STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965739	03/06/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Heron Club At Prestancia (the)	3749 Sarasota Square Blvd. Sarasota, FL 34238	
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 - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D

Specific Tag Findings:
These are the results of the Biennial survey conducted on ..... through ..... at The Heron Club at Prestancia, in Sarasota, FL.

The following is a description of non-compliance:

0010-Admissions - Continued Residency 58A-5.0181(4) FAC
Based on record review, observation and interview, the facility failed to ensure continued residency criteria was met for 1 (Resident #11) of 3 resident records reviewed. The facility maintains a standard license. Resident #11 developed a single pressure ..... and subsequently developed a second pressure ..... while at the facility. The initial pressure ..... remains and has failed to show improvement within 30 days.

The findings include:

1. Review of the 1823 Health Assessment on ..... for Resident #11 revealed that it documents an admission date of .

The assessment includes clinical diagnoses of a history of a ..... to the ..... and ..... and home health was ordered for ..... care." The resident has "mild ..... and is "hard of hearing." In addition, documentation on page 2, Section C., question 3 asks "Any ....., 3 or 4 pressure sores" and shows a "Y" under the comments section. Location of the "pressure ..... is ..... and there is no further description regarding the pressure ..... to include the stage of the .....

The facility conducted their own initial care assessment summary for the date of ..... and documentation shows on page 2, under "Special Medical Needs" for "skin care" as "resident does not have ..... However, under "healing wounds", documentation reveals, "Resident has healing wounds. Needs staff monitoring and assistance from an appropriately skilled professional."

During an interview on ..... at 11:53 a.m., with the resident's son, who is the health care surrogate, he stated his mother ..... at the facility and ..... her shoulder. She ended up getting a bedsore at the facility which developed on her ..... and she was still being treated for it. When asked how long Resident #11 has had the ....., he stated, "It's been probably 4 weeks?" He stated he'd been taking pictures of the ..... all along and consulting with his brother who is a physician.

The wellness record notes dated ..... documents the following, "Blue colored hard nodule observed on R ..... No drainage. HH (Home Health) no longer is following as ..... (Physical ..... through outpatient. (MD name) will see resident ..... C/o (complains of) pain when touching area."

Wellness record notes dated ..... documents the resident was seen by the physician and ordered home health to follow and treat the "area." The resident's son was notified.

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The physician's orders dated ... for ... care includes ... 1 % ... cream; apply to ... 3 times a week (to be administered by HH nurse).

The ALF Patient Process Communication Record from the HHA (Home Health Agency) Registered Nurse (RN) documents the following related to the ...

Initial assessment, undated: Location: ... (does not state which ... Size .3 x .3 x .1, no other assessment or description of the ... is documented; no stage of the ... is assessed.

... (does not state which ... Size: .5 cm x .5 cm x .1 cm, no other assessment of the ... is documented; no stage of the ... is assessed.

... (does not state which ... Size: .4 x .4 x .1, no other assessment of the ... is documented, no stage assessed.

... (does not state which ... Size .5 x .5 x .1, and a second entry entitled, ... (does not state which ... documents a size of .3 x .3 x .1, no assessment or description of either ... nor is either ... staged.

... (does not state which ... Size .5 x .5 x .1, no other assessment of the ... documented nor is Stage of the ... assessed. There was no indication that a second ... was present as documented on the ... HHA notes.

... (does not state which ... Size .5 x .5 x .1, no other assessment of the ... is documented, no stage assessed.

... (does not state which ... Size .5 x .5 x .1, no other assessment of the ... is documented; no stage of the ... is assessed.

... (does not state which ... # of wounds is "1" however, 2 areas on the ... are identified, Location #1, ... Size .5 x .5 x .1, Location #2, .25 x .25 x .1, no other assessment of the ... is documented, no stage assessed for either ...

