residency criteria.

The findings include:

Observation made on at 10:35 a.m., during the initial tour of the facility revealed that Resident #7 was in his up in a chair. Further observation revealed that the resident had a vac that was attached to his lateral right ankle. He stated that this was put on a few weeks back to help and heal the that he has on his ankle.

Clinical record review revealed that Resident #7 had an AHCA Form 1823, 2010 dated Review of Section 1: Health Assessment Section C the resident was coded as not having any , 3 or 4 pressure sores.

Review of fax dated at 4:38 p.m. to Resident #7s primary care physician states "(name of resident) has an open area on his right ankle bulb; per the home health nurse he has now developed one plus selling and it is not healing with hydrocolloid and she thinks it may need more. Please advise. The physician's response was on "These are hard to heal. Get Doppler and culture arrange for treatment at care center at Health Park."

Review of care progress notes dated revealed that the area was debrided again "... He says he can't sleep on his left side and he was told that there is no good way to offload that area." Review of the assessment and plan: "... I would like to get a TCOM to assess for ... If that shows he has good saturation to tissue, I will perform and additional debriding to get rid of the undermining and then we will order a VAC to place at the base of the at that time..."

Review of care progress notes dated "(name of resident) returns to care center today for follow-up of his right lateral ankle Today he had TCOMs done, which showed very high numbers in the 70's, especially around the area of the They all had good response to showing no signs of any significant He has no other complaints. They have ordered a VAC. It is supposed to be delivered today, but as of yet that have not received it. Physical examination: The looks

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Review of care progress notes noted "... His right ankle is essentially unchanged at 0.9 x 0.9 x 0.5 cm, and has a thick amount of at the base that requires debridement, but no signs of at all." Under assessment and plan: "... We are going to go ahead and place VAC to area today, and I will see him next week in follow-up..."

Review of care progress notes dated "(name of resident) returns to the care center today for the follow-up of his right lateral malleolus He has had the VAC in place now for about a week" ..."It measure 0.8 x 0.8 x 0.5 cm.."

Facility record review revealed that Resident #7 is assisted with a shower on Monday Wednesday and Saturday. Clinical record review lacked documentation that Resident #7 had a on his right outer ankle.

Clinical record review also revealed that the only care center notes the facility had in the clinical record was the visit from Resident #7 was first seen by the care center on . The facility had to contact the care center to get additional notes from the resident's visits.

Review of skilled nursing visit note dated "SNV to perform care. No new wounds. outer ankle cleansed with SNS. has appointment with new MD and the clinic." Review of the assessment sheet revealed that the right outer ankle was pink in color, moderate drainage, no odors and measure 4.0 x 4.0 x 0.3.

Review of ALF Communication Form dated "... performed care to right ankle with profore lite. R/V sat for care. Not on abt at this time."

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deceided to go with (name of doctor) at time of admission to follow the resident. was ordered to included OT and then he got out of his wheelchair and begain ambulating with a walker. Then all we know is the were being treated. The first time I was aware that there was a on his ankle when I faxed (name of doctor) on . We were informed by the spouse that she was leaving for vacation. I told her about the order and the need to schedule appointment for care. The spouse wanted care appointment scheduled before she left. The appointment was scheduled on . There was a case conference with the owners of facility on where all of the residents who were receiving home health were discussed to check on the resident's progress. The Administator told the spouse that the facility would need information about the staging size of the . The resident was seen by the care center on 10/1/13 and the Resident Care Corridinator called over to care center to determine the stage of the as well as what the treatment plan would be. The care center faxed the report over on . The spouse was informed that the have to be treated or the resident would not be able to stay at the facility. The condition of the right ankle was first brought to the facility's attenton after discussion with the home health nurse on .

During an interview conducted on at 12:05 p.m., the Home Health RN Clinical Supervisor stated our start of care date was . There was no other encounter with this resident since his admission to the facility. Our referral was for assessment and measurements and report findings back to the resident's primary care physician. The assessment dated there were 8 sites identified 4 were and 4 were dry scabbed areas. There were no areas noted to his right lower ankle. care was ordered on and treatment was performed to include 1 week 1 for initial visit. The order was written for 2 weeks twice a week. On the nurse documents 3 wounds. One on the right thigh and to lower extremities. No ankle was identified. She stated that she recalls the resident becoming ambulatory and kept bumping self. Notes dated on do not mention the right lower ankle. On nurses noted a scabbed on the right ankle was scabbed measuring 1 x 1 on the anterior right ankle. On nurses notes still present and scabbed measuring .8 x .5. Nurses noted on scabbed .5 x .5.

