STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967791	R
NAME OF PROVIDER OR SUPPLIER **A BANYAN RESIDENCE**	STREET ADDRESS, CITY, STATE, ZIP CODE **100 BASE AVE EAST** **VENICE, FL 34285**	

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

0000 Initial Comments

An unannounced follow-up to the Relicensure and Complaint Survey, CCR #2015009149 and CCR #2015008662 was conducted on at A Banyan Residence, an Assisted Living Facility in Venice, Florida.

The following is description of the deficiencies found at the time of the visit.

0030 Resident Care - Rights & Facility Procedures

Based on observation and interview, the facility failed to maintain a clean environment for residents.

The findings included:

A tour of the facility on at 10:30 a.m. revealed the following:

- heavily stained towel noted hanging in . Black scuffs marks noted along walls. Large black stain noted above kitchen cabinet. Black stains noted on . Paint missing along corner of wall.

- Black stains noted on shower floor.

- Shower floor noted to have open area along threshold with black stains noted on floor.

- Paint peeling behind .

Activity vent covered with large amount of gray substance with black stains surrounding it.

Medication Cart A - Right bottom drawer had white residue on bottom. Left bottom drawer containing medication bottles observed pieces of popcorn noted on bottom. box covered with gray substance. Surface of medication cart had large amount of light brown stains.

Medication Cart B - Stained towel noted on surface of cart containing a full water pitcher.

Medication Cart C - Plastic pill crusher had white substance inside, and black stains noted along rim. Adhesive cloth cover over pill crusher had black stains. Drawer inside cart had debris on bottom. Observed black stained labels on bottles of Ensure and 1 bottle of .

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During an interview with the Administrator on / at 2:15 p.m., she reported she will take care of these issues.

Class III

0054 Medication - Records

Based on observation, record review and interview, the facility failed to document missed dosed of medication and reason for 1 (Resident # 12) of 3 Residents sampled.

The findings included:

1. Record review of Medication Observation Record (MOR) for Resident #12 revealed the following medication prescribed by the Heath Care Provider: " D3 2000 IU, take 1 capsule every day." This medication was documented by staff as not given and no reason given on dates, / / through except date / .

The medication prescribed by Health Care Provider: "Gemfibrizol (medication) 600 mg tab, 1 tablet twice daily." This medication scheduled for 8:00 a.m. and 8:00 p.m., was charted by facility staff as not given on dates, / through , and no reason given on dates, / , , at 8:00 a.m., at 8:00 a.m. and at 8:00 a.m.

The medication prescribed by Health Care Provider, "Pravstatin (medication) 40 mg tablet, give 1 tablet by mouth every night at bedtime." This medication was charted by facility staff as not given and no reason documented on dates / and .

During an interview with the Administrator on / at 3:00 p.m., she reported she was not aware medications were not documented correctly.

Class III

0055 Medication - Storage and Disposal

Based on observation, record review and interview, the facility failed to dispose of expired medication within 30 days for 1 (Resident #12) out of 3 Residents sampled.

The findings included:

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NAME OF PROVIDER OR SUPPLIER **A BANYAN RESIDENCE**	STREET ADDRESS, CITY, STATE, ZIP CODE **100 BASE AVE EAST VENICE, FL 34285**	

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

Medication found in the medication cart for Resident #12, the label on medication bottle stated "All Day Pain Relief (medication) take 1 tablet by mouth as needed for pain." The expiration date on bottle was . Record review of resident's Medication Observation Record for dates / through / revealed resident was not currently prescribed this medication.

During an interview with Administrator on at 2:00 p.m., she reported she was not aware medication had expired.

Class III

0056 Medication - Labeling and Orders

Based on observation, record review and interview, the facility failed to have medications filled in a timely manner for 1 (Resident #12) of 3 residents sampled.

The findings included:

Record review of Resident #12's Medication Observation Record dated / / through / / medication revealed medications prescribed by Health Care Provider.

The medication prescribed by Health Care Provider, "Gemfibrizol ( ) (medication) 600 mg tab, 1 tablet twice daily" scheduled 8:00 a.m. and 8:00 p.m. This medication was documented by facility staff as not given on dates / through and reason documented by staff "not on cart" on dates 8:00 p.m., and 8:00 p.m.

The medication prescribed by Health Care Provider, "Pravstatin (medication) 40 mg tablet by mouth every night at bedtime" was documented by facility staff as not given on dates / through and reason documented "not on cart" for dates , , and .

The medication prescribed by Health Care Provider " D3 2000 IU, Take 1 capsule every day." Medication documented by facility staff as not given on date and reason documented by staff "not on cart."

During an interview with Administrator on at 5:00 p.m., she reported she would speak to Resident #12's Heath Care Provider. She reported Resident #12's son had called the facility's current pharmacy to change his mother's medications to CVS pharmacy. The surveyor observed Resident #12's current medications arrival at facility at 5:00 p.m. on 12/7 /15 from CVS pharmacy. The Administrator reported the current facility pharmacy did not report to her the son's wishes.

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

Class III

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11967791	A. Building B. Wing	12/8/2015

Name of Facility	Street Address, City, State, Zip Code
A BANYAN RESIDENCE	100 BASE AVE EAST VENICE, FL 34285

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix A0025 Reg. # 429.26(7) FS; 58A-5.0182(1 LSC		ID Prefix A0078 Reg. # 58A-5.019(2) FAC LSC		ID Prefix A0081 Reg. # 58A-5.0191(2) FAC LSC	
ID Prefix A0082 Reg. # 58A-5.0191(3) FAC LSC		ID Prefix A0089 Reg. # 429.178 FS LSC		ID Prefix AZ816 Reg. # 408.809(2)(a-c) FS LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By**	**Date:** 12-22-15	**Signature of Surveyor:** CLAIRE MC GILLIVRAY, RN	**Date:** 12-22-15	
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**	

Followup to Survey Completed on:

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

_ _ _ _ _ _ _ _ _ _, 2015

Administrator
A Banyan Residence
100 Base Ave East
Venice, FL 34285

Dear Administrator:

This letter reports the findings of a State Licensure Revisit Survey conducted on 7, 2015 by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

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 surveyor. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form and Revisit Report

YOSF

Fort Myers Field Office
2295 Victoria Avenue, Room 340
Fort Myers, FL 33901
Phone:(239) 335-1315: Fax:(239) 338-2372
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