STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966870	11/05/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Fruitville Holdings - Oppidan, Inc	4038 Fruitville Road Sarasota, FL 34232	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
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= G
St - A - 0092 - 58a-5.020(1) Fac - Food Service - General Responsibilities S-S= D

Specific Tag Findings:
These are the results of an unannounced Biennial survey conducted on at Fruitville Holdings, an Assisted Living Facility (ALF) in Sarasota, Florida.

The following is a description of the non-compliance:

0011-Admissions - Discharge 58A-5.0181(5) FAC
Based on observation, record review, and interview the facility failed to ensure 1 (Resident #2) of 2 sampled residents met the criteria for continued residency for an Assisted Living Facility (ALF). Resident #2 was assessed as requiring total assistance with Activities of Daily Living (ADLs) and is totally dependent on staff for transfers.

The findings included:

During an observation on at 9:30 a.m., Resident #2 was observed sitting outside in his electric wheelchair smoking a cigarette. A blue jacket covered with numerous holes from cigarettes ashes was across the front of his chest. The resident said if there was one thing he could change about the facility, it would be having the "right" people take care of him. The resident said he is unable to transfer and it takes 2 staff people to lift him out of bed and place him into his whee'chair. He said one staff member picks him up under his arms and the other picks him up under his legs and they lift him out of bed and place him into his wheelchair. He stated, "I've been dropped three times in the past." The resident said he has been transferred this way "for a long time." As he was speaking, ashes accumulated at the end of his cigarette, dropping onto his jacket and down the side of his wheelchair. The resident's shoulder and upper arm did not move. The resident's elbow was fixed against his upper body. He used his elbow to bend his lower arm and bent his head toward his fingers in order to inhale the cigarette.

In an interview with Staff B during this observation, he said it takes two people to lift Resident #2 out of bed. He said the resident is a total lift and does not participate in the process at all. He said one staff member lifts him under his arms while the other lifts him under his legs and they both transfer the resident. Staff B stated the resident's right arm is paralyzed and he is unable to use his left arm while transferring.

In an interview with Staff A on at 10:15 a.m., he stated, "We use one person to lift (Resident #2) under his arms and then the other person is at the legs and (Resident #2) doesn't hold onto us. He has no strength to hold onto us. He is a full lift. I've been lifting him like this for about 2 weeks now? I just came to this building to work and that's how we lift him."

Record review on documents Resident #2 was admitted to the facility on with diagnoses of and limited use of the left arm.

Review of the health assessment dated shows Resident #2 required total help with ambulation, bathing, and dressing and assistance with toileting, , and transferring.

Review of the current health assessment, dated , shows Resident #2 requires assistance with ambulation, bathing, dressing, toileting, and transferring. The assessment documents the resident is a 2 person

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assist pivot transfer. The assessment also documents the resident requires total care with ADLs.

In an interview on at 4:00 p.m., the Administrator and House Director admitted they were unaware Resident #2 was totally dependent on staff for transfers. Both said the resident was wearing multipodus boots on his feet which would help with the two person pivot transfer. They stated they did know there was an issue with the boots and had asked a physical to come and evaluate Resident #2 who recommended a slide board transfer. They had not trained their staff to use the slide board.

In an interview on at 4:10 p.m., Resident #2 verified a had evaluated him. He stated he would not and could not hold onto the slide board to assist with transfers.

Class III

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observation, record review, and interviews the facility failed to adequately supervise 1 (Resident #2) of 2 sampled residents for safe smoking. This failure contributed to Resident #2 repeatedly himself from hot ashes while smoking, causing and scabs to his fingers.

The findings included:

During an observation on at 9:30 a.m., Resident #2 was observed sitting outside in his electric wheelchair smoking a cigarette. A blue jacket covered with numerous holes from cigarettes ashes was across the front of his chest. Small scabbed areas were observed on the inside of his left and middle fingers. As he was speaking, ashes accumulated at the end of his cigarette, dropping onto his jacket and down the side of his wheelchair. The resident's shoulder and upper arm did not move. The resident's elbow was fixed alongside of his upper body. He used his elbow to bend his lower arm and bent his head toward his fingers in order to inhale the cigarette. Staff C, who is a licensed practical nurse, walked up to the resident, wiped ashes off of the front of the jacket, informed the resident he was going to the doctor, and walked back into the building.

Record review on documented Resident #2 was admitted to the facility on with diagnoses of and limited use of the left arm.

Review of the current health assessment, dated shows Resident #2 required assistance with ambulation, bathing, dressing, toileting, and transferring. The assessment documented the resident was a 2 person assist pivot transfer. The assessment also documents the resident required total care with Activities of Daily Living (ADL).

