STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965718	03/28/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Terracina Grand	6825 Davis Blvd Naples, FL 34104	

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 - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= G
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Specific Tag Findings:
These are the results of an unannounced complaint survey (CCR#2014002705) conducted on [redacted] through [redacted] at Terracina Grand, an Assisted Living Facility (ALF) located at Naples, FL.

Three allegations were substantiated. The facility received citations as a result of this survey.

The following is a description of the noncompliance:

0010-Admissions - Continued Residency 58A-5.0181(4) FAC
Based on record review, observation and interview, the facility failed to ensure an AHCA form 1823 (assessment) was completed for 3 (Resident #1, #2, and #3) out of 3 sampled residents experiencing a significant change of condition.

The findings include:

1. Review of the medical record for Resident #1, revealed that he was admitted to the facility on [redacted]. The most recent AHCA form 1823 (Resident Assessment), dated [redacted], documents [redacted] and [redacted]. The assessment also documents that the resident requires assistance with ambulation (walker and at times wheelchair), bathing, dressing, [redacted], toileting and transferring; and is independent with eating. There was no indication of a history of [redacted] on this assessment. Recent significant changes, as documented in the medical record, include: 16 [redacted] from [redacted] 2013 to [redacted] 2014, and a 10 pound weight loss in [redacted] 2014 requiring supervision/assistance with meals. The resident was admitted to Hospice on [redacted] and received hospice care until his discharge from the facility, to a higher level of care on [redacted], with diagnoses of Head Injury, [redacted] and Frequent [redacted].

Upon interview on [redacted] at 4:00 p.m., the facility administrator acknowledged that an AHCA form 1823 was not completed for the resident's significant change in condition.

2. Review of the medical record revealed that Resident #2 was admitted to the facility on [redacted]. Upon interview on [redacted] at 4:00 p.m., the Acting Director of Nursing stated that most recent AHCA form 1823 (Resident Assessment) was in the medical record with a date of [redacted]. This assessment documents diagnoses of Parkinson's [redacted], Scoliosis, [redacted] and [redacted] Rigidity, Gait [redacted], Mild [redacted]. The assessment also documents that the resident requires assistance with ambulation, bathing, dressing, [redacted] and transferring; and is independent with toileting and eating. The resident was admitted to Hospice on [redacted] and is presently receiving hospice services. The assessment did not address the resident's recent history of [redacted] (8 [redacted] since [redacted], the need for assistance with toileting (applying diaper at night, toileting after meals and [redacted] care) and a need for assistance with eating as documented in Hospice notes.

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Hospice notes dated . . . "Face to Face Encounter - Recertification Addendum" state "the . has had increased difficulty holding silverware, remote and is always dropping things (per wife). She now often assists him with eating. Only eats about 50% of most meals. Gait is unsteady, had a recent . . without injury. . . nutritional status: oral intake insufficient, . . . unable to feed self, anorexia." The facility's current "Service Plan" dated . . . and the Service Schedule used by facility caregivers, does not address the need for assistance or supervision with meals.

Interview of Staff A on . . . at 12:45 p.m., revealed that she placed Resident #1 on the toilet before breakfast this morning, gave him . . . care and used a wheelchair to transfer him to a chair by his bed. She also stated the resident calls (the kitchen) for his breakfast, eats alone in his he has not had any . in the past 6 months that she has been aware of. Staff A continued to state, "He can feed himself," and replied, "no" when asked if his hands shake when he eats. The surveyor and Staff A went to main dining . . this time to observe resident. Resident #2 was sitting at a table, next to the wall. The table could accommodate 2 people. He was sitting alone eating his meal. His location was somewhat private, and could not be readily observed by staff and residents in the dining . His hand was shaking as he brought the utensil to his mouth and food was falling back to the plate. His head was very close to the plate. It appeared that he had eaten about 25% of his food at that time. He said the food was good. When asked, Staff A stated that his wife was not in the dining . . the resident usually ate alone. In addition, Staff A acknowledged that the resident's hand was shaking as he was eating.

3. Resident #3 was admitted to the facility on The most recent AHCA form 1823 (Resident Assessment), dated , documents diagnoses of . Debility, . . Hypothyriodism, Hx of . . . , Lower Extremity . . . and Forgetful. The assessment also documents that the resident requires assistance with bathing, dressing, . and toileting; and indicates that the resident is independent with ambulation, eating and transferring. Upon interview at 4:00 p.m. on , the Acting Director of Nursing stated that the AHCA form 1823, dated . was the most current assessment. The resident was admitted to Hospice on . and is presently receiving hospice services. The facility did not complete a significant change of condition assessment relating to 11 unwitnessed . during the time period of through . . (6 months), and the need for supervision and/or assistance with ambulation and transfer.

