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 |
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| | AL11911741 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ARBOR GLEN ARBOR TRACE | 1000 ARBOR LAKE DRIVE NAPLES, FL 34110 |

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| A 000 | Initial Comments<br><br>This is an unannounced Complaint Survey CCR# 2012010537 conducted on [redacted] at Arbor Glen Arbor Trace, an Assisted Living Facility, with a census of 26 residents, 9 of which receiving ECC services.<br><br>The complaint contained four allegations of which all were substantiated and cited at A025, A030 and A054. | A 000 | | |
| A 025 | 58A-5.0182(1) FAC Resident Care - Supervision<br><br>An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility.<br>(1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following:<br>(a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C.<br>(b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual.<br>(c) General awareness of the resident ' s whereabouts. The resident may travel independently in the community.<br>(d) Contacting the resident ' s health care provider and other appropriate party such as the resident ' s family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.<br>(e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which | A 025 | | |

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| A 025 | Continued From page 1 | A 025 | | |

resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.

This Statute or Rule is not met as evidenced by:
Based on record review, observation, and interview the facility failed to ensure that residents received appropriate supervision during the administration of medications for 2 (Residents #1 and #2) of 2 residents sampled; and for residents requiring total assistance with eating.

The findings include:

1. Interview of Resident #1, on 11/1 : 11:00 a.m. revealed that medications were left in the resident's room, the resident's request. The resident stated, "I always take my medications when they leave them here. I am not always ready to take them when they come (to give them to me)."

Interview with Staff B on 11/1 : 11:30 a.m. revealed that medications were left in the room Resident #1 at the resident's request. Staff A stated the resident is very insistent that she wants the medication(s) left there and "she (the resident) is alert and oriented. I only do that if residents are alert and oriented."

2. Interview on 11/1 : 3:30 p.m., Resident #2 stated, "Yes" when asked if medications were left, by the nurse, to be taken at a later time. The resident continued to state "Not all the time, but sometimes I am doing something else and cannot take them."

3. Interview at 2:00 p.m. on 11/1 C

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| A 025 | Continued From page 2<br><br>stated "We all leave medications with Resident (#1) and do not watch her and some other residents who say "go away, I will take them. We also leave medications at the table in the dining residents who are and take them in their food."<br><br>4. Interview of Staff E at 5:00 p.m. on revealed that Staff D left medications in the of residents who were alert and oriented. Staff D stated, "I know this is not best practice, but I leave the medications because the resident(s) wants to take it at a later time." Staff D acknowledged that (a agent) was left in the Resident #1 on a routine basis on the evening shift, at approximately 10:00 p.m. When asked how it could be ensured that the resident took the medication as prescribed by the physician (relating to time), Staff D stated, "I did not consider that." In addition, Staff D acknowledged it was not a safe practice to leave this type of medication, or any medication, with a resident that required administration of medication per physician orders.<br><br>When asked if medications were ever given to Certified Nursing Assistants (CNA) to give to residents, Staff D stated, "Yes, at mealtime. The medications are mixed with food and the CNA feeds it to the resident." When asked why this was done, Staff D stated, "I know it is not best practice, but the residents need to be fed; and it takes them a long time to eat and take the medication."<br><br>4. Review of the facility policy and procedure entitled "9 Medications, Administration of Medications" (with no date) revealed "Policy: At no time will medication be administered to the | A 025 | | |

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| A 025 | Continued From page 3<br>resident at Arbor Glen at Arbor Trace by anyone other than a Licensed Nurse..." and "Procedure: In administering medication, the staff nurse will be responsible for the following: 3) Observing the resident taking the medication and utilizing the proper route."<br><br>Class III<br>Correction Date: | A 025 | | |
| A 030 | 58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures<br><br>(6) RESIDENT RIGHTS AND FACILITY PROCEDURES.<br>(a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C.<br>(b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.<br>(c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456. | A 030 | | |

