STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968916	04/28/2016
NAME OF PROVIDER OR SUPPLIER **BAYSHORE MEMORY CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1260 CREEKSIDE BLVD E** **NAPLES, FL 34109**	

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

0000 Initial Comments

An unannounced complaint survey for CCR #2016002102, CCR #2016002130, CCR #2016002583 and CCR #2016003986 was conducted on at Bayshore Memory Care, an Assisted Living Facility in Naples, Florida.

Complaint CCR #2016002102 contained 5 allegations, of which 1 was unsubstantiated and 4 were substantiated with deficiencies.

Complaint CCR #2016002130 contained 1 allegation, of which 1 was substantiated with a deficiency.

Complaint CCR #2016002583 contained 3 allegations, of which 3 were unsubstantiated.

Complaint CCR #2016003986 contained 1 allegation, of which 1 was unsubstantiated.

The following is a description of the deficiencies.

0007 Admissions - Criteria

Based on record review and interview, the facility failed to ensure 1 (Resident #7) of 3 residents met criteria for admission to an Assisted Living Facility.

The findings include:

1. Resident #7 was admitted on . . . . The state form 1823 Health Assessment documents the resident had an unstageable to the sacral area.

2. On . . . . at 12:26 p.m. the Executive Director said Resident #7 did not have any to her knowledge.

3. On . . . at 12:28 p.m. the Director of Nursing said Resident #7 had a , . . . upon admission, but it was healed when she was discharged.

Class III

0025 Resident Care - Supervision

Based on observation, record review and interview the facility failed to provide care and services to meet

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the needs of 3 (Residents #4, #5 and #6) out of 3 residents sampled.

The findings include:

1. Record review of Residents #4, #5 and #6 Health assessments (1823) revealed a weight loss for each resident not reported to their Health Care Provider.

2. Resident #6 health assessment dated / / revealed an initial weight of 181 pounds documented on date / /. Next weight documented was / / at 156 pounds. On weight was documented at 162 pounds.

Resident #4 health assessment dated / / revealed an initial weight of 150 pounds. On / / weight was documented by facility staff at 124 pounds. On weight was documented by facility staff at 122 pounds. On / / weight was documented by facility staff at 118 pounds.

Resident #5 health assessment dated revealed an initial weight of 124 pounds. On / / weight documented by facility staff at 123.5 pounds. On weight documented by facility staff was 118 pounds. On weight was documented by facility staff at 114.4 pounds.

Director of Memory Care reported on at 3:00 p.m., the initial weights for Residents #6 and #4 must have been an error. She exported she was not aware of the Resident's weight loss.

Class III

0028 Resident Care - Activities of Daily Living

Based on observation, record review and interview, the facility failed to offer supervision and or assistance of Activities of Daily Living (ADLs) for 3 (Residents #4, #5 and #6) out of 3 Residents sampled.

The findings include:

1. Record review of written and computerized documentation of ADLs being done by facility staff for Residents #4, #5 and #6 were incomplete for months of and , , 2016.

2. Executive Director reported on at 5:48 p.m., for computer charting of Resident ADLs if there is a hand symbol with an asterisk, it means an omission.

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3. Resident #5 was observed walking in the facility hallways at 10:00 a.m. and 2:00 p.m. unassisted by facility staff. Record review of Resident's Health assessment (1823) dated revealed resident required supervision of ambulation.

4. During observation of breakfast on at 9:45 a.m., there were 16 residents seating in the dining breakfast. Most of the residents were seated at the table and looking in to space, with blank stares on their face. Staff was present, but the residents were not being assist or cued by staff to eat. The only residents were being assisted were residents that had private duty aides. They included Resident #16 and Resident #8.

5. Interview with Resident #16 wife on at 5:30 p.m., revealed resident are not assisted with meals, that is why I have to be here all day long to ensure my husband gets the care and services he needs. I also employee a private duty added so he gets the Assistance for daily living that he needs. She went on to say, I don't the they facility has enough staff especially at meals and they do not assist the resident. She also said she has observed that staff do not respond to the resident, or understand this resident have memory issues, she added I think staff needs more training on how to work and respond to residents with . To ensure my husband safety I had to hire a private duty, so he gets the care and services he needs.

Class III

0030 Resident Care - Rights & Facility Procedures

Based on observation, interview and record review, the facility failed to serve food in a sanitary manner. This deficient practice can cause cross contamination of harmful micrograms and has the potential of causing food borne illness to residents receiving an oral diet. The facility failed to respond to resident (#8) family complaints.

The findings include:

During observation on at 12:15 a.m., the following observations revealed staff were handling food in an unsanitary manner.