A "Resident Observation Log" entry dated . at 12:30 p.m. documents . . record reviewed, spoke to Staff B (Hospice) resident is not a for . (physical due to , unable to retain information. Resident tries to walk unassisted, very poor safety awareness. Left message for son-in-law to please call to discuss residents care and to inform of apt. (apartment) available on memory care unit. 1:00 p.m., Spoke to '_____' he is agreeable to moving resident to memory unit. Recommended resident have private duty CNA (certified nursing assistant) for increase safety, he declined." Signed by Staff C.

Upon interview at 10:50 a.m. on , Staff C stated that there are plans to move Resident #3 to the Memory Care Unit into vacated by Resident #1, where he will be "getting a little more supervision." She continued to state that the carpet needed to be replaced in that . . . that the resident's son-in-law declined having a private duty CNA for the resident.

. . was observed to be vacant on . . (during tour of the facility) and again on . . at 1:00 p.m., 7 days after a decision was made by the facility and family to move the resident to provide increased supervision.

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Interview of Staff D at 9:20 a.m. on revealed that she got Resident #3 out of bed, washed and dressed him, and brought him to the toilet because "the Hospice Aid was not there yet." She also stated "When Hospice came, they had to undress and shower him. I left the they came. I may or may not see the resident again today. I have assignments on all 4 floors (in the facility) and my partner may take care of him, or someone will." When asked if the resident , Staff D said she did not know of any

Class III

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on record review, observation and interview, the facility failed to provide adequate supervision to prevent multiple for 3 (Resident #1, 2, and 3) out of a 3 sampled residents.

The findings include:

1. Review of the medical record, for Resident #1, revealed that he was admitted to the facility on The most recent AHCA form 1823 (Resident Assessment), dated , documents and The assessment also documents that the resident requires assistance with ambulation (walker and at times wheelchair), bathing, dressing, , toileting and transferring; and is independent with eating. There was no indication of a history of on this assessment. Recent significant changes, as documented in the medical record, include: 16 from 2013 to 2014, and a 10 pound weight loss in 2014 requiring supervision/assistance with meals. The resident was admitted to Hospice on and received hospice care until his discharge from the facility, to a higher level of care on , with diagnoses of Head Injury, and Frequent

The following entries noted in the Resident Observation Log (ROL) in the medical record:
record reviewed. Resident is currently under ____ hospice care";
record reviewed. Resident has poor safety awareness";
record reviewed. Resident is currently under ____ hospice care";
record reviewed. Resident has poor safety awareness. Apartment checked. No environmental factors present";
record reviewed. Additional toileting added to service plan";
record reviewed. Poor safety awareness impulsive";
record reviewed. Resident has poor safety awareness";
review committee. (patient) of ____ hospice. Poor safety awareness. Resident's service plan includes safety checks and assistance with toileting,wheelchair";
review. of ____ hospice. Poor safety awareness";
review. Resident receives ____ hospice services. Poor safety awareness";
record review. Poor safety awareness. Resident patient of ____ hospice";
review done, resident has poor safety awareness and weakened condition, he is an ____ hospice

The ROL dated at 9:30 p.m., states "Resident observed lying on floor supine next to bed in Resident must have while trying to get up out of bed and hit his head on either the bed or wheelchair. No signs of impact on either objects. Laceration on middle top (parietal) head, greater than 4 inches in length horizontally. ____ hospice called first, nurse on phone said to send him to ER (Emergency Resident

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was alert at the time of . Able to speak clearly, followed simple directions and complained of pain around laceration."

The ROL dated at 8 a.m., states "Per nurse '_____', resident admitted (to hospital) for Head Injury, and Frequent '

The ROL dated at 8:40 a.m., states "Spoke with '_____' at hospital, resident status quo. ' of ordered, awaiting approval from POA (power of attorney). Hospital was unaware resident is an ____ hospice .

The ROL dated at 1715 (5:15 p.m.) states record reviewed. Resident has no safety awareness. Is out to hospital. 5:30 p.m. Resident will be discharged to a skilled nursing facility. Social Worker at hospital is looking for an open medicare bed."

