STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965595	05/21/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
SEASONS BY RIVIERA	515 TOMOKA AVENUE ORMOND BEACH, FL 32174	

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

0000 - Initial Comments

An unannounced complaint survey, CCR #2015003513 was conducted on at Seasons by Rivera in Ormond Beach Florida. Deficiencies were identified during the visit.

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

Based on record review and staff interviews, the facility failed to provide care and services appropriate to the needs and have an awareness of the general health of 1 of 3 sampled residents (Resident #1). This resulted in Resident #1's toe being amputated.

The findings include:

Record review for Resident #1 revealed a female admitted on . Her diagnosis included . Review of the Health Assessment (1823) dated revealed she was alert with periods of needed supervision with bathing and dressing, required set up for meals, and used walker to ambulate independently.

A review of the Resident #1's care note written by the Executive Director (ED) dated at 7:30 am revealed Resident #1 was found to have a second toe on her right foot and complained of mild pain. The resident stated she had stubbed her toe. Upon examination of the toe, it was found to have a cloth wrapped around the base of the toe. The resident stated she had wrapped up the toe. The documentation showed that Resident #3's toe was red, but the top of her foot was pink and warm to the touch. The ED documented that the cloth appeared to be cutting off the circulation and there was an open area on the underside of the toe. A loose gauze dressing was applied and documented he would evaluate later. Also the toe was red but top of the foot was pink and warm to touch.

An interview was conducted with the ED on at 1:18 pm. When asked when he first became aware of Resident #1's toe being red and , he stated the medication technician (MT) (Employee A) had told him on . He reported that she told him Resident #1 had stubbed her toe and it was red and slightly The ED stated that he got busy and did not go and observe Resident #1's toe on . He stated that the facility did not have a nurse at the time of the incident, however, he was a Licensed Practical Nurse (LPN) and was able to evaluate the residents. The ED stated that he came in early on the morning of around 7:15 am. The caregiver on duty told him that he needed to look at Resident #1's toe on her right foot. The ED stated that when he observed Resident #1's second toe on her right foot, he found a piece of cloth wrapped tightly around the base of the second toe. He reported that the cloth was so tight, it appeared to cut off the circulation and stated that the toe was twice the size of the big toe with pus and observed. The ED stated that he applied a dressing and told the resident she should stay in bed. The ED stated that he left the facility and instructed the caregiver to observe Resident #1 and notify him if there were any changes. He stated that Employee A called him mid- morning and reported that the dressing had drainage and the toe was more The ED reported that a new Resident Care

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Director (RCD) had started on and that he called her to request that she examine Resident #1's toe and decide what needed to be done. The ED reported that the RCD observed Resident #1's toe and sent Resident #1 to the emergency evaluation. The ED stated that he took responsibility for not seeing the resident when he was first told by the staff of the injury. He was asked if he had notified the physician or family, he stated "no.

An interview was conducted with Employee A (MT) on at 2:12 pm. She reported that she had been told by Employee B (caregiver) about the condition of Resident #1's toes on her right foot. Employee A reported it was when the Employee B showed her the resident's toe. Employee A stated Resident #1's toe was slightly red and Resident #1 told Employee A that she had stubbed her toe and it was hurting. Resident #1 stated that she could not put her shoe on. When asked if she reported the injury, Employee A stated that she informed the ED and asked him to look at Resident #1's toe. She stated the facility did not have a nurse on staff at that time, however, the ED was a LPN. She stated that on Resident #1 was sent to the hospital. Employee A reported that Employee B came to her on and reported that Resident #1's toe was worse and needed attention. She stated she contacted the ED and told him he needed to look at Resident #1's toe. Employee A then said, when the ED looked at the toe on it looked bad with drainage and

Review of the hospital records for Resident #1 revealed she was seen on for right second toe redness and drainage of An X-ray taken of Resident #1's right foot showed extensive (bone The hospital records revealed that Resident #1 was diagnosed with (open to the skin) of the second right toe with extensor showing and underneath that, bone exposure. A consultation dated assessed Resident #1's condition and read that "surgical intervention would be the best" and recommended partial to total amputation of Resident #1's second toe on her right foot.

