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
	AL11932588	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALUSA HARBOUR	2525 E. FIRST STREET 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	{A 000}		

This is to report the results of an unannounced revisit Change of Ownership (CHOW) and Limited Nursing Service (LNS) survey conducted on for Calusa Harbour, an Assisted Living Facility (ALF) in Fort Myers Florida. The census on the day of the survey was 128 residents.

The prior citations from the original survey were cleared but a new deficiency was cited during this survey.

A 054	58A-5.0185(5) FAC Medication - Records	A 054		

(5) MEDICATION RECORDS.
(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.
(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.
(c) For medications which serve as chemical

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A 054	Continued From page 1	A 054		

, 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.

This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to insure complete and accurate documentation on the MOR (Medication Observation Record) for 3 (Residents #2, #3 and #4) of 4 residents reviewed.

The findings include:

1. Record review on , revealed there were 8 days on the MOR where it was not documented that Resident #2 received his scheduled dose of 0.4 mg dating from through

In an interview with Staff G and the Health Care Coordinator on , at 9:30 a.m., they verified the lack of documentation on the MOR that 0.4 mg was given to Resident #2 on the stated dates.

2. On Resident #3 presented at medication station with pain. Staff E stated to surveyor that the residenst already received her morning medications. She stated to surveyor she was going to give Resident #3 for pain.

Observation on at 10:09 a.m. revealed Staff E did not ask the resident how much pain she was having.

There was a pain scale on back of MOR that was not used by Staff E. After surveyor intervention, Staff E asked the resident how much pain she was in "From 1 to 5, or 5 to 10." Resident #3

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A 054	Continued From page 2	A 054		

stated her pain was a 5. Staff E was asked by the surveyor which medication she was going to give. Staff E stated the resident always asks for the Tramodol. Surveyor requested Staff E to ask resident which medication she wanted for pain. Resident #2 stated, "I don't know, give me whatever you think is best."

Staff G was called, she arrived and asked resident what her pain level was from 1 to 10. The resident responded that it is now around a 7. Then Staff E gave the resident Tramodol .. .. 50 mg, 1 tablet, po.

Staff G verified that the order written on the MOR does not have parameters for what medicaton to give for what pain level. Surveyor asked Staff G and Staff E to check instructions for administration on the medication card. They verified the order on the medication card was to give Tramodol .. .. 50 mg 1 tablet by mouth four times daily. Staff G checked the other Tramodol medication cards for Resident #3 in the medication drawer. The other medication cards dated , and all had directions to take 1 tab by mouth every 6 hours as needed.

Staff G stated that the medication card being used is probably from an old order when the resident was out of the facility. Staff G verified that the currently used medication card should have a change of order sticker on it alerting the staff to the order on the MOR.

3. Review of resident record for Resident #4 on .. .. .. revealed Resident #4 has an MD order for Capropril 25 mg take 1 tab 3 times a day, Hold for SBP<=100.

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A 054	Continued From page 3 No documentation of were found on the MOR of Resident #4 on 2nd at 9:00 a.m. and 1:00 p.m., 3rd at 9:00 a.m. and 1:00 p.m., 4th at 5:00 p.m., 9th at 1:00 p.m. and 10th at 1:00 p.m. Missing documentation on the MOR of for Resident #4 was verified by Facility Health Care Coordinator during an interview on at 11:00 a.m. Class III	A 054		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11932588	A. Building B. Wing	2/14/2013

Name of Facility

CALUSA HARBOUR

Street Address, City, State, Zip Code

2525 E. FIRST STREET
FORT MYERS, FL 33901

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix A0008 Reg. # 58A-5.0181(2) FAC LSC		ID Prefix A0052 Reg. # 58A-5.0185(3) FAC LSC		ID Prefix A0092 Reg. # 58A-5.020(1) FAC LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	Dadway, HFES	2-27-13	Dadway for: Cynthia Brandt, RNS	2-27-13
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:

12/20

Check for any Uncorrected Deficiencies. Was a Summary of Deficiencies (CMS-2567) Sent to the Facility? YES NO

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Calusa Harbour
2525 E. First Street
Fort Myers, FL 33901

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2013by a representative of this office.

Enclosed is the provider's copy of the Statement of Deficiencies and Plan of Correction (State Form 3020), which references the uncorrected deficiencies and/or new deficiencies, identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2013.**

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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Enclosures: State Form and Revisit Report

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Fort Myers Field Office
2295 Victoria Avenue, Room 340
Fort Myers, FL 33901
Phone (239) 335-1315; Fax (239) 338-2372