The facility Service Plan effective , for Resident #1, states the following interventions were in place as of:

Assist with AM Care. Assist with p.m. care. Escort resident to all meals. Resident must use walker at all times. Siderails up on bed. 12 a.m. Safety checks every two hours throughout the night, assist with toileting and report any changes to nursing station, you must sit him on the toilet a least three times during the night. Toileting 10 a.m., 2 p.m., 4:30 p.m. Be sure that his cushion is on the wheelchair."
Toileting 10:45 p.m. and 11:30 p.m."
Weekly weights and vital sign(s)."

As of the Service Plan toileting schedule cited every 2 hours during night (starting at 12 a.m.) 10:00 a.m., 2:00 p.m., 4:30 p.m., 10:45 p.m. and 11:30 p.m. The plan did not include toileting between 4:30 p.m. and 10:45 p.m., a period of 6 hours and 15 minutes. Five (5) were documented as occurring during that 6 hour time period between and (after "additional toileting" was added to the Service Plan). Four (4) out of these 5 resulted in injury. 1 resulting in a shoulder : 1 (occurring on had a ROL note dated stating "large lump on right upper arm the size of a golf ball", 1 resulting in an open area and to left hand that required an x-ray to rule out and 1 resulting in a 4 inch laceration to the head which resulted in admission to a higher level of care/permanent discharge from the facility. In addition, a "Monthly Review" dated states "Scabbed over skin on right side of head. Right arm still black and blue with golf ball sized lump."

Upon interview at 3:45 p.m. on the Administrator and Director of Nursing acknowledged that no prevention interventions were developed and implemented, during the time period through except to toilet the resident at 10:45 p.m. and 11:30 p.m., which was implemented on the service plan on . They also acknowledged that "poor safety awareness and ____ hospice resident" do not represent a safety plan to prevent based a coordination of services with Hospice. It was also recognized and acknowledged, at this time, that the toileting intervention implemented on was ineffective and not re-evaluated or revised.

2. Review of the medical record revealed that Resident #2 was admitted to the facility on . Upon interview on at 4:00 p.m., the Acting Director of Nursing stated that most recent AHCA form 1823 (Resident Assessment) was in the medical record with a date of . This assessment documents diagnoses of Parkinson's , Scoliosis, and Rigidity, Gait Mild . The assessment also documents that the resident requires assistance with ambulation, bathing, dressing, and transferring; and is independent with toileting and eating. The resident was

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admitted to Hospice on [illegible] and is presently receiving hospice services.

The assessment does not address the resident 's recent history of [illegible] (8 [illegible] since [illegible], the need for assistance with toileting (applying diaper at night, toileting after meals and [illegible] care) and a need for assistance with eating as documented in Hospice notes.

The resident has the following history of [illegible] at 12:15 p.m., [illegible] at 12:25 p.m. [illegible] out of scooter), [illegible] at 11:30 a.m., [illegible] at 8:30 a. m., [illegible] at 11 a.m., [illegible] at 7:30 p.m., [illegible] at 8:00 p.m., [illegible] at 12:00 p.m., [illegible] at 11:00 a.m., a total of 9 [illegible] (8 [illegible] since [illegible] as documented in the Resident Observation Log (ROL).

The following entries were also noted in the ROL: [illegible], 12:30 [illegible] record reviewed. Resident is under ____ hospice care; " [illegible], 12:15 p.m." [illegible] record reviewed. Resident has [illegible] Parkinson's [illegible] and is currently receiving services from ____ Hospice;" [illegible], 10:30 a.m. [illegible] record review. Resident has [illegible] Parkinson's [illegible] ad has ____ Hospice Services; " [illegible] (no time) [illegible] record review. Resident is patient of Hospice. Poor safety awareness; " [illegible] 12:20 p.m. [illegible] record review. Poor safety awareness. [illegible] of ____ Hospice;" [illegible], 12:15 p.m., [illegible] record review. Resident is under hospice care."

Hospice notes dated [illegible] "Face to Face Encounter - Recertification Addendum" states "the [illegible] has had increased difficulty holding silverware, remote and is always dropping things (per wife). She now often assists him with eating. Only eats about 50% of most meals. Gait is unsteady, had a recent [illegible] without injury. [illegible] nutritional status: oral intake insufficient, [illegible] (difficulty swallowing), unable to feed self, anorexia." The facility's current "Service Plan" dated [illegible] and the Service Schedule used by facility caregivers, does not address the need for assistance or supervision at meals.

