STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964626	05/20/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Harborchase Of Naples	7801 Airport Pulling Road N.E. Naples, FL 34109	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0028 - 58a-5.0182(4) Fac - Resident Care - Activities Of Daily Living S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D

Specific Tag Findings:
An unannounced Complaint Survey, CCR#2014003185 which was conducted on [redacted] at Harborchase, an Assisted Living Facility (ALF) in Naples.

Two allegations were substantiated. The facility received citations as a result of this survey.

The following is a description of the noncompliance:

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on record review, observation, and interview, the facility failed to ensure that the responsible party, for Resident #6, was notified by the facility regarding an injury requiring [redacted] care treatments provided by a third party service.

The findings include:

Review of the medical record, for Resident #6, revealed that she was receiving [redacted] care treatments, from a Home Health Care Agency. This was also reported to the surveyor by the facility.

Interview of the resident's responsible party, on [redacted] at 11:40 a.m., revealed that the facility never informed her of the injury sustained by Resident #6 on [redacted]

Review of the medical record revealed a Resident Progress Note, dated [redacted] at 8 p.m., stating, "Nurse called to resident's [redacted] noted to right lower leg; resident stated that she sustained [redacted] earlier during the day while she was being showered over to SNF (skilled nursing facility); first aid provided, ____ Home Health referral to evaluate and treat; MD aware."

Upon interview, on [redacted] at 1:30 p.m., the caregiver authoring the foregoing documentation stated that the resident's responsible party was not notified by the facility regarding the incident. The caregiver continued to state, in writing, "Resident stated that daughter was already aware; daughter was seen in the building that day at an earlier time."

Class III

0028-Resident Care - Activities of Daily Living 58A-5.0182(4) FAC
Based on record review, observation, and interview, the facility failed to provide assistance with activities of daily living, relating to [redacted] care and hearing aid application for 1 (Resident #6) out of 6 sampled residents.

The findings include:

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Resident #6 was observed sitting in a lounge chair, with legs elevated, in her apartment on [redacted] at 9:30 a.m. She was sleeping at this time. The resident was observed again at 10:00 a.m. She was awake and alert.

Upon interview she repeatedly stated, "I can't hear you, I need my hearing [redacted]" She stated that she had been sitting in the chair since 8:00 a.m. She also stated, "My daughter thinks that I am neglected." When asked if she needed to be toileted, she stated, "No, I wear Fancy Pants [redacted] pull up brief)."

[redacted] hearing aides were observed being placed in Resident #6's ears at 11:15 a.m. by Staff A. Upon interview, Staff A stated that the resident was brought to the dining [redacted] breakfast, this date, and did not have the hearing [redacted] in at that time. Staff A acknowledged that this was the first time Resident #6 had the hearing [redacted] in use today. No explanation was given to address the delay in application.

Resident #6 was observed being transferred from the lounge chair to a high back wheelchair, with assist of 2, at 11:45 a.m. The resident's daughter was present at this time. No gait belt was used although it was within sight hanging from the resident's walker. Review of the medical record revealed Physical [redacted] Discharge Summary of [redacted] and Occupational [redacted] Discharge Summary [redacted] included a plan for use of a gait belt with transfer to avoid tugging at the resident's upper extremities.

[redacted] care was not given to Resident #6 for a period of 7 hours on [redacted] This time period was confirmed by the resident, this date, when interviewed at 10:00 a.m., 11:30 a.m. and 1:30 p.m. It was also confirmed by Staff A who stated, when in the resident's apartment at 11:15 a.m., that the resident was gotten out of bed and brought to breakfast at 7:00 a.m. and returned to her apartment at 8:00 a.m. When asked if Staff A would be changing the resident's [redacted] brief, or placing her on the toilet prior to lunch, Staff A stated, "She (the resident) asks when she wants to go on the toilet." Staff A left the apartment and returned, with Staff B, at approximately 11:40 a.m. The resident was observed being transferred from her lounge chair to a high back wheelchair and then brought to the first floor for lunch.

The resident was observed again at 1:30 p.m. sitting in her apartment in a high back wheelchair facing her television. Due to the position of the wheelchair, the resident had no access to a glass of water that was on a table next to her lounge chair. Upon interview, the resident stated that she called for help "30 minutes ago." The resident was asked if her "Fancy Pants" were changed since 8:00 a.m., and she stated, "No."

