STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964264	**04/09/2018**
NAME OF PROVIDER OR SUPPLIER **HARBORCHASE OF VENICE**	STREET ADDRESS, CITY, STATE, ZIP CODE **950 PINEBROOK ROAD** **VENICE, FL 34292**	

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

0000 - Initial Comments

An unannounced complaint survey for CCR #201800635 was conducted through at Harborchase of Venice, an assisted living facility (license #8813) in Venice, Florida.

The following is description of the deficiencies.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and interview, the facility failed to have a face to face examination with a health care provider after a significant change for 1 (Resident #3) of 3 residents sampled.

The findings included:

Resident #3 was admitted on . There had been a change in condition regarding food and liquid intake that began on . Resident #3's health assessment dated listed for Activities of Daily Living (ADLs), the resident required supervision for eating. The second health assessment dated listed for ADLs, the resident was independent for eating. The facility failed to get an updated heath assessment for ADLs after Resident #3 began refusing to eat or drink on , requiring assistance by staff for eating. There was no documentation in the facility records of a health care provider notification for significant change by facility staff on .

During an interview on at 2:15 p.m., Staff C said Resident #3 had declined with eating and drinking liquids, he would only take sips of water or very small amounts of food. Staff C said the nurses were aware of Resident #3's change in condition.

Significant change is defined (58A-5.0131) as a deterioration of health status as unplanned weight change. Resident #3's health assessment dated documented the resident's height was 68 inches and weight was 170 pounds. The second health assessment, dated , documented the resident's height was 68 inches and weight was 158 pounds. There were no other weights available in the facility records for Resident #3.

Class III

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

Based on record review and interview, the facility failed to monitor the quantity of food consumed after a

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decline in eating and drinking and maintain an updated written record as needed for 1 (Resident #3) of 3 residents sampled.

The findings included:

Resident #3 had a decline in eating and drinking on . The facility failed to monitor and document quantity of food consumed by Resident #3 and the resident's refusal to comply with a therapeutic diet. The facility also failed to notify the resident's health care provider of such refusal.

During an interview on at 2:15 p.m., Staff C said Resident #3 declined with eating and drinking, he would only take sips of water or very small amounts of food. Staff C said the nurses were aware of Resident #3's change in condition.

Class III

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

Based on observation and interview, the facility failed to provide residents in Memory Care with access to a telephone to facilitate resident's rights to unrestricted and private communication. The facility failed to notify a health care provider of change in condition for 1(Resident #3) of 3 residents sampled.

The findings included:

1. Observation on at 11:30 a.m., revealed the Memory Care unit had no phone in the unit for resident use.

During an interview on at 1:30 p.m., the Executive Director reported he was unaware the residents in Memory care had to have access to a facility phone.

2. Resident #3 was admitted on . There had been a change in condition regarding food and liquid intake that began on . Resident #3's health assessment dated listed for Activities of Daily Living (ADLs), the resident required supervision for eating. The second health assessment dated listed for ADLs, the resident was independent for eating. The facility failed to get an updated heath assessment for ADLs after Resident #3 began refusing to eat or drink on , requiring assistance by staff for eating. There was no documentation in the facility records of a health care provider notification for significant change by facility staff on .

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During an interview on at 2:15 p.m., Staff C said Resident #3 had declined with eating and drinking liquids, he would only take sips of water or very small amounts of food. Staff C said the nurses were aware of Resident #3's change in condition.

Significant change is defined (58A-5.0131) as a deterioration of health status as unplanned weight change. Resident #3's health assessment dated documented the resident's height was 68 inches and weight was 170 pounds. The second health assessment, dated , documented the resident's height was 68 inches and weight was 158 pounds. There were no other weights available in the facility records for Resident #3.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the facility failed to maintain a safe living environment, free from hazards, for residents residing in Assisted Living and Memory Care.

The findings included:

During a tour of the assisted living facility on at 10:30 a.m., the following was observed:
-Resident #4's Memory Care unit at 11:10 a.m., had numerous stained towels scattered on the floor beside her bed, a towel on her bed, and in the . There were damp towels with black stains under the sink in a large amount of black sooty substance was found on vanity floor under the towels. The bed sheets had stains and the floor had scrambled eggs and other food debris.

During a tour on at 11:30 a.m., the following was observed:
had 2 window blinds with a large amount of dust on both.
had a stained carpet.
Resident #5's Memory Care wheelchair had multiple stains on armrests.

On at 11:30 a.m., Resident #4's Memory Care a small table next to a couch in her a plastic placemat. The plastic placemat was stained with food debris and under the placemat had sticky food debris. The small couch had stained cushions.

During an interview on at 11:30 a.m., the Maintenance Director said he had just finished cleaning the he had cleaned the couch. He said the couch belonged to the resident and she

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would have to throw it out if the stains do not come out.

Observation of Resident #4's wheelchair revealed multiple areas of old and new food debris along sides of wheel chair.

During an interview on at 11:30 a.m., Staff B said Resident #4 had issues with drooling and had dropped her plate of scrambled eggs. She said she placed a work order to housekeeping/maintenance at 9:00 a.m. to clean the .

During an interview on on at 11:30 a.m., the Director of Assisted Living reported housekeeping/maintenance cleans Memory Care every Friday only. She reported if needed to be cleaned during other times the staff are supposed to place a work order.

During an interview on at 12:35 p.m., Staff A said housekeeping/maintenance needs to be cleaning the memory care unit at least every other day. She said when you place a work order to housekeeping/maintenance they are supposed to respond within 24 hours. She had placed a work order for cleaning last Saturday and as of Monday had no response. Staff A also reported that Resident #1's daughter would bring her own cleaning supplies to the facility to clean Resident #1's , when the resident resided in Memory Care.

Class III