Interview of Staff A, on [illegible] at 12:45 p.m., revealed that she placed Resident #1 on the toilet before breakfast this morning, gave him [illegible] care, used a wheelchair to transfer him and transferred him to a chair by his bed. She also stated the resident calls (the kitchen) for his breakfast, eats alone in his [illegible] he has not had any [illegible] in the past 6 months that she has been aware of. Staff A continued to state, "He can feed himself" and responded, "no" when asked if his hand shakes when he eats. The surveyor and Staff A went to main dining [illegible] at this time, to observe resident. Resident #2 was sitting at a table, next to the wall. The table could accommodate 2 people. He was sitting alone eating his meal. His location was somewhat private, and could not be readily observed by staff and residents in the dining [illegible] His hand was shaking as he brought the utensil to his mouth and food was falling back to the plate. His head was very close to the plate. It appeared that he had eaten about 25% of his food at that time. He said the food was good. When asked, Staff A stated that his wife was not in the dining [illegible] the resident usually ate alone.

Review of the facility service plan dated [illegible], revealed no plan to supervise/assist the resident with eating and did not address the resident's recent history of [illegible] The last up date, of the plan, was made on when the use of [illegible] hose was initiated.

The facility has not developed a plan to provide supervision for this resident to prevent [illegible] and potential weight loss/choking.

3. Resident #3 was admitted to the facility on [illegible] The most recent AHCA form 1823 (Resident Assessment), dated [illegible], documents diagnoses of [illegible] Debility, [illegible]

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Hypothyriodism, Hx of [redacted] Lower Extremity [redacted] and Forgetful. The assessment also documents that the resident requires assistance with bathing, dressing, [redacted] and toileting; and indicates that the resident is independent with ambulation, eating and transferring. Upon interview at 4:00 p.m. on [redacted], the Acting Director of Nursing stated that the AHCA form 1823, dated [redacted] was the most current assessment. The resident was admitted to Hospice on [redacted] and is presently receiving hospice services. The facility did not complete a significant change of condition assessment relating to 11 unwitnessed [redacted] during the time period of [redacted] through [redacted] (6 months), and the need for supervision and/or assistance with ambulation and transfer based on frequent [redacted].

The resident has the following history of [redacted] at 3:00 p.m., [redacted] (no time indicated), [redacted] at 3:00 p.m., [redacted] at 3:00 p.m., [redacted] (no time indicated), [redacted] at 8:00 p.m., [redacted] at 7:30 a.m., [redacted] at 8:45 a.m., [redacted] at 11:00 p.m., [redacted] at 7:00 p.m. and [redacted] at 2:30 p.m. as noted in the Resident Observation Log (ROL). All 11 [redacted] were unwitnessed and indicted the resident was found on the floor. In addition, on [redacted] at 5:00 p.m., the ROL states "Black and blue [redacted] of unknown origin noted on left upper arm approximately 20 cm x 5cm and resident states that the area is tender to touch."

The following entries were also noted in the ROL: [redacted] record reviewed. Resident is currently receiving hospice;" [redacted] record reviewed. Poor safety awareness; " [redacted] reviewed. Resident is patient on Hospice. Two [redacted] and [redacted] without injury. Poor safety awareness;" [redacted] " Denies need for care conference. Asked about moving resident to memory care. Contacted ____ Hospice to discuss service plan. Will meet with Hospice by end of week [redacted] 2014 and discuss findings with POA (power of attorney); " [redacted] 12:00 p.m. [redacted] record reviewed. Resident has poor safety awareness. ____ hospice resident;" [redacted] 5:30 p.m. " [redacted] record reviewed. Resident is currently under hospice services. No recommendations at this time."

A "Resident Observation Log" entry dated [redacted] at12:30 p.m. documents, " [redacted] record reviewed, spoke to Staff B (Hospice) resident is not a [redacted] for [redacted] (physical [redacted] due to [redacted], unable to retain information. Resident tries to walk unassisted, very poor safety awareness. Left message for son-in-law to please call to discuss residents care and to inform of apt. (apartment) available on memory care unit. 1:00 p.m. Spoke to '_____' he is agreeable to moving resident to memory unit. Recommended resident have private duty CNA (certified nursing assistant) for increase safety, he declined." Signed by Staff C.

Interview of Staff D at 9:20 a.m. on [redacted], revealed that she got Resident #3 out of bed, washed and dressed him, and brought him to the toilet because "the Hospice Aid was not there yet. I never know when the Hospice Aid will come." She also stated "When Hospice came, they had to undress and shower him. I left the [redacted] they came. I may or may not see the resident again today. I have assignments on all 4 floors (in the facility) and my partner may take care of him, or someone will." When asked if the resident [redacted], Staff D said she did not know of any [redacted].