A Home Health Care nurse entered the apartment at 1:40 p.m. and stated she was going to do a treatment on the resident's left leg. She stated she would find a facility caregiver to help her. Upon her return with Staff B, she said she could do the treatment while the resident was sitting in her chair. At the surveyor's request, Resident #6 was placed in bed to be given [redacted] care. The resident was in agreement with this procedure. The [redacted] brief was removed and observed to be saturated with [redacted] and had a strong odor. The resident's [redacted] were bright red. The Home Health Care nurse pressed the resident's [redacted] stating, "The areas are blanchable" and told the resident she would need to stay in bed to relieve the pressure to this area. Staff B acknowledged, at this time, that the resident's [redacted] brief had been worn since she was gotten out of bed at approximately 7:00 a.m., a period of 7 hours. The resident concurred this timeframe stating, "I was brought downstairs to breakfast at that time."

Resident #6 has a history of [redacted] of the [redacted] that occurred in [redacted] 2014 per her medical record.

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Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on record review, observation and interview, the facility failed to implement procedures to ensure acceptable standards of care relating to incontinence and privacy for 2 (Residents #5 and #6) out of sample of 3 sampled residents.

The findings include:

1. Resident #6 was observed sitting in a lounge chair, at 9:30 a.m. on 10:00 a.m. and 11:15 a.m. on When asked, the resident stated she had been sitting in the chair since 8:00 a.m. and did not have to use the she was wearing "Fancy Pants" brief). At 11:30 a.m. a large supply of briefs were observed on an upper shelf in Resident #6's closet. The resident's daughter, who was present at this time, stated, "These briefs are provided by the Veterans Administration; they don't use them." At 11:40 a.m. the resident was observed being transferred from the lounge chair into a high back wheelchair. The procedure was performed by Staff A and B.

Upon interview at this time, Staff A and B acknowledged that Resident #6 had been sitting in the lounge chair since 8:00 a.m. and that this was her first transfer, out of the lounge chair, since that time.

The resident was observed again at 1:30 p.m. sitting in her apartment in a high back wheelchair facing her television. Due to the position of the wheelchair, the resident had no access to a glass of water that was on a table next to her lounge chair. Upon interview, the resident stated that she called for help "30 minutes ago." The resident was asked if her "Fancy Pants" were changed since 8:00 a.m., and she stated, "No."

A Home Health Care nurse entered the apartment at 1:40 p.m. and stated she was going to do a treatment on the resident's left leg. She stated she would find a facility caregiver to help her. Upon her return with Staff B, she said she could do the treatment while the resident was sitting in her chair. At the surveyor's request, Resident #6 was placed in bed to be given care. The resident was in agreement with this procedure. The brief was removed and observed to be saturated with with a strong odor. The resident's were bright red. The Home Health Care nurse pressed the resident's stating, "The areas are blanchable" and told the resident she would need to stay in bed to relieve the pressure to this area. Staff B acknowledged, at this time, that the resident's brief had been worn since she was gotten out of bed at approximately 7:00 a.m., a period of 7 hours. The resident concurred this timeframe stating, "I was brought downstairs to breakfast at that time."

Review of the medical record revealed a form entitled "Subsequent Medical Evaluation" dated and signed by the physician stating 3-4 centimeters." A physician order dated states "Home Health to evaluate and treat wounds to right and left ." In addition, a "Resident Personal Service Plan and Assisted Living Evaluation", dated , states "Toilet resident every 2 hours, place on recliner to prevent chair from getting wet, pads and diapers in the closet."

2. Upon interview on at 10:45 a.m. Resident #5 stated, "A large male caregiver unlocked my door this morning and came in. I was frightened when I woke up and saw him and told him to leave. I never saw him before. I don't know if he locked the door again when he left (resident is wheelchair bound/uses an electric wheelchair)." The resident continued to state that she submitted a request not to be disturbed during the night.

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Upon interview on at 2:30 p.m. Staff C stated that he did unlock and enter Resident #5's at 7:00 a.m., this date because she did not answer when he knocked. He said he did not know she did not want to be disturbed and asked him to leave. Staff C continued to state it was his first time working in this assignment and was not advised regarding the resident's wishes.