... (does not state which ... # of wounds is now "1", no measurements are documented, no documentation related to whether there was a second ... as noted on the ... assessment, no stage of the ... documented.

... (does not state which ... # of wounds is "1", Size .5 x .5 x .1, no other assessment of the ... is documented, no stage assessed.

Current treatment to the ... is dated ... and is ... 1 % ... cream; apply to ... 3 times a week (to be administered by HH nurse).

The RCD (Resident Care Director), who is a LPN (Licensed Practical Nurse), was interviewed on ... at 2:30 p.m. She stated she discovered the pressure ... to the resident's "right upper ... and to her it looked like a blackish blue hardened nodule. She obtained orders for HHA as their license does not permit them to treat wounds. When asked how she was monitoring the progress of the ..., she stated she would communicate

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with the home health nurse when she was at the facility who told her it was improving. However, she was not informed, nor did she ask, how the ... was improving. She confirmed she did not review the documentation submitted by the home health nurse concerning the ... She did not question the lack of documentation related to absence of ... stage, specific ... area (right vs. left ..., or ... description. She was not aware the ... dimensions showed the ... was not healing, nor was she aware of the development of the second ... She confirmed she never went back to look at the ...

Observation of the resident's ... in the presence of the RCD, Home Health RN, and Director of Nursing (DON) for the Home Health Agency on ... at 3:59 p.m. revealed an open area, size of a quarter, to the right of the resident's sacral-coccygeal area. The ... periphery was pinkish purple in color and the skin texture appeared hard. The base of the ... after cleansed by the RN twice, was approximately the size of a ... and presented with a yellowish sinewy tissue and could not be removed. The resident flinched in pain when the RN touched the area. No appearance of ... tissue was observed to the ... base. The depth of the ... was undeterminable due to the failure of the nurse's ability to wipe away the yellow tissue.

Interview with the RN at the time of the observation revealed the ... would start to get better, then worsen and then she developed a second ... next to the original ... She did not indicate why she did not stage the ...d(s) or why she did not provide a detailed description of the ...d(s). She confirmed the second ... healed, however, the resident remains with the same pressure ... with worsening dimensions than originally assessed.

Class III

0011-Admissions - Discharge 58A-5.0181(5) FAC
Based on record review, observation and interview, the facility failed to ensure continued residency criteria was met for 1 (Resident #11) of 3 resident records reviewed. The facility maintains a standard license. Resident #11 developed a single pressure ... and subsequently developed a second pressure ... while at the facility. The facility failed to initiate the discharge process after the development of the second pressure ... as well as after the initial pressure ... failed to show improvement within 30 days.

The findings include:

1. Review of the 1823 Health Assessment on ... for Resident #11 revealed that it documents an admission date of ...

The assessment includes clinical diagnoses of a history of a ... to the ... and ... and home health was ordered for ... care." The resident has "mild ... and is "hard of hearing." In addition, documentation on page 2, Section C., question 3 asks "Any ... 3 or 4 pressure sores and shows a "Y" under the comments section. Location of the "pressure ... is ... and there is no further description regarding the pressure ... to include the stage of the ...

The facility conducted their own initial care assessment summary for the date of ... and documentation shows on page 2, under "Special Medical Needs" for "skin care" as "resident does not have ... However, under "healing wounds", documentation reveals, "Resident has healing wounds. Needs staff monitoring and assistance from an appropriately skilled professional."

During an interview on ... at 11:53 a.m., with the resident's son, who is the health care surrogate, he stated

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his mother . . l at the facility and . . . . . l her shoulder. She ended up getting a bedsore at the facility which developed on her . . . . . and she was still being treated for it. When asked how long Resident #11 has had the , he stated, "It's been probably 4 weeks?" He stated he'd been taking pictures of the . . . . . l all along and consulting with his brother who is a physician.

The wellness record notes dated . . . . . documents the following, "Blue colored hard nodule observed on R . No drainage. HH (Home Health) is no longer following as . . (Physical . . . through outpatient. (MD name) will see resident . . C/o (complains of) pain when touching area."