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| A 030 | Continued From page 4<br>(d) The statewide toll-free telephone number of the Florida Hotline " 1(800)96 or 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents.<br>(e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility ' s policies with respect to such issues, for example, as resident responsibilities, the facility ' s and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements.<br>(f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law.<br>(g) The facility shall provide residents with convenient access to a telephone to facilitate the resident ' s right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility shall not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there shall be, at a minimum, an accessible telephone on each floor of each building where residents reside.<br>(h) Pursuant to Section 429.41, F.S., the use of physical shall be limited to half-bed rails, and only upon the written order of the resident ' s physician, who shall review the order | A 030 | | |

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biannually, and the consent of the resident or the resident ' s representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical

429.28 Resident bill of rights.-
(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
(a) Live in a safe and decent living environment, free from and neglect.
(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.
(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.
(e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident ' s

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representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a [illegible] his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Access to adequate and appropriate health care consistent with established and recognized standards within the community.
(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally [illegible], the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without [illegible], interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the

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residents ' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

This Statute or Rule is not met as evidenced by:
Based on record review, observation, and interview the facility failed to ensure that an appropriate Medication Administration policy and procedure was developed, implemented, and evaluated.

The findings include:

On : between the 8:00 a.m. and 5:45 p.m. the following was identified:

1. Interview of Staff A, Staff B, Staff D and Staff E revealed that medications were:
- pre-poured and pre-signed, indicating administration of medications prior to them being given.
- not supervised, during administration, to assure that they were taken by oriented and residents.
- not appropriately secured at all times.

2. Interview of Staff C revealed that the facility medication administration procedure was different from the ways things were done at other places of employment and involved pre-pouring and pre-signing of medications.

3. Interview of Residents #1 and #2 revealed that medications were left in their : at their request and not taken under the supervision of

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qualified staff.

3. Review of the Medication Administration Records (MAR) for Residents #3, #4, #5, #6, #7, #8, #9, #10, #11 and #12, at 8:15 a.m. on [redacted], revealed that 9:00 a.m. were initialed to indicate the medications had been administered.

Observation of medication administration, by Staff A and Staff B revealed that these pre-signed medications were pre-poured into souffle cups and administered in the dining [redacted]. Residents #3, #4, #5, #6, #7, and #8 and administered in the resident's [redacted]. Residents #9, #10, #11 and #12 between 8:25 a.m. through 9:10 a.m.

4. Review of the physician orders for Residents #1 and #2 revealed that the resident's required administration of medications.

Interview of the Director of Nursing revealed that all residents, in the facility, had physicians orders for administration of medications.

5. Review of the facility policy and procedure entitled "Administration of Medications" (page 17 - not dated) revealed no procedure for:
- pre-pouring medications to include the labeling of souffle cups with a resident's name/initial.
- administering medications using a basket containing multiple "resident labeled" souffle cups and how to deal with medication spillage (out of a souffle cup) into the basket.
- updating the Medication Administration Record (MAR) "after" administration of a medication.
- securing medications at all times to include not leaving medications in the resident [redacted] in the dining [redacted]; and a procedure for reporting missing/found medications.

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| | Class III<br>Correction Date: | | | |
| A 054 | 58A-5.0185(5) FAC Medication - Records | A 054 | | |
| | (5) MEDICATION RECORDS.<br>(a) For residents who use a pill organizer managed under subsection (2), the facility shall keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider ' s name, the resident ' s name, the date dispensed, the name and strength of the drug, and the directions for use.<br>(b) The facility shall maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications or medication administration. A MOR must include the name of the resident and any known the resident may have; the name of the resident ' s health care provider, the health care provider ' s telephone number; the name, strength, and directions for use of each medication; and a chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The MOR must be immediately updated each time the medication is offered or administered.<br>(c) For medications which serve as chemical , the facility shall, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician ' s annual evaluation of the use of the medication.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review, observation and interview the facility failed to ensure that | | | |

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medication records were not pre-signed by staff and that documentation of medication was completed when medications were given for 10 (Residents #3, #4, #5, #6, #7, #8, #9, #10, #11, and #12) of 10 sampled residents.