Interview of the Director of Assisted Living, at 3:00 p.m., revealed that Resident #5 was on a listing entitled "Do Not Disturb at Night." Her name was the first one on the list. In addition, a "Resident Personal Service Plan and Assisted Living Evaluation" form, dated "sound sleeper, wakes 7-8 a.m."

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observation, record review and interview, the facility failed to secure and dispose of a prescription ointment for Resident #6.

The findings include:

At 11:30 a.m. on Resident #6 was observed sitting in a lounge chair in her apartment. Her daughter was visiting at this time. The surveyor observed a tube of ointment on top of a table located against the wall at the foot of the residents bed, right side. When asked, the daughter stated, "I don't know what that is. I have not seen it before."

Staff A and B were present in the resident's this time. When asked, Staff A and B stated they did not use the cream but thought that the evening shift CNA (Certified Nursing Assistant) used it on the resident's

The label on the ointment read Oint (ointment), apply to twice daily as needed for redness or irritation (order only)."

Review of the medical record reviewed that the treatment was ordered on by a physician that is no longer taking care of the resident. Further review of the medical record revealed no current order for the use of this ointment.

Upon interview at 6:00 p.m. on the facility Executive Director (ED) and Director of Assisted Living acknowledged that the Resident #6 is no longer under the care of the physician and has no order for application of the ointment. She also stated that the ointment would be reordered by the resident's new physician to treat redness or irritation of the

Class III

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC
Based on record review, observation and interview, the facility failed to ensure a safe living environment relating to dining and secured side rails on beds.

The findings include:

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1. On [redacted] the luncheon meal was observed at 11:45 a.m. through 12:30 p.m. in the main dining [redacted] on the first floor of the facility. Residents in wheelchairs were placed in a back area of the dining [redacted] next to the private dining [redacted] The area was very crowded. Food delivery was observed to be difficult, with plates and beverages often observed being passed over resident's heads by staff. Exiting the area was slow and sometimes required movement of other resident's that were still eating.

Upon interview at 6:00 p.m. on [redacted], the facility Executive Director (ED) agreed that the main dining [redacted] was very tight and acknowledged that emergency exit of the area would be difficult. The ED also stated that renovation is planned to correct this problem.

2. A tour of the facility was conducted at 4:00 p.m. on [redacted]. Every resident apartment was observed to ascertain if side rails were being used on the bed(s); and if these side rails were secured to prevent movement resulting in a gap between the mattress and the bed.

During this tour, 23 residents were observed with side rails securely fastened to be bed. These residents were listed on a document entitled "Bed Rails [redacted]" One resident, Resident #7, was not on this document. Resident #7 was observed to have a quarter side rail on the right side, top portion, of his bed. This rail easily slid out from the bed causing a 12 inch gap between the mattress and side rail, where the residents head could be entrapped. Injury and [redacted] have been linked to side rails that are not attached to the bed to prevent movement that would create a gap between the side rail and the mattress (http://www.mcknights.com/bed-rail-entrapments-still-a-problem/article/112809). The Director of Assisted Living was present when this observation was made by the surveyor.

Upon interview a 6:00 p.m. the ED stated that she was unaware an unsecured side rail was on Resident #7's bed and stated, "I have no control over families bringing these (side rails) in. It was probably brought in yesterday. The Director of Assisted Living stated, at this time, that she makes rounds monthly to detect the presence of unsecured side rails. When asked if the side rail had been removed or secured since it was observed on tour this date, the Executive Director said, "No."

The surveyor, ED and Director of Assisted Living went to Resident #7's apartment at 6:05 p.m. Resident #7 was being visited by his granddaughter and her husband. The ED explained the reason for the visit and easily removed the side rail from the resident's bed. The resident's granddaughter stated, "We bought that for him (Resident #7) because he [redacted] out of bed. The ED stated, "The rail needs to be secured to the bed." The granddaughter stated, "Why now. It has been here for 2 months."

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Harborchase Of Naples
7801 Airport Pulling Road N.E.
Naples, FL 34109

Re: CCR #2014003185

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on , 2014 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after 2014 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

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Enclosure: State Form

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