The facility "Service Plan" dated [redacted] for Resident #3, revealed a plan to toilet Resident #3 with AM and PM care. but does not address the need for assistance with transfer and ambulation or a history of frequent [redacted]. The last entry on the Service Plan was [redacted] "Do resident's personal laundry and put away." An entry dated [redacted] states "Assist resident with incontinence care, make sure resident's clothes are not soiled, escort resident to and from all meals daily. Make sure he is wearing his pendant." In addition, an entry of [redacted] states "Remind resident to take his medication, hand him the pill box and ensure that he takes his medication. Also remind him to apply cream to affected areas."

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Upon interview at 10:50 a.m. on , Staff C stated that there are plans to move Resident #3 to the Memory Care Unit into vacated by Resident #1, where he will be "getting a little more supervision." She continued to state that the carpet needed to be replaced in that that the resident's son-in-law declined having a private duty CNA (Certified Nursing Assistant) for the resident.

was observed to be vacant on (during tour of the facility) and again on at 1:00 p.m., 7 days after a decision was made by the facility and family to move the resident to provide increased supervision.

The facility has not implemented a plan for the supervision of this resident, with a diagnosis of Advanced , to prevent

Class II

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on record review and interview, the facility failed to provide a safe environment and coordinate care relating to frequent for 3 (Resident #1, #2, and #3) out of a sample of 3 residents with a history of and receiving hospice services.

The findings include:

1. Interview of Staff B at Hospice on at 10:30 a.m. (via telephone), revealed that a Hospice case manager is not currently assigned to the facility. She also stated that a Hospice nurse would not be coming to the facility this date; but a nurse, not the assigned case manager, had been at the facility yesterday The surveyor asked where this nurse's notes were kept. Staff B stated that the notes would be faxed to the facility this date for the surveyor's review relating to Resident #2 and #3.

When asked if Hospice and the facility coordinated the care plan, relating to frequent experienced by Resident #1, #2 and #3; Staff B stated that Hospice had discussed Resident #1, #2, and #3 at their Interdisciplinary Team Meetings, and stated that facility staff do not attend those meetings. When asked if any notes were kept regarding those meetings, Staff B said, "No." When asked if any recommendations (by Hospice) were made to prevent Staff B said that she did not know. She also stated that the Hospice nurse (case manager) meets with the facility nurse, when they are in the facility, to discuss the residents' status.

Staff B and Staff E (Hospice) arrived at the facility at 1:00 p.m. on and requested to see the surveyor. At this time a copy of the notes documenting the Hospice nurse visit, made on relating to Resident #2 and Resident #3, were provided to the surveyor. No additional information was provided relating to how care has been coordinated, between the facility and hospice, relating to the frequent experienced by Resident #2 and #3.

2. Review of the closed medical record for Resident #1 revealed that the resident experienced 16 from 2013 to 2014, and a 10 pound weight loss in 2014.

A Hospice physician "Hospice Recertification" dated states "increasing , with multiple , significant at high risk for

Further review of the record revealed 5 documented as occurring between and , Four (4) out of these 5 resulted in injury. 1 resulting in a shoulder , 1 (occurring on had a

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ROL note dated , stating "large lump on right upper arm the size of a golf ball;" 1 ! resulting in an open area and to left hand that required an x-ray to rule out ; and 1 ! resulting in a 4 inch laceration to the head which resulted in admission to a higher level of care/permanent discharge from the facility. In addition, a "Monthly Review" dated , states "Scabbed over skin on right side of head. Right arm still black and blue with golf ball sized lump."

Review of the Hospice "Plan of Care Report" dated for Resident #1, revealed
"PIO: At risk for increased due to progression, start date , assess every visit, last severity: 1, managed with current POC (plan of care) interventions/monitoring, no reported this week.
Goal: Maintain desired level of safety (no with injury), start date , not assessed every visit, set for: facility staff, last outcome: 1, Met with on-going IDT (interdisciplinary team) actions. Demonstrates tasks/skills/information learned most of time. Sometimes performs them independently/makes some decisions, requires occasional reinforcement of instructions. And/or verbalizes goal mostly met.
Intervention: Anticipate future caregiving needs regarding equipment, supplies and staffing, start date last performed on
Intervention: Assess environment to identify/suggest modifications needed for safety, start date , last performed , results/outcome done."

The Hospice goal of "Maintain desired level of safety (no ! with injury)" was not met based on the , with injury, experienced by Resident #1. No review/revision in the Hospice plan of care was documented, and no collaboration with the facility was evidenced.