The findings include:

1. Review of the Medication Administration Record (MAR), on at 8:15 a.m., for Residents #3, #4, #5, #6, #7, #8, #9, #10, #11, and #12 revealed that their MAR was signed to indicate that their 9:00 a.m. medications were administered. The Director of Nursing (DON), who was present at this time, was asked for a copy of the facility policy for Administration of Medications. The DON stated, "These nurses have been here for many years and know what they are doing." The DON also stated that all residents, in the facility, have orders for administration of medications; and that no resident was receiving assistance with self administration of medications.

Staff A, assigned to administer medications to the residents, was observed carrying a white plastic basket containing 10 souffle cups containing pills and capsules. Each souffle cup had a resident name written on it.

Upon interview at this time, Staff A stated that this is the standard procedure used to administer medications to residents. Staff A also acknowledged that the medications in the basket were scheduled for 9:00 a.m. and were signed as administered on each resident's MAR. Staff A was then observed administering the medications, contained in the white plastic basket, to Residents #3, #4, #5, #6, and #7 who were eating breakfast in the dining

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8:25 a.m. and 8:45 a.m. this date.

Staff A was observed holding the white basket under her left arm between her elbow and arm pit. During the procedure, one of the pills was observed to l out of a souffle cup into the basket. Staff A was observed picking the pill up with a plastic spoon and placing it in one of the 9 souffle cups remaining in the basket. When asked how she knew what cup to put it in, Staff A stated, "I know what pills the residents get."

2. Staff B was observed administering medications, scheduled to be given at 9:00 a.m., to Residents #8, #9, and #10 between 8:50 a.m. and 9:10 a.m. on . Prior to administration of the medications, Staff B acknowledged that the MAR was signed to indicate that the medications had already been given.

3. During an interview at 2:30 p.m. on , Staff C stated, "I pour medications after report in the mornings, it takes 30 minutes. Each souffle cup is individually marked wit each resident's initial. I sign the MAR when I am pouring the medications. It takes another 30-45 minutes to give the medications to the residents." Staff C also stated, at this time, that she heard about a nurse misplacing a basket of medications on the evening shift. The nurse went into the dining . . . . . make coffee and left the basket of pills in there. Someone found the basket and brought it back to the nurse.

4. Upon interview on . . . . . at 4:30 p.m., Staff E stated that within the past 30 days a white basket was misplaced and could not be found during Staff E's evening shift. Staff E stated, "I left the facility without finding the basket and it

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| A 054 | Continued From page 12<br><br>was found in the dining on a high shelf, on the night shift. They called me at home." When asked if it was possible that there were medications in the basket that were pre-signed as given, and not administered; Staff E stated, "I'm not sure if there were any (medications) left in the basket." Staff E acknowledged, at this time, that medications are signed on the MAR, as given, when they are placed in a souffle cup in the white basket; not after they are administered.<br><br>4. The facility policy and procedure entitled "9 Medications, Procedural Guidelines: Medication/Treatment Record Keeping" (no date) states: "The facility maintains Medication Administration Records (MARs) to track medication administration. The MAR is immediately updated each time medication/treatment is administered to Resident with the administering nurse verifying such by initialing the MAR."<br><br>Class III<br>Correction Date: | A 054 | | |

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

*Better Health Care for all Floridians*

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Arbor Glen Arbor Trace
1000 Arbor Lake Drive
Naples, Florida 34110

Dear Administrator:

Re: CCR #2012010537

This letter reports the findings of a complaint survey that was conducted on , 2012 by representative(s) of this office.

Attached is the provider's copy of the State (3020) 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 , 2012 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(s). Should you have any questions please call this office at 239-335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

HW:ss
Enclosure: State Form
XG90

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