STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969091	04/11/2017
NAME OF PROVIDER OR SUPPLIER **TUSCAN GARDENS OF VENETIA BAY**	STREET ADDRESS, CITY, STATE, ZIP CODE **841 VENETIA BAY BLVD** **VENICE, FL 34285**	

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

0000 - Initial Comments

An unannounced initial Extended Congregate Care (ECC) survey was conducted on at Tuscan Gardens of Venetia Bay, an Assisted Living Facility, License #12918, in Venice, Florida.

The following is description of the deficiencies.

E206 - ECC - Service Plans - 58A-5.030(7) FAC

Based on observation, record review and interview, the facility failed to ensure the service plan was agreed upon at the time it was developed for 1 (Resident #5) of 1 resident receiving ECC (Extended Congregate Care) services.

The findings included:

Observation on at 9:45 a.m., found Resident #5 in his in a chair. He said he had been at the facility since it opened and had a , ⌣ (⌣ ,) tube in place because he was unable to swallow. He said he has been through , , , to no avail. He said the nurses take care of the tube to include cleaning the site, making sure the connector is ok and assists with some of his medications. He said he does his own medications at night. He said he doesn't take anything by mouth.

On , the physician ordered tube feedings to be administered by the nursing staff.

A service plan was completed on by the former Director of Health Services (DOHS). She documented Resident #5 needed assistance with routine medications and , ⌣ tube feedings. She documented Resident #5 was pleasantly and forgetful to time and place. The service plan documented staff were to monitor for any adverse effect of the medications. At the bottom of this service plan, the DOHS documented, "Admit to ECC (Extended Congregate Care Services) for tube feedings per MD orders."

Record review showed the service plan was not reviewed with Resident #5 until , one month later.

In an interview with the interim DOHS on at 3:00 p.m., she confirmed the service plan was not reviewed with Resident #5. She said she was just assigned to the facility, saw it hadn't been reviewed and reviewed the service plan with Resident #5 herself.

Class

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E207 - ECC - Services - 58A-5.030(8) FAC

Based on observation, record review, and interview, nursing staff failed to ensure physician's orders were in place for administration of medications through a ˘ ˘ tube; failed to follow physician's orders for tube feeding flushes; and failed to obtain orders for the flow rate of tube feedings through a ˘ ˘ tube for 1 (Resident #5) of 1 resident receiving Extended Congregate Care (ECC) services.

The findings included:

Observation on at 9:45 a.m. found Resident #5 in his in a chair. He said he had been at the facility since it opened and had a ˘ (˘ ˘) tube in place because he was unable to swallow. He said he has been through to no avail. He said the nurses take care of the tube to include cleaning the site, making sure the connector is ok, and assists with some of his medications. He said he does his own medications at night. He said he doesn't take anything by mouth.

In an interview on at 3:42 p.m., Staff A, an LPN (Licensed Practical Nurse), said Resident #5 self-administers his medications except for (a powdered) and his (liquid) ˘ medicine. Staff A said the nurses at the facility change the dressing on his ˘ tube site daily, administer his tube feeding and flushes, and check for residual feedings daily. She said they document the procedure in their nursing notes.

Record review showed an 1823 Health Assessment dated indicating Resident #5 was able to self-administer his own medications.

On , the physician ordered tube feedings to be administered by the nursing staff. Orders included: Isosource 1.5 x 2 cans and Nutren 2.0 x 1 can in a.m. when awakened, Isosource 1.5- 2 cans at 1:00 p.m. and Isosource 1.5- 2 cans at 6:00 p.m. Nursing staff were to flush the ˘ tube before and after feedings with 50 cc's of water. In addition, nursing staff were to check for residuals and document levels at the end of the day and check the ˘ tube site and clean daily. The physician did not order a flow rate for the tube feeding. He did not indicate whether the tube feeding should be via gravity or through a pump intermittently.

There was no clarification order obtained by the nursing staff from the physician for the flow rate of the tube feeding.

A service plan was completed on by the Director of Health Services (DOHS). She documented Resident #5 needed assistance with routine medications and ˘ tube feedings. She documented

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUSCAN GARDENS OF VENETIA BAY	**841 VENETIA BAY BLVD VENICE, FL 34285**

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

Resident #5 was pleasantly and forgetful to time and place. The service plan documented staff were to monitor for any adverse effect of the medications. At the bottom of this service plan, the DOHS documented, "Admit to ECC (Extended Congregate Care Services) for tube feedings per MD orders." There was no plan listed for the administration of medications.

Review of the Self-Administration of Meds Assessment form dated showed the DOHS documented Resident #5 was unable to correctly pour and/or measure the appropriate amount of medication from a container (tablets, liquids).

Documentation provided by the facility failed to show the physician was notified of Resident #5's inability to safely self-administer his own medications and required the administration of his medications through his tube by nursing staff. In spite of the DOHS identifying he required this need on the service plan and assessment, the record did not show Resident #5 was administered all of his medications by the nursing staff.

Review of the nursing progress notes between and found nursing staff failed to consistently follow the physician's orders for tube feeding flushes.

On , , , , , , and , progress notes showed nursing staff flushed the tube with 60 cc's of water instead of 50 cc's of water ordered by the physician.

Review of the nursing progress notes between and showed nurses documented the flow rate of the tube feedings as "moderate".

In an interview on at 4:45 p.m., Staff A confirmed there was no flow rate of the tube feeding ordered by the physician. She stated, "I don't know how the others do it, I just hook it up and let it drip slowly by gravity. We don't use a pump." When asked what "moderate" meant for flow rate as documented in the nursing notes, Staff A did not respond.

During an interview on at 5:20 p.m., the interim DOHS said she was going to conduct another assessment of Resident #5. She said Resident #5 requires administration of all of his medications and tube feedings and would clarify the record and orders with the physician.

Class III