During an interview conducted on at 1:35 p.m., the Home Health RN stated she has been coming to the facility to treat the resident for In the cupboard at the facility is where the home health charts are kept. Every time the resident is seen I will write a note in the resident's chart. There should be a note in the chart when I had notice the area on the resident's ankle. I spoke to the Resident Care Director and tell her about my visit before I leave. When I first saw the on his right ankle. I did not know what it was. It was underneath his sock. That is the first time I saw the area. She asked the resident what had happened and he indicated that he was hitting it against the wheel of the walker. I spoke to the resident's previous physician and he ordered hydrocolloid to be applied to the area. Shortly after the resident was being followed by another doctor, the resident was referred to the care center. The care center took over the care after that. When the resident goes to the clinic the clinic takes care of all of the care. The resident would be seen twice a week at the care and I would see the resident once a week. The resident has some short term memory problems and does not always recall what has happened.

During a telephone interview conducted on at 3:21 p.m., the LPN at the care center stated the type of that that the resident had on the first visit to the care center on suggests that it is a due the location of the being on a boney prominence. The depth of the at the time of the visit was 0.04 and was classified as a The most recent measurements taken on were 0.5 and the area remains a

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967791	10/22/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
A Banyan Residence	100 Base Ave East Venice, FL 34285	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

During a telephone interview conducted on at 10:20 a.m., the Resident #7's care doctor stated the first time the resident went to the care center was on and the area on the resident's ankle suggests the may be pressure related due the resident favoring his right side when sleeping. She stated that she ordered some test to rule out if the was caused by a lack of flow to the area. She states that the area to the resident's ankle was classified as a on after the testing to the area came back within normal limits. The area remains a and the resident is scheduled to return to care today.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation and interview the facility failed to treat the residents with respect and personal dignity.

The findings include:

It was observed during lunch on at 12:32 p.m., that 10 out of 10 residents in the memory care unit were served their fluids in disposable drinking cups. The other 34 residents in the facility received their fluids in non-disposable drinking cups.

An interview was conducted on at 12:00 p.m. with the Administrator. She was asked about the memory care residents receiving their fluids in disposable drinking cups during meals. She stated that she was not aware of this.

Class III

0078-Staffing Standards - Staff 58A-5.019(2) FAC
The facility failed to ensure that newly hired staff have a statement from a health care provider within 30 days of hire stating that the person does not have any signs or symptoms of a communicable including

The findings include:

Employee Record review revealed that Employee C was hired on Her communicable and statement was dated

On at 12:30 p.m., an interview was conducted with the Resident Director. She stated that she did not have an Communicable and statement dated any earlier for Employee C.

Class

0081-Training - Staff In-Service 58A-5.0191(2) FAC
Based on record review and interview the facility failed to ensure that 3 (Staff A, B, and C) of 3 staff records reviewed had the proper training.

The findings include:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967791	10/22/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
A Banyan Residence	100 Base Ave East Venice, FL 34285	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Review of staff records for Staff A, B, and C revealed that they failed to show that they had received the 3 hour required training in Resident Behavior and Needs and Providing Assistance with the Activities of Daily Living (ADL).

During an in interview conducted on at 12:00 p.m. the Administrator stated that she was unaware that this training was required and that her staff did not receive this training.

Class III

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on observations, review of the facility's current menu and staff interview, the facility failed to ensure that menus were followed and that the facility had at least 6 months of meal substitutions on file.

The findings include:

Observation made on at 12:30 p.m., revealed that the winter menu 2013 was posted in the main dining . According to the menu the residents were to receive baked potato with sour cream. Observation made on at 12.58 p.m., during the noon meal revealed a male dietary aide was observed plating up mashed potatoes with butter instead of baked potatoes with sour cream noted on posted menu. All of the residents with exception of 2 received mashed potatoes with butter.

Interview conducted on at 1:07 p.m., stated he substituted mashed potatoes with baked potatoes because he thought that mashed potatoes went better than baked potato with the meat loaf.

During an interview conducted on at 12:46 p.m., the Dietary Supervisor stated that she does not have 6 months worth of substitution kept on file. The substitutions are normally written on the daily menu so the residents know what is going to be served. I have only been keeping the past menus for 3 months however; I do not have any of these. She thinks her last substitution was approximately a month and a half ago when noodles were substituted for rice.

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

Dear Administrator:

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

Attached is the provider's copy of the State (5000-3547) 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

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