Wellness record notes dated . . . . . documents the resident was seen by the physician and ordered home health to follow and treat the "area." The resident's son was notified.

The physician's orders dated . . . . . for . . . . . care includes . . 1 % . cream; apply to . . . . . l 3 times a week (to be administered by HH nurse).

The ALF Patient Process Communication Record from the HHA (Home Health Agency) Registered Nurse (RN) documents the following related to the . . . . . .

Initial assessment, undated: Location: . . . . (does not state which . Size .3 x .3 x .1, no other assessment or description of the . . . . . l is documented; no stage of the . . . . l is assessed.

. . . . . : . (does not state which . Size: .5 cm x .5 cm x .1 cm, no other assessment of the . . . . . l is documented; no stage of the . . . . . l is assessed.

. . . . . : . . . . . (does not state which . Size: .4 x .4 x .1, no other assessment of the . l is documented, no stage assessed.

. . . . . : . . . . . (does not state which . Size .5 x .5 x .1, and a second entry entitled, ... ' (does not state which . documents a size of .3 x .3 x .1, no assessment or description of either . . . . l nor is either . staged.

There was no documentation to support the facility initiated discharge proceedings once it was noted a second pressure . developed.

The HHA's documentation includes:

. . . . . : . . . . . (does not state which . Size .5 x .5 x .1, no other assessment of the . . . . l documented nor is Stage of the . assessed. There was no indication that a second . . . . . l was present as documented on the . . . . . HHA notes.

. . . . . : . (does not state which . Size .5 x .5 x .1, no other assessment of the . . . . . l is documented, no stage assessed.

. . . . . : . . . . . (does not state which . Size .5 x .5 x .1, no other assessment of the . . . . l is documented; no stage of the . . . . . l is assessed.

. . . . . : . . . . . (does not state which . # of wounds is "1" however, 2 areas on the . are identified, Location #1, . Size .5 x .5 x .1, Location #2, .25 x .25 x .1, no other assessment of the

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is documented, no stage assessed for either .

(does not state which # of wounds is now "1", no measurements are documented, no documentation related to whether there was a second as noted on the assessment, no stage of the documented.

(does not state which # of wounds is "1", Size .5 x .5 x .1, no other assessment of the is documented, no stage assessed.

Current treatment to the is dated and is 1 % cream; apply to 3 times a week (to be administered by HH nurse).

The RCD (Resident Care Director), who is a LPN (Licensed Practical Nurse), was interviewed on at 2:30 p.m. She stated she discovered the pressure to the resident's "right upper " and to her it looked like a blackish blue hardened nodule. She obtained orders for HHA as their license does not permit them to treat wounds. When asked how she was monitoring the progress of the , she stated she would communicate with the home health nurse when she was at the facility who told her it was improving. However, she was not informed, nor did she ask, how the was improving. She confirmed she did not review the documentation submitted by the home health nurse concerning the . She did not question the lack of documentation related to absence of stage, specific area (right vs. left or description. She was not aware the dimensions showed the was not healing, nor was she aware of the development of the second . She confirmed she never went back to look at the .

Observation of the resident's in the presence of the RCD, Home Health RN and Director of Nursing (DON) for the HHA on at 3:59 p.m., revealed an open area, size of a quarter, to the right of the resident's sacral-coccygeal area. The periphery was pinkish purple in color and the skin texture appeared hard. The base of the , after cleansed by the RN twice, was approximately the size of a and presented with a yellowish sinewy tissue and could not be removed. The resident flinched in pain when the RN touched the area. No appearance of tissue was observed to the base. The depth of the was undeterminable due to the failure of the nurse's ability to wipe away the yellow tissue.

