STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966171	02/03/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Barrington Terrace Of Naples	5175 Tamiami Trail East Naples, FL 34113	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0010 - 429.26(1&9) Fs; 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0025 - 429.26(7) Fs; 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0031 - 58a-5.0182(7) Fac - Resident Care - Third Party Services S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0092 - 58a-5.020(1) Fac - Food Service - General Responsibilities S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D

Specific Tag Findings:
A Change of Ownership with Extended Congregate Care survey was conducted on to for Barrington Terrace of Naples, and assisted living facility in Naples, Florida.

The following deficiencies were identified during the visit.

0010-Admissions - Continued Residency 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review, observation, and interview, the facility failed to ensure timely discharge for 1 (Resident #1) resident who did not meet the criteria for continued residency.

The findings included:

Upon interview on at 9:45 a.m., the Resident Care Director said Resident #1 was receiving care from a home healthcare agency. When asked what type of it was, the Resident Care Director said she did not know.

Review of the medical record revealed a Nursing Progress Note, dated at 4:00 p.m., stating, "Resident has an open area noted to left inner ankle. This nurse notified Dr. [name]. Received t.o. [telephone order] for Home Health to provide care -- area has no s/s [signs/symptoms] of noted at this time. First aid applied."

A Physician Progress Note, dated , states, "Seen for a follow-up visit. He has developed a on his left ankle. He is having more of the lower extremities. Assessment: Open of ankle without complication. Check x-ray of the ankle to rule out . Consult home health for care."

A Home Health Nursing Addendum Note, dated , states, measurements left inner ankle 1.2 cm [centimeters] length, 1.0 cm width, 0.2 cm depth."

Upon interview on at 3:00 p.m., the Resident Care Director, a licensed practical nurse, and the Executive Director (Registered Nurse/ECC Administrator) said the home health care agency nurse came into the facility twice a week and they acknowledged there were no measurements of this , in the facility records, from until . In addition, they acknowledged the cause of the was not identified and the measurements, recorded on , had not changed since .

The surveyor contacted the Home Health Agency Nurse on at 3:30 p.m., via telephone. The nurse said Resident #1 "has an unstageable on his left ankle, which was originally identified as a . The nurse said she would fax the care records to the facility, including the physician orders for treatment.

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

The home health care agency faxed records were received/reviewed on and included the following:
(1) A home health assessment, dated with physician signature of , states, "Assessment of patient with ankle, , unstageable."
(2) Graph documentation demonstrates the left ankle measurements increased from 1 cm x 1 cm x 0.2 on to 1.2 cm x 1.0 cm x 0.2 cm on

The Home Health Nurse was interviewed in the facility on at 11:15 a.m. The Executive Director and Resident Care Director were present at this time. The nurse said the resident's physician was aware Resident #1 had an unstageable on his ankle because the physician signed the orders identifying the as a

Observation of the resident's left ankle was done on at 12:45 p.m., with the Home Health Care Nurse and the Executive Director present. The was located on the inner aspect of the resident's left ankle. It presented as the size of a quarter, with 75% black eschar in the center surrounded by 25% yellow tissue on the outer irregular edges. The was surrounded by approximately 2 inches of reddened tissue and emitted an odor.

The Executive Director acknowledged, at this time, the resident's unstageable did not meet the criteria for continued stay in an assisted living facility.

Class III

0025-Resident Care - Supervision 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review, observation, and interview, the facility failed to be aware of a change in the physical condition of 2 (Residents #1 and #8) of 16 sampled residents.

The findings included:

1. Upon interview on at 9:45 a.m., the Resident Care Director, a licensed practical nurse, said Resident #1 was receiving care from a Home Health Agency. When asked what type of it was, the Resident Care Director said she did not know. Resident #1 was admitted on with diagnosis including , , and

Review of the medical record revealed a Nursing Progress Note, dated at 4:00 p.m., stating "Resident has an open area noted to left inner ankle. This nurse notified Dr. [name]. Received t.o. [telephone order] for Home Health to provide care -- area has no s/s [signs/symptoms] of noted at this time. First aid applied."

A Home Health Nursing Addendum Note, dated , states, measurements left inner ankle 1.2 cm [centimeters] length, 1.0 cm width, 0.2 cm depth."

