STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966091	02/07/2018
NAME OF PROVIDER OR SUPPLIER **JACARANDA TRACE**	STREET ADDRESS, CITY, STATE, ZIP CODE **3600 WILLIAM PENN WAY** **VENICE, FL 34293**	

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

0000 - Initial Comments

An unannounced complaint survey for CCR #2018001858 was conducted on at Jacaranda Trace, an assisted living facility (license #10358) located in Venice, Florida.

The following is description of the deficiencies.

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

Based on a record review and staff interview, the facility failed to ensure there was supervision and interventions when residents had a change in condition or behavior for 2 (Resident #2 and #3) of 3 residents reviewed.

The findings included:

1. Record review on , showed an admission date for Resident #2 of . Resident #2 had a noted in the incident reporting system on , which resulted in a . There were also on and , no injuries were noted. There was no documentation of any interventions for this resident to prevent further .

On at 3:00 p.m., the Administrator confirmed that the resident had received physical and occupational , . She agreed the facility had not tried other interventions to prevent further for this resident.

Further record review showed the nurse's note from documented Resident #2 having an open area on the left measuring 1.2 centimeters (cm) by 1.2 cm and an open area on the , measuring 1.5 cm by 1 cm in size. The nurse noted the use of barrier cream to both of these areas. The resident's power of attorney and the physician were notified and a request was made for home health to provide care to both of these areas. As of , there was no further documentation about this skin issues and there was no documentation that home health was providing care to this resident.

During an interview on at 2:22 p.m., the Licensed Practical Nurse (LPN) said she was unaware of the Resident #2's current skin status. During the same interview, the Administrator said she was also unaware the resident had skin issues.

2. Record review found Resident #3 had documentation of multiple on , , , , , , and . There was no documentation in the record for any interventions to reduce

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the number of for Resident #3. Some of the were noted to be part of behaviors this resident has. There was no documentation in the record showing any interventions to prevent for this resident.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on record review, staff interview, and observation, the facility failed to ensure a resident's rights to be free of were promoted and the resident was safe from injury for 1 (Resident #1) of 3 records reviewed.

The findings included:

1. Record review showed Resident #1 was admitted to the facility on . Among the resident's diagnoses was of 's type. On , the nurse's notes documented that the resident became very combative when attempting to give the resident a shower. was given prior to the shower and was not effective. It took 4 staff members to give the resident a shower.

On , the nurse's notes documented that it took 4 staff members to give a shower and dress the resident. The resident was yelling and tried to hit the staff during the procedure. The doctor was notified.

There was continued documentation that the resident had behaviors, would refuse medications, and became agitated and combative at times.

The nurses notes documented on at 8:47 p.m. the resident was given a shower by 3 staff members as she was "resistant and smelled."

Approximately 1 hour afterward the POA (power of attorney) noted watching the resident's wrist swell. The POA thought it might be broken and took the resident to urgent care. Upon return from urgent care, the resident was noted to have a diagnosis of hematoma in the wrist. On , the nurse noted the resident had from the knuckles to wrist.

The urgent care admission record indicated that Resident #1 was seen on for pain in her left wrist from struggling with nurses while showering and now has on her left wrist.

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On , an observation of Resident #1's left revealed a raised area 3 inches, in an egg shape, raised approximately 3/4 inch above the skin. The resident indicated the area hurt a little.

Multiple interviews where conducted with staff A, B, C, D, and E on between 11:35 a.m. and 12:03 p.m. All indicated Resident #1 was a problem when it came to showering, the resident was afraid of water. This was confirmed with the Administrator on at 2:22 p.m.

The documentation in the nurse's notes did not show any interventions to make the shower an easier process and no alternatives were tried, resulting in an injury to the resident.

Class II