Interview with the RN at the time of the observation revealed the would start to get better, then worsen and then she developed a second next to the original . She did not indicate why she did not stage the d(s) or why she did not provide a detailed description of the d(s). She confirmed the second healed, however, the resident remains with the same pressure with worsening dimensions than originally assessed.

The facility failed to ensure the was adequately monitored to determine whether discharge proceedings should be initiated after the second developed as well as when the initial failed to improve within 30 days.

Class III

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on record review, observation and interview, the facility failed to adequately supervise the care and services provided for 1 (Resident #11) of 3 resident records reviewed. Resident #11 developed a single pressure and subsequently developed a second pressure while at the facility. The facility failed to ensure they

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were acutely aware of the size, stages, location or changes of the status of the pressure sores being treated by the home health agency on behalf of the resident.

The findings include:

1. Review of the 1823 Health Assessment on ... for Resident #11 revealed that it documents an admission date of ...

The assessment includes clinical diagnoses of a history of a ... to the ... and ... and home health was ordered for ... care." The resident has "mild ... and is "hard of hearing." In addition, documentation on page 2, Section C., question 3 asks "Any ... 3 or 4 pressure sores and shows a "Y" under the comments section. Location of the "pressure ... is ... and there is no further description regarding the pressure ... to include the stage of the ...

The facility conducted their own initial care assessment summary for the date of ... and documentation shows on page 2, under "Special Medical Needs" for "skin care" as "Resident does not have ... However, under "healing wounds" documentation reveals, "Resident has healing wounds. Needs staff monitoring and assistance from an appropriately skilled professional."

During an interview on ... at 11:53 a.m. with the resident's son, who is the health care surrogate, he stated his mother ... at the facility and ... her shoulder. She ended up getting a bedsore at the facility which developed on her ... and she was still being treated for it. When asked how long Resident #11 has had the ..., he stated, "It's been probably 4 weeks?" He stated he'd been taking pictures of the ... all along and consulting with his brother who is a physician.

The wellness record notes dated ... documents the following, "Blue colored hard nodule observed on R ... No drainage. HH (Home Health) is no longer following as ... (Physical ... through outpatient. (MD name) will see resident ... C/o (complains of) pain when touching area."

Wellness record notes dated ... documents the resident was seen by the physician and ordered home health to follow and treat the "area." The resident's son was notified.

The physician's orders dated ... for ... care includes ... 1 % ... cream; apply to ... 3 times a week (to be administered by HH nurse).

The ALF Patient Process Communication Record from the HHA (Home Health Agency) Registered Nurse (RN) documents the following related to the ...

Initial assessment, undated: Location: ... (does not state which ... Size .3 x .3 x .1, no other assessment or description of the ... is documented; no stage of the ... is assessed.

... (does not state which ... Size: .5 cm x .5 cm x .1 cm, no other assessment of the ... is documented; no stage of the ... is assessed.

... (does not state which ... Size: .4 x .4 x .1, no other assessment of the ... is documented, no stage assessed.

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(does not state which Size .5 x .5 x .1, and a second entry entitled, '(does not state which documents a size of .3 x .3 x .1, no assessment or description of either nor is either staged.

(does not state which , Size .5 x .5 x .1, no other assessment of the documented nor is Stage of the assessed. There was no indication that a second was present as documented on the HHA notes.

(does not state which , Size .5 x .5 x .1, no other assessment of the is documented, no stage assessed.

(does not state which , Size .5 x .5 x .1, no other assessment of the is documented; no stage of the wound is assessed.

(does not state which , # of wounds is "1" however, 2 areas on the are identified, Location #1, Size .5 x .5 x .1, Location #2, .25 x .25 x .1, no other assessment of the is documented, no stage assessed for either .

(does not state which , # of wounds is now "1", no measurements are documented, no documentation related to whether there was a second as noted on the assessment, no stage of the documented.

(does not state which , # of wounds is "1", Size .5 x .5 x .1, no other assessment of the is documented, no stage assessed.