The Hospice "Plan of Care Report" dated also identified Nutritional/Hydration Diminished due to starting for fair appetite. The goal, to maintain optimum nutritional status with nutritional supplements, was cited as met on with on-going interdisciplinary team actions.

A facility Resident Observation Log note, dated , states "Resident lost 10 lbs. in the past month. Resident with poor appetite, has refused to eat meals even with assist of CNA." No review/revision in the Hospice plan of care was documented; and no collaboration with the facility was evidenced.

The facility Service Plan effective for Resident #1, states the following interventions were in place as of:
Assist with AM Care. Assist with p.m. care. Escort resident to all meals. Resident must use walker at all times. Side rails up on bed. 12 a.m. Safety checks every two hours throughout the night, assist with toileting and report any changes to nursing station, you must sit him on the toilet a least three times during the night. Toileting 10 a.m., 2 p.m., 4:30 p.m. Be sure that his cushion is on the wheelchair."
Toileting 10:45 p.m. and 11:30 p.m."
Weekly weights and vital sign(s)."

The service plan did not contain interventions in response to the resident frequent with injury; and did not address the need to supervise/assist at meals due to decreased appetite and potential for choking (as identified by Hospice).

The following entries were noted in the Resident Observation Log (ROL) completed by the facility:
! record reviewed. Resident is currently under ____ hospice care";
! record reviewed. Resident has poor safety awareness";
! record reviewed. Resident is currently under ____ hospice care";
! record reviewed. Resident has poor safety awareness. Apartment checked.

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SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)

No environmental factors present";
. . . . . l record reviewed. Additional toileting added to service plan";
. . . . . l record reviewed. Poor safety awareness impulsive";
. . . . . l record reviewed. Resident has poor safety awareness";
. . . . . l review committee. . . (patient) of ____ hospice. Poor safety awareness. Resident's service plan includes safety checks and assistance with toileting.wheelchair";
. . . . . l review. . . of ____ hospice. Poor safety awareness";
. . . . . l review. Resident receives ____ hospice services. Poor safety awareness";
. . . . . l record review. Poor safety awareness. Resident patient of ____ hospice";
. . . . . l review done, resident has poor safety awareness and weakened condition, he is an ____ hospice .

The Service Plan and Resident Observation Log entries did not reflect collaboration of care with Hospice services.

3. Review of the medical record revealed that Resident #2 has the following history of . . . . . at 12:15 p.m., ... at 12:25 p.m. . . out of scooter), ... at 11:30 a.m., ... at 8:30 a. m., ... at 11 a.m., ... at 7:30 p.m., ... at 8:00 p.m., ... at 12:00 p.m., ... at 11:00 a.m., a total of 9 . . . (8 . . . since . . . as documented in the Resident Observation Log (ROL).

The following entries were also noted in the ROL: . . . . . 12:30 p.m., . . . l record reviewed. Resident is under ____ hospice care; " . . . . . 12:15 p.m., . . . l record reviewed. Resident has . . . . Parkinson's . . . . . and is currently receiving services from ____ Hospice; " . . . . . 10:30 a.m., . . . l record review. Resident has . . . . Parkinson's . . . ad has ____ Hospice Services;" . . . . . (no time), . . . l record review. Resident is patient of Hospice. Poor safety awareness; " . . . . . 12:20 p.m., . . . l record review. Poor safety awareness. . . . of ____ Hospice; " . . . . . 12:15 p.m., . . . l record review. Resident is under hospice care. "

"Review of the Hospice "Plan of Care Report" dated . . . . . states "At risk for . . . increased due to . . . . . progression with a goal to maintain desired level of safety." Interventions include to assess environment dated . . . . . collaborate with facility staff regarding . . 's needs dated . . . . . and instruct in principles of safety, supervision and assisted activity dated 11 . . . .

The Hospice plan shows no evidence of review or revision based on the resident experiencing 8 . . . since 11 . . . , and fails to demonstrate collaboration with the facility related to a plan to prevent . . . .

Hospice notes dated . . . "Face to Face Encounter - Recertification Addendum" (completed by the Nurse Practitioner) states "the . . has had increased difficulty holding silverware, remote and is always dropping things (per wife). She now often assists him with eating. Only eats about 50% of most meals. Gait is unsteady, had a recent . . l without injury. . . l nutritional status: oral intake insufficient, ... (difficulty swallowing), unable to feed self, anorexia."

The Hospice "Plan of Care Report" dated . . . . also . . . to address . . . . and anorexia. "Airway clearance altered due to excess secretions" was identified on . . . . . without any revision relating to goals and interventions.

