Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965056	A. BUILDING: _____ B. WING _____	07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS OF FT. MYERS	15950 MCGREGOR BLVD. FORT MYERS, FL 33908

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced survey for complaint #2021015467 was conducted on [redacted] at Arden Courts of Ft. Myers, an assisted living facility in Fort Myers, Florida. Complaint #2021015467 was substantiated at A0162. The following is description of the deficiency.	A 000		
A 162	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. [redacted], 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance [redacted], 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, [redacted], or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a	A 162		

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A 162	Continued From page 1	A 162		

therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable.
(e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C.
(f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually.
(g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract.
(h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C.
(i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C.
(j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S.
(k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S.
(l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for ( ), CF-ES 1006, , which is hereby incorporated by reference

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A 162	Continued From page 2 and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the [illegible] of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's [illegible], DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be	A 162		

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A 162	Continued From page 3 retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record reviewed and staff interview the facility failed to maintain complete resident records that were to be utilized when residents had significant changes or illnesses that resulted in medical attention or other changes that resulted in the provision of additional services (transfer to the hospital) for 8 (Residents #1, # 2, #3, #4, #5, #6, #7 and 8) out of 8 resident records reviewed. Facility failed to follow their policy and procedure in transferring residents for acute care. Facility failed to train staff based on their policy and procedure for transferring residents. Facility's failure to follow policy and procedure resulted in not providing Emergency Medical Services ( ) with the pertinent health information during resident #1's transfer to the hospital. Findings included: Requested and obtained Policy and procedure titled " Transfers" Original date: . Procedure: Under 2: A Transfer Form is completed on all residents transferred out of the community due to	A 162		

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A 162	Continued From page 4 a change of condition. Transfer forms should be prepared in advance with a second copy always available. Information on the form may be obtained from the resident's Resident Record, sheet and service plan. 3. The transfer form is part of the packet maintained for each resident in a binder and protected in a plastic sleeve in each house. The transfer form includes: -Transfer form sheet. A copy of insurance information. Legal paperwork: POA ,DPOA, Guardian, Surrogate. Signed acknowledgement. State . Current medications/Treatments. 6. All staff should participate in an in-service that provides information on transfer documentation and location of transfer forms. Record review for Resident #1 found a note dated . Per text note the facility's Resident Service Coordinator (RSC) received a call on at 1:00 a.m. from Staff A indicating that Resident #1 was agitated. RSC was able to hear resident in the background yelling and cursing. Caregiver reported Resident #1 was yelling out, banging on walls and doors as well as trying to hit staff. Staff was unable to redirect resident #1. RSC instructed staff to call 911 to have resident transported to ER for evaluation. Emergency transfer packet for resident #1 included only the transfer form, sheet and insurance information. No medication list, pertinent diagnosis or critical medication was listed on the form. Also there was no advance directive provided. In an interview on at 10:02 a.m., there	A 162		

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A 162	Continued From page 5 Administrator said: "I am always the one that gives the information to . If I am not here the RSC or the overnight nurse will give the information to them. Some times we give them a double packet. One for them and one for the hospital. I never had any issues. I got a call, I think it was for Resident #1, some time in saying that I did not send out the packet. I don't know why they would say that. We gave it to them. I don't know what happened after the resident left. It was there. They had it. No, I didn't question the staff that worked overnight to see if they sent the proper information. I assumed they did." In an interview on at 10:41 a.m., the RSC said: "It was last year. Our regular overnight nurse called out and we didn't have time to get a replacement. I told the staff I will be on call. They called me around 1:00 a.m. because Resident #1 was yelling, screaming, banging the doors and trying to hit the staff. We didn't have a nurse here at the time. The nurses are the ones having access to medication list and the 1823. The nurses give them that information (meaning). I didn't know the hospital called and complained because we didn't send paperwork. The overnight nurse is the one that puts the packet together. No, it is not me and I never check the packet. It's the overnight nurse that does that. Not me. Between the overnight nurse and her up they are here all the time. Its unusual what happened that night. The staff called me and told me what was going on. I directed them over the phone and they sent Resident #1 out for evaluation." In an interview on at 11:10 a.m., Staff A said: "I remember it was so hard I didn't know what to do. Resident #1 was agitated. The RSC	A 162		

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told me to call 911 and give them the emergency packet that we have. When came in, he complaint that he did not have enough information for Resident #1, but there was nothing I could do. I don't have access to print medications. I don't have any other forms. I didn't have any information to give him. The nurses do that not me. I gave him what I had. He was asking all these questions, I had no answer. I know he complained about it. I don't remember if I told anyone. I didn't know what to do. I didn't have anything to give him."

In a follow up interview on at 11:13 a.m., the Administrator said: "Staff A never came and told me anything after the issue related to resident#1's transfer. I didn't know something was missing. The hospital called me and complained they didn't have information included in the packet. I don't know what to say. What happened was very unusual. We always have nursing coverage. I know we didn't follow our policy. There is nothing I can say. It is a problem. I will make sure we will fix it right away. When they called me I think one of the nurses sent the information right away, but I don't remember who the nurse was who sent that out. It was so long ago."

Per facility's Procedure, staff are to receive in-service in providing information on transfer documentation and location of transfer form. The Administrator was asked on at 11:16 a.m. if the staff was in-serviced regarding the transfer. The Administrator said : "I am not going to lie to you, no I don't have an in-service. I know when they first get hired they get in-serviced on , and orientation and so many other training's, but no I don't have an in-service." She provided an in-service log which did not include in-service

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A 162	Continued From page 7 in providing information on transfer documentation. On at 11:20 a.m., a telephone interview was conducted with Staff B the overnight practical nurse responsible for putting the emergency packet together. She said: "What I put in the packet is: Transfer form, sheet, insurance card, when applicable, living will or POA. If there is a status changes they will give me the copy. At the time they go out, usually a nurse will make copy of the medication list. If there is no nurse, they will call and notify me. Whoever comes in will send it in right away. I was not here the night it happened but I follow our policy and send everything out. I print the medication list right before they leave since medications change all the time. No we don't give the 1823. Its not part of the packet and it is not in our policy." Reviewed randomly selected prepared emergency packets for Residents #2, #3, #4, #5, #6, #7, #8. All packets included transfer form, sheet, insurance information and living will or Durable power of attorney. Only resident #5's packet included a acknowledgement form. Only resident #6, #7, #8 emergency transfer packet included an actual form. None of the records included resident's medication list, diagnosis, treatment, or list of critical medications. On at 11:23 a.m., the Administrator said the staff had a red binder and there is a separate tab for each resident. He first item under each resident name is a form. If there is no form resident is a full code. Class III	A 162		