Current treatment to the is dated and is 1 % cream; apply to 3 times a week (to be administered by HH nurse).

The RCD (Resident Care Director), who is a LPN (Licensed Practical Nurse), was interviewed on at 2:30 p.m. She stated she discovered the pressure to the resident's "right upper and to her it looked like a blackish blue hardened nodule. She obtained orders for HHA as their license does not permit them to treat wounds. When asked how she was monitoring the progress of the she stated she would communicate with the home health nurse when she was at the facility who told her it was improving. However, she was not informed, nor did she ask, how the was improving. She confirmed she did not review the documentation submitted by the home health nurse concerning the . She did not question the lack of documentation related to absence of stage, specific area (right vs. left , or description. She was not aware the dimensions showed the was not healing, nor was she aware of the development of the second . She confirmed she never went back to look at the .

Observation of the resident's in the presence of the RCD, Home Health RN, and Director of Nursing (DON) for the Home Health Agency on at 3:59 p.m. revealed an open area, size of a quarter, to the right of the resident's sacral-coccygeal area. The periphery was pinkish purple in color and the skin texture appeared hard. The base of the , after cleansed by the RN twice, was approximately the size of a and presented with a yellowish sinewy tissue and could not be removed. The resident flinched in pain when the RN touched the area. No appearance of tissue was observed to the base. The depth of the was undeterminable due to the failure of the nurse's ability to wipe away the yellow tissue.

Interview with the RN at the time of the observation revealed the would start to get better, then worsen

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and then she developed a second [redacted] next to the original [redacted]. She did not indicate why she did not stage the [redacted]nd(s) or why she did not provide a detailed description of the [redacted]nd(s). She confirmed the second [redacted] healed, however, the resident remains with the same pressure [redacted] with worsening dimensions than originally assessed.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observations, record reviews and interviews, the facility failed to assist 2 (Residents #9 and #14) of 5 residents observed receiving assistance with self-administration of their medications by not identifying the medication to Resident #14 and not assisting Resident #9 to self-administer a medication in accordance with physicians orders.

The findings include:

1. On [redacted] at 11:50 a.m., Resident #14 was observed being assisted with her medications by Staff H. Staff H was observed at the medication cart removing Resident #14's medication from the pharmacy packaging and placing the pill into a plastic medication cup. Staff H proceeded to the resident's [redacted] handed the medication cup to the resident. Staff H did not identify the medication to the resident that she was assisting the resident to self-administer.

On [redacted] at 2:00 p.m., the surveyor discussed with the Resident Care Director (RCD) that Staff H did not identify the medication to Resident #14 when assisting her.

2. On [redacted] at 12:18 p.m., Resident #9 was observed being assisted with her medications by Staff G. Staff G was observed removing the medications from the pharmacy packaging and identifying the medication to the resident as she was placing the medications in a plastic medication cup. Staff G was observed removing a card of capsules labeled Micro K 10meq takes 4 caps (40meq) every morning. Staff G was observed removing 2 capsules of the medication and placing them into the medication cup. Staff G handed the medication cup to Resident #9 after removing all the residents' morning medications from the cards. The resident's Medication Observation Record (MOR) for [redacted] 2014 was reviewed and indicated the resident was to receive 4 capsules of the Micro K 10 meq at 11:00 a.m. The surveyor discussed with Staff G that the label and MOR directed the resident was to take 4 capsules and that she had only given the resident 2 capsules.

On [redacted] at 12:30 p.m., the surveyor discussed with the Resident Care Director that the resident had only received 2 capsules (20 meq) of the Micro K. The Resident Care Director confirmed the resident was to receive 4 capsules of the medication.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

12, 2014

Administrator
Heron Club At Prestancia (the)
3749 Sarasota Square Blvd.
Sarasota, FL 34238

Dear Administrator:

This letter reports the findings of a Biennial survey that was completed on 2014 by representatives 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 12, 2014 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
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