Upon interview on at 3:00 p.m., the Resident Care Director and the Executive Director (Registered Nurse/ECC Supervisor) said the home health care agency nurse came into the facility twice a week and they

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acknowledged there were no measurements of this l in the facility records, from until In addition, they acknowledged the cause of the l was not identified and the measurements, recorded on , had not changed since

The surveyor contacted the Home Health Agency Nurse via telephone on at 3:30 p.m. The nurse said Resident #1 "has an unstageable on his left ankle, which was originally identified as a l . The nurse said she would fax the l care records to the facility, including the physician orders for treatment.

The home health care agency faxed records were received/reviewed on and revealed the following:
(1) A Home Health assessment, dated with physician signature of states, "Assessment of patient with , ankle, , unstageable."
(2) Physician orders dated state, "SN [skilled nurse] to cleanse left inner ankle twice weekly per clean techniques with NS [normal , apply medihoney to l bed cover with gauze and secure with tape.
(3) A physician order, dated , states SN to perform l care to left inner ankle unstageable , as follows: Cleanse l with NS, apply AG [silver] foam to l bed, cover with gauze, wrap with gauze and secure with tape twice weekly until healed."
(4) l Graph documentation demonstrates the left ankle l measurements increased from 1 cm x 1 cm x 0.2 on to 1.2 cm x 1.0 cm x 0.2 cm on

The Home Health Agency Nurse was interviewed in the facility on at 11:15 a.m. The Executive Director and Resident Care Director were present at this time. The nurse said the resident's physician was aware Resident #1 had an unstageable on his ankle because the physician signed the orders identifying the l as a .

Observation of the resident's left ankle l was done on at 12:45 p.m., with the Home Health Nurse and the Executive Director present. The l was located on the inner aspect of the resident's left ankle. It presented as the size of a quarter, with 75% black eschar in the center surrounded by 25% yellow l tissue on the outer irregular edges. The l was surrounded by approximately 2 inches of reddened l tissue and emitted an odor.

The Executive Director acknowledged, at this time, that the resident's unstageable did not meet the criteria for continued stay in an Assisted Living Facility.

2. Resident #8 was observed eating lunch, on at 12:15 p.m., in the 200 hall unit dining . Her left hand had a 4 x 4 bandage that was grossly soiled with a black substance and only partially covering a l on the top of her hand. Upon closer observation, the l was noted to encompass the entire area between her knuckles and wrist. The l was open adjacent to the knuckles, displaying dried l and a torn steri-strip bandage. There were approximately 8 intact steri-strips observed on the rest of the . Resident #8 was visible to the unit charge nurse, at this time, when she introduced the resident to the surveyor. Other nursing staff were interacting with the resident serving her a beverage, main entree and dessert; but no one questioned why the bandage was not dry and intact.

Upon interview at this time, Resident #8 stated, "It has been itching me [referring to the , so I had to take care of it." The Resident Care Director and the unit charge nurse were immediately notified. The Resident Care Director cleaned and bandaged the l and said she would have to investigate how the injury occurred and who applied the steri-strips.

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On at 11:00 a.m., the Resident Care Director said interview of nursing staff did not reveal how Resident #8's injury occurred or who applied the steri-strips. She also said the Staff admit to seeing a bandage but there was no documentation in the medical record regarding how or when the injury and treatment occurred.

At 2:30 p.m., on the Executive Director and Resident Care Director acknowledged Resident #8's care was not appropriately supervised and her hand injury was not reported to the physician for treatment and responsible party was not notified. They also acknowledged the resident's hand , as observed by the surveyor, was at high risk for due to contaminated dressings (steri-strips and 4 x 4 dressing) and an open area with dried

Class III

0031-Resident Care - Third Party Services 58A-5.0182(7) FAC

Based on record review, observation, and interview, the facility failed to coordinate services with the third party provider for one (Resident #1) of 16 sampled residents.

The findings included:

The facility "Third Party Providers - Florida" policy dated states: In instances where Residents require services from a third party provider, the Resident Care Director will take action to assist in facilitating the provision of those services and coordinate with the provider to meet the specific service goals, unless Residents or their representatives decline the assistance.

Resident #1 was admitted on with diagnosis including and Upon interview on at 9:45 a.m., the Resident Care Director (RCD), a licensed practical nurse, said Resident #1 was receiving care from a home health agency. When asked what type of it was, the RCD said she did not know.

