

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969278	(X3) DATE SURVEY COMPLETED 12/11/2018
NAME OF PROVIDER OR SUPPLIER ALL SEASONS IN NAPLES	STREET ADDRESS, CITY, STATE, ZIP CODE 15450 TAMiami TrL N NAPLES, FL 34110	

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

0000 - Initial Comments

An unannounced complaint survey #2018013973 was conducted on _____ at All Seasons in Naples, an assisted living facility (license #13141) in Naples, Florida.

The complaint contained one allegation which was substantiated.

The following is a description of the deficiency found at the time of this survey.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28() FS 429.27

Based on resident and staff interviews, a review of the facility's grievance log, resident council meeting minutes and pendant response time logs, the facility failed to honor resident rights by not resolving grievances through the grievance log and resident council. The facility does not respond to the residents' pendants timely and the resident wait over one hour for their dinner meal.

The findings included:

1. Five of eight residents interviewed concerning waiting a long time to be served their meals had complaints. They all said the dinner meal is the worst. On _____ at 11:45 a.m., Resident #1 said dinner is "always late." She has to wait up to one hour for her dinner meal.

On _____ at 11:20 a.m., Resident #5 said she waits a long time for her dinner. She complained to the Administrator two weeks ago about this. Now every Wednesday the Chef, Administrator, and Residents are meeting concerning this. There is not enough staff. It has not gotten better.

On _____ at 11:30 a.m., Resident #6 said she has a complaint about the dinner being served very late.

On _____ at 11:35 a.m., Resident #7 said the only thing she has a complaint about is waiting up to one hour for her dinner. It has been going on for a while and it has not gotten better.

On _____ at 1:45 p.m., Resident #10 said he has to wait over one hour for his dinner to be served. He knows there have been several complaints from other residents about this issue.

2. A review of the grievance log showed a complaint from two residents concerning the wait time for dinner. It showed this complaint is resolved. However, during an interview with the Chef, Administrator,

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 01/08/2019
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969278	(X3) DATE SURVEY COMPLETED 12/11/2018
NAME OF PROVIDER OR SUPPLIER ALL SEASONS IN NAPLES	STREET ADDRESS, CITY, STATE, ZIP CODE 15450 TAMiami TrL N NAPLES, FL 34110	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)		
and Director of Nursing (DON) on at 1:00 p.m., they all said this issue is on-going. The Chef has "crafted a reservation system" to help resolve this issue. It has not been implemented as of yet. A review of the resident council meeting minutes for the last three months showed the residents continue to complain about their dining experience by waiting too long for their dinner. There were no complaints about breakfast and lunch. 3. Six of eleven residents interviewed concerning the staff's response time for answering their pendants had complaints. On at 11:19 a.m., Resident #4 said he's had to wait from 5 minutes (min) to 1 hour for staff to answer his pendent. On at 11:20 a.m., Resident #5 approximately two weeks ago had to wait up to 2 hours for staff to answer her pendent. A review of the pendant response time log showed on 11/23/18 at 8:52 a.m., her pendant was turned on and then turned off at 11:03 a.m., (2 hours, 11 minutes). On at 12:30 p.m., Resident #8 said he's had to wait over 1 hour for staff to answer his pendant. A review of the pendant response time log showed on at 8:45 a.m., his pendant was turned on and then turned off at 9:49 a.m., (1 hour, 4 minutes). On at 8:03 a.m., his pendant was turned on and then turned off at 8:59 a.m. (56 minutes). On his pendant was turned on at 5:55 p.m., and turned off at 6:41 p.m., (46 min). On at 8:56 a.m., his pendant went on and was turned off at 9:51 a.m., (55 min). On at 12:45 p.m., Resident #9's private duty care giver said she remembers some of these wait times from the pendants. She has talked with the staff concerning the wait times. The wait time to answer Resident #9's pendant has been over one hour. A review of the pendant response time log showed on at 2:16 a.m., her pendant was turned on and then turned off at 3:57 a.m., (1 hour, 41 min). On at 7:38 p.m., her pendant was turned on and then turned off at 12:08 a.m. (4 hours, 30 min). On at 4:46 a.m., her pendant was turned on and then turned off at 5:04 p.m., (12 hours 18 min). On at 11:17 p.m., her pendant was turned on and turned off at 12:02 a.m., (45 min). On at 1:45 p.m., Resident #10 said he's had to wait over 1 hour for the staff to answer his pendant on several occasions. On at 12:30 p.m., Resident #11 said she's had to wait up to one hour or more for a staff to answer her pendant. Other residents have complained and she thinks the staff are working on some type of system to fix it. A review of the pendant response time log showed on at 8:47 a.m., her pendent was turned on and was turn off at 10:42 a.m., (1 hour, 55 min).		

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 01/08/2019
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969278	(X3) DATE SURVEY COMPLETED 12/11/2018
NAME OF PROVIDER OR SUPPLIER ALL SEASONS IN NAPLES	STREET ADDRESS, CITY, STATE, ZIP CODE 15450 TAMiami TRL N NAPLES, FL 34110	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)		
4. A review of the pendant response time for the past . /2 months showed there were 44 calls from residents and the response time from the staff was over one hour in , 2018; 61 over one hour in , 2018; 56 over one hour in , 2018; and 17 over one hour the first 10 days in ; 2018. On at 12:55 p.m., the Administrator said the previous Director of Nursing reviewed these response times and would report to her concerning these long wait time periods. However, there was no documentation showing these investigations. At this time the new Director of Nursing and Administrator are looking into some of these response times but there is no documentation showing if these issues have been resolved. A review of the grievance log showed Resident #5 made a formal grievance concerning the response time to her pendant. It showed the issue was resolved. However, since this grievance the residents continue to complain about this. The response time on the facility log showed residents continue to wait over an hour for the staff to respond to their pendants. Class III		