

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11942925	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIDDEN OAKS OF FORT MYERS			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 HIDDEN TREE LANE FORT MYERS, FL 33901		
(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 These are the results of Complaint survey CCR #2012012620 conducted on _____ through _____ at Hidden Oaks of Fort Myers, an Assisted Living Facility. The complaint contained three allegations, one of which was confirmed.		A 000		
A 030	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (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. (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. (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. (d) The statewide toll-free telephone number of		A 030		

AHCA Form 3020-0001

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

0099

U35G11

If continuation sheet 1 of 9

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11942925	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIDDEN OAKS OF FORT MYERS			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 HIDDEN TREE LANE FORT MYERS, FL 33901		
(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 030	Continued From page 1 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. (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. (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. (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. (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 biannually, and the consent of the resident or the	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11942925	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIDDEN OAKS OF FORT MYERS		STREET ADDRESS, CITY, STATE, ZIP CODE 3625 HIDDEN TREE LANE FORT MYERS, FL 33901		
(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 030	Continued From page 2 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 representative, designee, surrogate, guardian, or	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11942925	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIDDEN OAKS OF FORT MYERS		STREET ADDRESS, CITY, STATE, ZIP CODE 3625 HIDDEN TREE LANE FORT MYERS, FL 33901			
(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 030	Continued From page 3 attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a _____ 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 _____, 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 _____, interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11942925	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIDDEN OAKS OF FORT MYERS		STREET ADDRESS, CITY, STATE, ZIP CODE 3625 HIDDEN TREE LANE FORT MYERS, FL 33901			
(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)	
A 030	Continued From page 4 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 and interview, the facility failed to respect the resident rights for 2 of 3 residents reviewed by becoming Representative Payee without authorization for (Resident #9) and deducting money from the personal needs account without written consent for (Resident #6). The findings include: 1. A review of Resident #9's facility records revealed Resident #9 was admitted to the facility on _____. Further review of the record revealed a letter (dated _____ from the facility to the Social Security Administration (SSA) requesting to be the Representative Payee for Resident #9. The letter reads, "I request that the Social Security Benefits for [Resident #9] be paid to [the facility] as representative payee. [Resident #9] needs a payee because she has a mental _____. I would be the payee for [Resident #9] because I take care of her. I will know about [Resident #9's] needs because she is cared for by our organization." "[Resident #9] has no relatives or close friends who live with or are interested in being her representative payee." The record contained an undated letter from the SSA which granted the facility the opportunity to serve as representative payee for Resident #9's Social Security benefits. An additional letter from the SSA to the facility was discovered in Resident #9's records. The letter _____ the SSA's		A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11942925	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIDDEN OAKS OF FORT MYERS			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 HIDDEN TREE LANE FORT MYERS, FL 33901		
(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 030	Continued From page 5 decision to have the facility serve as Representative Payee for Resident #9. The letter states, "We have decided that it would be best for [Resident #9] to have her checks sent to her." On at 5:50 p.m. an interview was conducted with the facility's Business Office Manager (BOM). The BOM stated, "The facility did serve as Representative Payee for Resident #9 for about a month." She stated, "That's because we did it [became representative payee] and immediately after she called Social Security and told them she didn't want it [the facility to be her representative payee] and then she moved out." The BOM stated she received authorization from the administrator to send a request to the SSA to request permission to act as Resident #9's Representative Payee. The BOM declined to answer if she had consent from Resident #9 to do so. On at approximately 6:00 p.m. the administrator was interviewed. He stated, "What was happening is that we were warned that if we weren't [representative] payee for her [Resident #9] we would never get our money back." He continued by saying, "The day of admission we talked about it, that day. I explained it to her and I said, 'Since I heard you have problems paying your bill. The only way we can do this is if we [the facility] were going to be [representative] payee.'" The administrator denied having written consent to become Resident's #9's representative payee. at 2:52 p.m., Resident #9 was interviewed. Resident #9 denied giving the facility written or verbal consent to become her representative payee. She stated the facility became her representative payee with her knowledge. She stated that she became aware	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11942925	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIDDEN OAKS OF FORT MYERS			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 HIDDEN TREE LANE FORT MYERS, FL 33901		