Review of the record revealed a Nursing Progress Note, dated at 4:00 p.m., stating, "Resident has an open area noted to left inner ankle. This nurse notified Dr. [name]. Received t.o. [telephone order] for Home Health to provide care -- area has no s/s [signs/symptoms] of noted at this time. First aid applied."

A Home Health Care Nursing Addendum Note, dated stated measurements left inner ankle 1.2 cm [centimeter] length, 1.0 cm width, 0.2 cm depth."

Upon interview on at 3:00 p.m., the RCD and the Executive Director (Registered Nurse/ECC Administrator) said the home health care agency nurse came into the facility twice a week. They acknowledged there were no measurements of this in the facility records from until They acknowledged the cause of the was not identified and the measurements recorded on had not changed since

The surveyor contacted the Home Health Agency Nurse via telephone on at 3:30 p.m. The nurse said Resident #1 "has an unstageable on his left ankle, which was originally identified as a The nurse said she would fax the care records to the facility, including the physician orders for treatment.

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The home health care agency faxed records were received/reviewed on ... and revealed the following:
(1) A home health assessment, dated ..., with physician signature on , stated "Assessment of patient with ... heat failure], , ankle, , unstageable."
(2) Physician orders dated , stated "SN [skilled nurse] to cleanse left inner ankle twice weekly per clean techniques with NS [normal apply medihoney to ... bed cover with gauze and secure with tape.
(3) A physician order, dated , stated SN to perform ... care to left inner ankle unstageable ... as follows: Cleanse ... with NS, apply AG [silver] foam to ... bed, cover with gauze, wrap with gauze and secure with tape twice weekly until healed."
(4) ... Graph documentation demonstrated the left ankle ... measurements increased from 1 cm x 1 cm x 0.2 on ... to 1.2 cm x 1.0 cm x 0.2 cm on ...

The Home Health Agency Nurse was interviewed in the facility on ... at 11:15 a.m. The Executive Director and RCD were present at this time. The nurse said the resident's physician was aware Resident #1 had an unstageable on his ankle because the physician signed the orders identifying the ... as a . The nurse, the Executive Director, and Resident Care Director could not explain why documentation of the status of this , was not a part of the resident's record in the facility.
The RCD said she thought she saw Resident #1's ankle ... when it was discovered in 2014, but did not know it was a She stated, "I would not know what I was looking at to make that determination."
The Executive Director said she had not observed the ankle ... and was not aware it was a .

Resident #1's left ankle was observed on ... at 12:45 p.m. with the Home Health Agency Nurse and the Executive Director present. The was located on the inner aspect of the resident's left ankle. It presented as the size of a quarter, with 75% black eschar in the center surrounded by 25% yellow tissue on the outer irregular edges. The was surrounded by approximately 2 inches of reddened tissue and emitted an odor. The ... was measured by the Home Health Care Nurse as 2.3 cm length x 2.2 cm width. The nurse had no explanation why Home Health Care records, written by her on dated , measured the as "1.2 x 1.0 x 0.2 cm." The Executive Director acknowledged, at this time, the resident's unstageable did not meet the criteria for continued stay in an assisted living facility.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC

Based on observation and interview, the facility failed to ensure that a medication , located in the 400 hall, is kept locked when not in attendance of licensed nursing staff.

The findings included:

At 9:30 a.m. on , the 400 hall medication ... observed unattended and unlocked. A resident was observed sitting in the medication ... this time.

Upon interview at 9:35 a.m., Licensed Practical Nurse Staff E acknowledged the ... left unlocked and unattended, with the door open. The nurse said there were medications in unlocked cabinets in the .... She also said she was aware the medication ... not be left unlocked when nursing staff were not in attendance.

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0056-Medication - Labeling and Orders 58A-5.0185(7) FAC

Based on record review, observation, and interview, the facility failed to ensure a medication prescription was filled in a timely manner for 1 (Resident #9) of 4 sampled residents observed for assistance with self-administration of medications and administration of medications. The resident received twice as much of the medication as was ordered.

The findings included:

Resident #9 was observed on at 8:55 a.m. during a medication pass. The resident was observed to receive 25 milligrams (mg) 1 tab by mouth. The label on the medication read 25 mg 1 tab by mouth 2 times a day. is a medication which lowers rate and

Review of the Medication Administration Record (MAR) revealed documentation that 25 mg 1 tab by mouth two times a day was discontinued at 5:00 p.m. 12.5 mg 1 tab by mouth two times a day was started at 5:00 p.m. at

Review of the medical record revealed physician orders dated that state, "decrease to 12.5 mg po [by mouth] [2 times a day]."