The facility's current "Service Plan" dated . . . . . and the Service Schedule used by facility caregivers, does not

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965718	03/28/2014
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SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

address the need for assistance or supervision at meals.

There is no collaboration between the facility and Hospice services to prevent frequent ... and prevent weight loss and .

4. Review of the Hospice "Plan of Care Report" dated ... for Resident #3, revealed:

"PIO: ... increased due to Altered Mobility, start date , not assessed every visit, last severity: 1, managed with current POC interventions/monitoring, results/outcome: today without injury.
Goal: Maintain desired level of safety (facility and family will be able to anticipate safety needs and put into place as needed), start date , assess every visit: no, set for: patient and family, facility staff, meet by: ongoing, last outcome: 1, Met with ongoing interdisciplinary actions. Demonstrates tasks/skills/information learned most of time. Requires occasional reinforcement of instructions. And/or verbalizes goal mostly met. results: ... without injury.
Intervention: Anticipate future caregiving needs regarding equipment, supplies and staffing, start perform every visit: no, results/outcome: Teaching with of always pressing call button for all assistance with transfers. Placed emergency pendant/call light around his neck. "

A "Face-to Face Encounter - Recertification Addendum" completed by the Hospice ARNP (Nurse Practitioner) on , identifies a "Hospice diagnosis of , a Secondary diagnosis of ... without behavioral disturbance and ... factors of Advanced ... Had a this morning per staff without injury. Unable to transfer without assistance. Increasing with minimal exertion. ... and forgetful. Unable to make needs known. No spontaneous communication during my visit. Sleeping about 18 hours a day."

Resident #3 was observed on ... at 11:15 a.m. and ... at 2:30 p.m., sleeping in bed in his apartment. A walker was observed next to his bed. He was alone and no staff was observed in the adjacent hallway.

The facility "Service Plan" dated ... for Resident #3, revealed a plan to toilet Resident #3 with AM and PM care, but does not address the need for assistance with transfer and ambulation or a history of frequent ...
The last entry on the Service Plan was . "Do resident's personal laundry and put away." An entry dated ... states "Assist resident with incontinence care, make sure resident's clothes are not soiled, escort resident to and from all meals daily. Make sure he is wearing his pendant." In addition, an entry of ... states "Remind resident to take his medication, hand him the pill box and ensure that he takes his medication. Also remind him to apply cream to affected areas."

There is no evidence that the facility coordinated with Hospice services to develop and implement a plan to maintain a safe environment to prevent frequent ...

Class II

0165-Risk Mgmt & QA; Adverse Incident Report 429.23 FS; 58A-5.0241 FAC
Based on record review and interview, the facility failed to initiate an adverse incident report for an event which resulted in the admission of Resident #1 to a hospital, due to a with injury, because the facility did not institute timely ... prevention measures.

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The findings include:

Review of the medical record for Resident #1, revealed that he was admitted to the facility on . The most recent AHCA form 1823 (Resident Assessment), dated documents and . The assessment also documents that the resident requires assistance with ambulation (walker and at times wheelchair), bathing, dressing, toileting and transferring. There was no indication of a history of on this assessment. The resident was admitted to Hospice on and received hospice care during his entire residency at the facility.

The resident had the following recent history of at 11:10 a.m., at 8:30 p.m., at 11:00 p.m., at 2:00 p.m., at 10:30 p.m., at 7:00 a.m., at 11:00 p.m., at 7:00 p.m., at 1:00 p.m., at 10:30 p.m., at 12:28 p.m., at 6:15 a.m., at 8:00 p.m., at 9:15 a.m., at 6:30 p.m., at 9:30 p.m. as documented in the Resident Observation Log (ROL); a total of 16 during the 5 month period, 8 of which occurred between 6:30 p.m. and 11:00 p.m.

The following entries noted in the Resident Observation Log (ROL) in the medical record:
record reviewed. Resident is currently under ____ hospice care";
record reviewed. Resident has poor safety awareness";
record reviewed. Resident is currently under ____ hospice care";
record reviewed. Resident has poor safety awareness. Apartment checked. No environmental factors present";
record reviewed. Additional toileting added to service plan";
record reviewed. Poor safety awareness impulsive";
record reviewed. Resident has poor safety awareness";
review committee. (patient) of ____ hospice. Poor safety awareness. Resident's service plan includes safety checks and assistance with toileting.wheelchair";
review. of ____ hospice. Poor safety awareness";
review. Resident receives ____ hospice services. Poor safety awareness";
record review. Poor safety awareness. Resident patient of ____ hospice";
review done, resident has poor safety awareness and weakened condition, he is an ____ hospice

The ROL dated at 9:30 p.m. states "Resident observed lying on floor supine next to bed in . Resident must have while trying to get up out of bed and hit his head on either the bed or wheelchair. No signs of impact on either objects. Laceration on middle tope (parietal) head, greater than 4 inches in length horizontally. ____ hospice called first, nurse on phone said to send him to ER (Emergency . Resident was alert at the time of . Able to speak clearly, followed simple directions and complained of pain around laceration."