Record review on documented a "Monthly Client Service Plan/Assessment Report" completed by the Administrator (ADM) for the date of Documentation included: "There was one reported injury during this reporting period. On it was noted that (Resident #2) had a on his right thumb and a scabbed area on his left little finger. (Resident #2) stated that when he was smoking, the hot off his cigarette off onto his fingers. This has since resolved."

An incident report dated at 4:30 p.m., documented an intact to Resident #2's right thumb, measuring 1 cm x ½ cm. A pencil size scabbed area is documented to the left hand. Documentation included "Client has 2 on his left hand on the thumb and pointer finger state cigarette Staff found at 4:45 while client was smoking out back."

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There was no documentation to support any staff intervention after cigarette to the resident's fingers were observed. There was no documentation to support the physician was notified.

A second incident report completed at 10:20 p.m. documented, "While putting client in noticed left hand above thumb area. Also on right should looks just like a Client state that they been there awhile." Documentation includes, above the right thumb, 1 cm x 1 cm scab with pink at area right thumb, above. No discharge noted."

There was no documentation to support staff intervention to ensure Resident #2 was safe to smoke. There was no documentation to support the physician was notified.

During an interview on at 1:39 p.m., Staff C stated, "Staff don't have to sit outside with the resident." She stated, "There's not too much I can do except ask him to be careful. Smoking is all he's got." There was no documentation to support staff were monitoring the affected areas. Staff D said she usually doesn't notify the physician about the "Only if there is an The doctor would have my butt in the sling if I called him."

In an interview on at 4:00 p.m., the Administrator and House Director were unaware Resident #2's fingers were currently scabbed from by cigarettes. The Administrator admitted they had not considered any interventions to assist Resident #2 to safely smoke. She stated, "What are we supposed to do? He's not going to quit smoking."

Class II

0092-Food Service - General Responsibilities 58A-5.020(1) FAC
Based on observation, record review and interview, the facility failed to provide food services within the facility; failed to have a separate approved menu by a Registered Dietitian (RD); failed to ensure the food designee was current with food service training; and failed to ensure 1 (Resident #1) of 2 sampled residents was provided the choice of eating at the facility or facility of his choice.

The findings included:

During an interview on at 9:01 a.m. with Resident #1, he said he eats his meals in the facility "Next door." He said he does not eat where he lives, he is to go over to the other facility for his meals. He was not aware of the daily menu. He was not aware he had a choice of eating his meals where he currently resided.

In an interview on at 9:32 a.m., Resident #2 said he doesn't go over to the other facility to eat. He said staff takes him out grocery shopping where he buys his meals and they cook it for him when he gets back.

During the tour of the facility on at 9:00 a.m., no menu was posted. No in-house menu was available.

Review of the admission contracts for Residents #1 and #2 confirmed the facility is to provide regular diets to both residents.

An interview was conducted with the Administrator (ADM) and House Director (HD) on at 2:00 p.m. The HD said Resident #1 eats over at their sister facility which is next door and confirmed it holds a separate licensed. She said they could cook it over at the other facility and bring it over to this one. She said there are no meals contracted or brought over to Fruitville Holdings. She stated there is a menu approved by the RD, however, it is

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shared by both facilities and the menu is posted as well as available over at the other facility. The Administrator said the House Director is the person responsible for food service.

Personnel record review on . . . . of the House Director's file failed to contain evidence of 2 hours of continuing education annually for the period of

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Fruitville Holdings - Oppidan, Inc
4038 Fruitville Road
Sarasota, FL 34232

Dear Administrator:

This letter reports the findings of a biennial re-licensure inspection survey conducted on , 2014, a by 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).

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

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Directed Corrective Actions:

1. The Assisted Living Facility is required to assess Resident #2 for smoking safety. This assessment is to be completed no later than . 2014.

2. The Assisted Living Facility is required to provide Resident #2 with appropriate safety equipment for smoking (such as cigarette holder to minimize | of fingers; smoking apron to minimize | from cigarette ashes; etc.) based on needs to ensure Resident #2 is safe while smoking. Appropriate safety equipment for smoking is to be provided by no later than , 2014.

3. The Assisted Living Facility is required to train all staff on use of smoking safety equipment. This training to be completed by no later than , 2014.

4. The Assisted Living Facility is required to assign staff to monitor Resident #2 for safe smoking and maintain documentation of assignments.

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Fruitville Holdings - Oppidan, Inc
, 2014

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,

Jon Seehawer, R.N.
Acting Field Office Manager

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