Class II

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

Based on observation and interview, the facility failed to ensure residents were treated with consideration and respect of personal dignity and the need to privacy by locking resident and This had to potential to impact all 23 residents at the facility

The findings include:

A tour of the facility was conducted on at 8:45am. The facility is locked facility requiring key code to go in and out between the buildings. A tour of the building housing the A & B units found that resident were locked and required key access. A tour of the building housing units C & D at 9:20am revealed resident were locked with the exception of 2

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The Residential Care Director (RCD) was interviewed on at 9:05am. When asked why all the resident doors were locked, she stated it had been that way since she started 6 weeks ago. She stated that she assumed it was for resident safety.

An interview was conducted with the caregiver on the A unit on at 9:10am. She stated all were kept locked with the exception of residents in 3 on the unit. She reported that those residents were able to use their key to get in and out. The caregiver stated she was told to keep the locked so that residents could socialize by staying out of their She further added that the and shower were kept locked as well. When asked how the residents able to use the she stated that the alert residents will ask and the residents are taking via a toileting schedule. She reported that she was told to keep the locked for safety reasons.

In an interview with administrator on at 10:15am, he stated that shower were kept locked for safety. He reported that are kept locked to keep other residents out. The Administrator stated that it is not policy, but that is the way it has always been.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

6/3/:

Mr. Blake Breedlove
515 TOMOKA AVENUE
ORMOND BEACH, FL 32174

Dear Mr. Breedlove,

This letter reports the findings of a licensure complaint survey (CCR#2015003513) conducted on .2015 by a representative of the Agency for Health Care Administration. Attached is the provider's copy of the State (5000) Form, which indicates there were deficiencies noted during the inspection.

The inspection resulted in findings of non-compliance in the following areas:

1) St-A0025- Class II- Resident Supervision

The facility failed to provide appropriate supervision, care, and services for Resident #1 after injuring her toe. This resulted in Resident #1 not receiving medical attention for 5 days and led to the amputation of her right second toe.

You are directed to complete the following tasks:

1) The facility must do skin assessments on all residents at the facility. The skin assessments must be completed by a Registered Nurse (RN) and be documented. The skin assessment documentation along with a copy of the RN's license must be kept on kept on file at the facility, and be available for review by the Agency. The skin assessments must be completed no later than If any resident is observed or reports having skin integrity issues during the skin assessment evaluation, the facility must contact the resident's primary health care provider and consult for course of treatment. This contact and course of treatment must be documented in the resident's file.

2) The facility must implement a written, detailed plan on how resident's medical concerns brought to any staff member's attention, gets documented and followed up on in a timely manner. This plan must include a timeframe for documenting the concern after it is observed or reported and a timeframe for when the follow up action will occur. The plan must identify the parties responsible for conducting the follow up. This plan must be developed and implemented by All employees must be in-serviced on the plan, no later than The plan and documentation of staff in-service, must be kept on file at the facility and available for review by the Agency.

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Tallahassee, FL 32308
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921 North Davis Street, A-135
Jacksonville, Florida 32209
(904) 798-4201
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3) The facility must complete in-service training for all staff regarding resident supervision as it pertains to Florida Administrative Code 58A-5.0182(1). The in-service must have an agenda and sign-in sheet and must be completed by . . . . The in-service must be kept on file at the facility and available for review by the Agency.

All required documentation set forth above, should be directed to the attention of Mrs. Jana Meyering, Health Facility Evaluator Supervisor and sent to:

Agency for Health Care Administration
Health Quality Assurance, Jacksonville Field Office
Attention: Jana Meyering
921 N. Davis Street, Bldg. A, Suite 115
Jacksonville, FL 32209
Phone: (904) 798-4201
Fax: (904) 359 - 6054

Nothing in this Directed Plan of Correction limits the Agencies authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call . . . . Laura Manville, Survey and Certification Support Branch, at 727-552-1955 or Jana Meyering, Jacksonville Field Office, at 904-798-4201.

Sincerely,

Jana Meyering

Jana L. Meyering, Q.I.D.P.
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

JD/JM/RED/sm