The ROL dated at 8 a.m. states "Per nurse '_____', resident admitted (to hospital) for Head Injury, and Frequent '

The ROL dated at 8:40 a.m. states "Spoke with '_____' at hospital, resident status quo. of ordered, awaiting approval from POA (power of attorney). Hospital was unaware resident is an ____ hospice

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The ROL dated at 1715 (5:15 p.m.) states record reviewed. Resident has no safety awareness. Is out to hospital. 5:30 p.m. Resident will be discharged to a skilled nursing facility. Social Worker at hospital is looking for an open medicare bed."

Review of the Service Plan effective for Resident #1, states the following interventions were in place as of:

Assist with AM Care. Assist with p.m. care. Escort resident to all meals. Resident must use walker at all times. Siderails up on bed. 12 a.m. Safety checks every two hours throughout the night, assist with toileting and report any changes to nursing station, you must sit him on the toilet a least three time during the night. Toileting 10:00 a.m., 2:00 p.m., 4:30 p.m. Be sure that his cushion is on the wheelchair."

Toileting 10:45 p.m. and 11:30 p.m."

Weekly weights and vital sign(s)."

The service plan toileting schedule cited every 2 hours during night (starting a 12:00 a.m.), 10:00 a.m., 2:00 p.m., 4:30 p.m., 10:45 p.m. and 11:30 p.m. The plan did not include toileting between 4:30 p.m. and 10:45 p.m., a period of 6 hours and 15 minutes.

5 occurred during that 6 hour time period between and (after "additional toileting" was added to the Service Plan). 4 out of these 5 resulted in injury. 1 resulting in a shoulder , 1 (occurring on had a ROL note dated stating "large lump on right upper arm the size of a golf ball;" 1 resulting in an open area and to left hand that required an x-ray to rule out ; and 1 resulting in a 4 inch laceration to the head which resulted in admission to a higher level of care/permanent discharge from the facility.

Upon interview at 3:45 p.m. on , the Administrator and Director of Nursing acknowledged that no prevention interventions were developed and implemented during the time period through except to toilet the resident at 10:45 p.m. and 11:30 p.m., which was implemented on the service plan on They also acknowledged that "poor safety awareness and hospice resident" do not represent a safety plan to prevent ; and, the toileting intervention was ineffective and not re-evaluated or revised.

The Administrator commented at this time that he did not report the experienced by Resident #1 on as an adverse incident because it could not have been prevented.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

14, 2014

Administrator
Terracina Grand
6825 Davis Blvd
Naples, FL 34104

Dear Administrator:

This letter reports the findings of a Complaint inspection survey conducted on 2014 through 2014, by a representative of the Agency for Health Care Administration (Agency).

Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **five business days** of receipt of this report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= G
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Directed Corrective Actions:

1. The facility, in consultation with medical and physical professionals, will develop Prevention policies and procedures to be implemented in the facility. These policies and procedures will be implemented no later than 2014.

2. The facility will evaluate all residents in the facility for risk and medication interactions. These evaluations will be completed by a Registered Nurse or the Resident's primary physician and will be completed no later than 2014.

3. The facility will develop an individualized plan to reduce the risk of falling for each resident identified as a risk. These plans will be developed by a Registered Nurse and will be completed no later than 2014. Each individualized plan to reduce the risk of falling for each resident who is a Hospice resident will be shared/coordinated with the resident's hospice provider.

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Fort Myers Field Office
2295 Victoria Avenue,
Fort Myers, FL 33901
Phone (239) 335-1315; Fax (239) 338-2372

4. All staff will be in-serviced on the facilities newly developed Prevention policies and procedures no later than 2014.

5. All staff will be in-serviced on each resident's plan to reduce the risk of by no later than 2014.

6. The facility administrative staff will monitor the implementation of the facility's Prevention policies and procedures, as well as monitor the implementation of each individual resident's plan to prevent This monitoring will take place on all shifts and will continue for at least 90 days.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call this office at 239-335-1315.

Sincerely,

Harold D. Williams
Field Office Manager