Upon interview at 9:05 a.m., Staff A, the nurse who provided assistance with self-administration of the 25 mg tablet, to Resident #9, stated, "There is an X on the label, that means the order is changed." When asked why she gave the medication if she knew the order was changed, the nurse acknowledged she did not compare the label on the medication with the MAR. The Resident Care Director, who was present at this time, said the pharmacy did not send the medication (ordered by the physician on

Further review of the MAR revealed the resident received 25 mg of , twice a day, 33 times in 2015 and 5 times in 2015.

Class III

0092-Food Service - General Responsibilities 58A-5.020(1) FAC
Based on observation the person in charge of food service failed to ensure staff practiced proper hygiene while assisting residents in the dining

The findings included:

On at 12:00 p.m., the meal service was observed in the dining the 200 hall. A Resident Aide was observed entering the dining sitting down next to Resident #16. The was observed to put the index finger of her right hand in her right ear appearing to remove some matter. The then was observed to run the fingers of her right hand through the resident's hair. The then picked up a spoon and attempted to feed the resident. The stated, "She's sleeping" and got up from the table and left the dining

The failed to wash her hands before, during, or after attempting to feed the resident. Her hands were considered to be contaminated after placing her finger in her ear and running her fingers through the resident's hair. Hand washing facilities and supplies were observed to be readily available in the dining

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0093-Food Service - Dietary Standards 58A-5.020(2) FAC

Based on record review, observation and interview, the facility failed to follow the menu, as approved by a dietician, for 29 out of 29 residents on the Memory Care Unit and failed to record substitutions made to the posted menu.

The findings included:

The luncheon meal was observed, on [redacted] at 11:30 a.m., on the 200 hall unit (Memory Care). The unit charge nurse was asked the location of the meal menu. She stated, "We do not have one here, they are mailed to the resident's family."

Observation of meal delivery revealed the same entree was served to all the residents. Residents were not asked what they wanted to eat prior to being served the entree (chili over rice with green beans) or if they wanted something else to eat if they were not eating the entree. Orange sherbet was served for dessert.

The Food Service Director (FSD) and Executive Director were interviewed on [redacted] at 1:30 p.m., and were told that a menu was not posted on the Memory Care Unit. The FSD stated it was on the wall but needed to be posted on the door of the dining [redacted] the time of meals.

The FSD was asked why all resident's got the same meal. He said that only one meal was served on the Memory Care Unit. it was chili over rice. He said that if they don't eat it, the alternate is given or something else is provided and "the staff know what they like." The FSD was advised, that when asked, the memory care staff did not know what the alternate was and did not offer it to any resident that was not eating. The only thing offered was orange sherbet.

The [redacted] (Monday) menu was reviewed with the FSD who said only the yellow highlighted items were served to residents on the Memory Care Unit and that is why they all received chili over rice and green beans. He continued to state that they are offered the alternate if they do not eat the entrée served. He stated the staff has to call and have the alternate sent from the kitchen.

When asked why there was no salad served on the Memory Care Unit, as listed on the menu prepared by the dietician; the FSD said "It would be too difficult for the residents to chew." When asked why corn bread and orange sherbet was served, instead of "crisp garlic toast" and "cherry pie" as listed on the menu; the FSD said "the garlic bread was served by mistake yesterday and sherbet/ice cream is always served on Monday at lunch instead of the listed dessert. He continued to say the cherry pie would be served at the evening meal along with the listed dessert of "rice pudding," because "that is the way the unit staff want to do it."

During the luncheon meal, 5 residents were observed not to eat any part of their entree, and staff did not provide them with the alternate. Staff were observed to ask "do you want anything else to eat" without providing any information as to what may be available other than chili.

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The Administrator and FSD acknowledged that the dietician's menu items of tossed salad and cherry pie were not followed. They also acknowledged corn bread was substituted for garlic bread and not recorded on the substitution log. They acknowledged the quality and quantity of the food served to residents on the Memory Care Unit was not being appropriately monitored.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Barrington Terrace Of Naples
5175 Tamiami Trail East
Naples, FL 34113

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2 through 3, 2015 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 **03/23/2015** 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,

Jon Seehawer, RN
Field Office Manager

JS
Enclosure: State Form

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