(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 030	Continued From page 6 of the facility's action when she received a letter from the SSA stating the change had taken place. 2. A review of Resident #6's facility records revealed a signed contract (dated _____ for Resident #6 to pay the facility \$943.00 per month in exchange for _____ board, meals, and assistance with Activities for Daily Living at the facility. Further review of Resident #6's record revealed a letter from the facility to the Social Security Administration (SSA) (dated _____ requesting to be the representative payee for Resident #6. The SSA stated the facility will receive \$997.00 a month for Resident #6. This covers the \$943.00 Resident #6 agreed to pay the facility and leaves \$54 for personal funds per month to be deposited in the resident's Resident Trust Account (RTA). A review of Resident #6's RTA account ledger revealed Resident #6's received \$54.00 for her personal funds from 01/01 _____ ledger reflects only \$34.00 of personal funds being deposited per month in the resident's RTA between the 08/03 _____ 12/11, _____ total difference of \$100.00 (\$20.00 a month). On 01/07 _____ 5:50 p.m. the Business Office Manager (BOM) was interviewed. The BOM stated, "That's because [Resident #6] borrowed money one month and that's the only way we can get it back is to take it out of her trust." She reports the facility takes \$20.00 per month out of the resident's RTA account. The BOM continued by saying, "Her daughter borrowed money on her behalf and they were supposed to pay it back and they never paid us back so [the administrator] told me to take \$20 a month until we get it."	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11942925	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIDDEN OAKS OF FORT MYERS			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 HIDDEN TREE LANE FORT MYERS, FL 33901		
(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 030	Continued From page 7 An interview was conducted with the administrator on [redacted] at approximately 6:00 p.m. He admitted the facility allowed Resident #6 to use a portion of her Social Security (The portion which would normally cover [Resident #6's rent] check to give to her daughter. The administrator stated, "And [Resident #6's daughter] was paying it back in small increment because it was no way that [Resident #6] could come up with the full amount of money there is just no way. [Resident #6] is on a fixed income." Resident #6 was interviewed on [redacted] at 6:25 p.m. She explained the facility allowed her to give her daughter money in lieu of her paying one month's rent. Resident #6 states she understood this to be a gift. She stated, "I understood that it was going to be no money owed." Resident #6 went on to say that she did not authorize the facility to take \$20.00 a month out of her RTA. She commented that she could use some money. Resident #6 stated, "I don't want to get them in trouble, but it's [not have money in her account] hurting me a lot." On [redacted] at approximately 6:30 p.m. the administrator was re-interviewed. He maintained the money was a loan and stated, "On [Resident #6's daughter] borrowed the money. We didn't start taking the \$20.00 out until [redacted] (9 months later) and it [the amount of money dispersed] was \$600.00." On [redacted] at 10:18 a.m., an interview was conducted with the Resident #6's daughter. Resident #6's daughter described she was in a financial bind and decided to remove her mother from the facility back into her home, but the facility agreed to let her mother have one month free which allowed Resident #6 to use her social	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11942925	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HIDDEN OAKS OF FORT MYERS			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 HIDDEN TREE LANE FORT MYERS, FL 33901		
(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 030	Continued From page 8 security and give it to her daughter. She stated, "It was a gift between him and me and the women that works there that wrote the check. I would have just taken my mother out of the facility." Resident #6's daughter went on to explain that she went without any issues or discussion of repayment, until approximately 6 months later when Resident #6 decided she did not want to live at that facility anymore. She states at that time the facility decided they wanted to be repaid. Resident #6's daughter stated, "If it was a loan then a contract would have been written there was nothing, it was a gift." Class II	A 030			



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

. 2013

Administrator
Hidden Oaks of Fort Myers
3625 Hidden Tree Lane
Fort Myers, Florida 33901

Dear Administrator:

Re: CCR #2012012620

This letter reports the findings of a complaint survey that was conducted on . 2013 by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency 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 . 2013 to verify that the necessary corrections are in place to correct the deficiency 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

HW:ss

Enclosure: State Form