1. Observed Staff I with thumbs on rim of placing thumb inside soup bowl and then serving the bowl to a resident. She then proceeded to return to the pantry, take a sip of soda out of a bottle, and return to the dining continues to serve resident lunch without washing hands.

2. Staff J observed moving furniture around in the dining , Staff J then repositioned Resident #12,

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adjusted foot support and proceeded to serve Resident #13 her lunch, but failed to wash hands between her actions. Staff J was than observed messaging Resident #11 shoulders, then assisting to feed another Resident #15, was never observed washing her hands. Staff J also was assisting to feed Resident #11 and 15 at the same time, and used her right hand to feed both residents.

3. Staff G observed with her thumb on rim of residents plates before serving to the residents.
A meeting was held with the Certified Dietary Manager (CDM) on the same day at 3:40 p.m. CDM confirmed the staff should not be handling food in this manner, said staff had been trained in the proper way of handling food. CDM provided the Approved policy for Hand Washing, which documents the following;

4. Interview with Resident #8's husband on / at 6:30 p.m., revealed the following. My wife has been a resident since they opened in . I visit my wife 2 times a day. When I came into visit her, she was always wet and soiled, to include her clothing and bedding. Almost every day, I had to change and wash my wife, because they never changed her diaper. The staff also never toileted my wife, they just let her stay in her soiled wet diaper in clothes. Many days her bedding was soiled and wet. Often what staff would do is put a clean sheet over her dirty/soiled bedding rather than fully changing the sheets. I let administration know, but nothing was ever done. I also spoke to staff about my concerns, and they said that many times my wife would refuse care, that is why she was not changed. I also had to come in a feed my wife, because I found that staff was not feeding her. I finally had to hire private duty for my wife for seven days a week for 24 hours to ensure she gets the care and services she needs.

"To ensure that culinary personnel wash their hands following action that is a potential for the spread of to food, to residents/visitors, and other employees. Such action includes but not limited to: Coming on duty, Use of , toughing face, hair, working with soiled dishes, and assisting other residents."

0093 Food Service - Dietary Standards

Based on observation, interview and record review, the facility failed to ensure the facility's menus were posted appropriately. The facility also failed to ensure the quality of food was at its highest standard. This was evidenced by interview with several family members and a test tray to determine the quality of the food.

The findings include:

1. Observed dining on at 12:00 p.m. The resident received Home-style meat loaf, Mashed

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Potatoes and Scalloped corn for lunch. Review of the posted menu documented the resident were to receive barbeque chicken potatoes and a vegetable. The Certified Dietary Manager was made aware the food the resident received was not the same as what was posted. CDM said the posted menu, is not the most recent, she added the menu we are using is the one the Registered Dietitian (RD) gave me to use. CDM said she did not even realize the wrong menu was posted.

2. On a test tray was requested 12:30 p.m. The following is a result of the food being tested:

Mashed potatoes and scalloped corn were bland to taste; Vegetable soup was also very bland. The food was warm to the taste. Orange juice was , and did not taste like Orange Juice.

3. During an interview with Resident #14 son on / at 11:00 a.m. He said the food is not of high quality and does not taste very good.

Interview with Resident on the same date at 5:00 p.m. wife said "Bad care bad food."

Interview with Resident #16 wife on the same day at 5:30 p.m. said the quality of the food is not of the highest standards, but the CDM tries.

Interview with the Husband of Resident #8 on the same day at 6:15 p.m. Said taste and quality of food are not the best.

0152 Physical Plant - Safe Living Environ/Other

Based on observation, interview and record review, the facility failed to ensure the kitchen equipment was maintaining in a sanitary manner.

The findings include:

Tour of the kitchen was conducted on / at 10:00 a.m. Observed the range top and connecting back splash were soiled and dirty. The range top grates had numerous areas with burnt and caked on food. The back splash of the range was scorch in several areas, and was coating with a greasy substance. The deep fryer exterior and interior were coated with grease, the interior rim was observed to have burnt on food particles and a build- up of grease and grime.

Observation of the storage bins revealed they had significant smudging and a build -up of dust and dirt on the handles.

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Observation of the dish | there were cloth mats on the floor, rather than rubber mats.

The concerns observed in the kitchen were addressed with the Certified Dietary Manager (CDM) on the same day at 3:00 p.m. CDM confirmed the range top and fryer should have been clean, she also said the Matts in the dish only placed there due to a staff member falling in the kitchen, and were only meant to be a temporary measure to prevent another . CDM confirmed the mats were not appropriate.

Review of the facility's approved cleaning schedule fails to include assignments for cleaning the range top.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Bayshore Memory Care
1260 Creekside Blvd E
Naples, FL 34109

RE: CCR #2016003986, 2016002102, 2016002130, 2016002583

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by representative(s) 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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(s). 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

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