Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964447	A. BUILDING: _____ B. WING _____	03/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDERMAN OAKS RETIREMENT CENTE	727 HUDSON AVENUE SARASOTA, FL 34236

(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 Biennial survey was conducted from through at Alderman Oaks an Assisted Living Facility (ALF) In Sarasota, FL. State deficiencies were identified as a result of this survey.	A 000	Preparation and /or execution of this plan of correction does not constitute admission or agreement of the provider of preparation and/ or execution of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is filed as evidence of the facility's desire to comply with the requirements of state and federal law, and to continue to provide high quality resident care. Nothing herein shall be deemed to waive any right of the facility to contest the allegations set forth in the statement of deficiency.	
A 010	58A-5.0181(4) FAC Admissions - Continued Residency (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (e) of this subsection, criteria for continued residency in any licensed facility shall be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a face-to-face medical examination by a licensed health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 58A-5.0131, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule. The form must be completed in accordance with that paragraph. After the effective date of this rule, providers shall have up to 12 months to comply with this requirement. (a) The resident may be bedridden for up to 7 consecutive days. (b) A resident requiring care of a pressure may be retained provided that: 1. The facility has a LNS license and services are provided pursuant to a plan of care issued by a licensed health care provider, or the resident contracts directly with a licensed home health agency or a nurse to provide care; 2. The condition is documented in the resident ' s record; and	A 010		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMIN STRATOR — (X6) DATE

STATE FORM 4696 UPY411 If continuation sheet 1 of 79

Darin B. Shipley
Executive Director

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A 010	Continued From page 1	A 010		

3. If the resident ' s condition fails to improve within 30 days, as documented by a licensed health care provider, the resident shall be discharged from the facility.
(c) A ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:
1. The resident qualifies for, is admitted to, and consents to the services of a licensed hospice which coordinates and ensures the provision of any additional care and services that may be needed;
2. Continued residency is agreeable to the resident and the facility;
3. An interdisciplinary care plan is developed and implemented by a licensed hospice in consultation with the facility. Facility staff may provide any nursing service permitted under the facility ' s license and total help with the activities of daily living; and
4. Documentation of the requirements of this paragraph is maintained in the resident ' s file
(d) The administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility.
(e) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C.
(5) DISCHARGE. If the resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident ' s needs, as determined by the facility administrator or licensed health care provider, the resident shall be discharged in accordance with Section 429.28(1), F.S.

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A 010	Continued From page 2 This Statute or Rule is not met as evidenced by: Based on record review, interview and observation, the facility failed to ensure appropriateness of continued residency for 3 (Residents #1, #3, and #7) of 11 residents reviewed resulting in the hospitalization of 1 (Resident #3) resident and the continued potential for injury for 3 (Residents #1, #3, and #7) residents. The findings include: 1. Resident #3 is a female who moved into the facility on . The resident is an dependent that required injections of Lantus twice daily to manage her . Review of the observation log notes on the Licensed Practitioner Nurse (LPN) working for the facility at the time noted, "Resident arrived at 1PM with husband to community. Resident alert with at all times." During an interview with the Administrator of the facility on at 11:00 a.m., he was asked how he evaluates residents for continued residency in the facility. He stated, "I rely on the 1823 and what the medical doctor tells me." Review of the 1823 dated for Resident #3 shows the medical doctor stated the resident needed administration of medications. The resident received Lantus 36 units in the AM and 20 units in the PM according to the 1823. The Medication Administration Record (MAR) shows Lantus being given by unlicensed staff at 8:00 a.m. and 8:00 p.m. daily starting on	A 010	Tag A 010 CORRECTIVE ACTION Alderman Oaks is now using a Health Assessment form in conjunction with the 1823 form to assure compliance with 58A-5.0181 (4) FAC Admissions – Continued Residency. We have begun at our expense to contract a RN or LPN to conduct face to face evaluations using our new form of new potential residents as to compliance with 58A – 5.0181 (4). A nurse evaluation using our new form and an 1823 form are being used for evaluating residents returning from Rehab Centers, and existing residents who have had significant changes in health. The Administrator will make the final determination of eligibility after reviewing the nurse evaluation, and form 1823 which we always endeavor to have completed before admission and re-admission.	4/30/13

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A 010	Continued From page 3 Review of the observation record shows unlicensed staff contacting a medical doctor with concerns no were being done for the resident. On a CNA noted, "Staff communicated to Dr. XX as to whether he wished resident to perform glucose level) as she is on and 2 medications. As of PM no response." Review of the medical record showed a Fax sheet dated . It is addressed to a Physician's Assistant and reads, "We need an updated 1823 for Resident #3. Our files show her old doctor checked the box "Needs Medication Administration." We assist Resident #3 with self administraion." On the bottom of the fax is written, "This is important as medication administration is skilled nursing." The fax has the name of a Certified Nursing Assistant (CNA) on staff listed as a contact person. The resident had an 1823 dated filled out by the PA. The form shows the resident can have assistance with self administrationof medications. An interview was conducted with the PA by phone on at 3:00 p.m. He stated he felt medication assistance was assisting with and assisting the resident with their pens. He was not aware the facility did not have a nurse on staff to assist the resident with her He stated, "We never heard anything from them (the ALF) so we assumed they were able to provide the care." By reviewing the facilities documentation of administration and the MAR, on the first obtained on the resident in the facility her sugar was below normal. On an observation note reads, "Sugar 52 in AM apple sauce with banana. Ordered breakfast tray for	A 010	We will have a finalized version of our evaluation form completed by 30. We have already started using nurses for those face to face evaluations described above. All 1823's of existing residents are less than a year old, and nurse assessments are underway for all current assisted living residents. These assessments will be completed by a nurse for all residents before 19, 2013. The administrator currently believes that all residents meet the requirement.	

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A 010	Continued From page 4 am need to eat feels by lunch. 5 PM staff assisted her to dinner." There is no documentation as to who wrote the note in the log. The note, by its content and style of writing, shows an untrained person wrote it. Review of the facility's documentation of administration shows the resident received 36 units of Lantus with a sugar of 52. There is no documentation the was held or the medical doctor was notified before giving this resident On an observation note written by an LPN on staff with the facility at that time reads, sugar 48 at PM. Orange juice and banana given to increase sugar level. 5:20 PM sugar 98... Staff re-educated to monitor all resident's meals closely to prevent event. Staff understood teachings." There is no documentation the resident's medical doctor was ever notified. The MAR shows the resident received 20 units of Lantus at 8:00 p.m. on the night of There is no documentation a sugar was obtained before administering the medication. An accepted nursing standard of practice would be to obtain a sugar before administering that amount of to a resident with known An interview was conducted with the Administrator on at 11:00 a.m. He stated there had been a LPN working at the facility as a supervisor of healthcare. According to the Administrator there has not been a nurse on staff at the facility for 2 to 3 months. During an interview with Staff B at 10:45 a.m. on she stated the LPN had not worked at the facility since of 2012.	A 010		

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A 010	Continued From page 5 On . . . . Staff B documents in the observation record, "Resident seen by psych nursing. Nurse advised that resident's . . . . are probably due to . . . . . and that her . . . is caused by low . . . . Review of the facilities documentation of . . . . . administration forms shows the resident had a . . . . glucose level of 56 on . . . . The form shows she was given orange juice. There is no documentation of the low . . . . sugar in the observation record. An interview was conducted with Staff B on . . . . at 10:00 a.m.; she stated she was the one who obtained the resident's . . . . . glucose that morning. She stated she did not recheck the . . . . . or notify the medical doctor before giving the resident 36 units of Lantus. On . . . . the unsigned observation note for the 7-3 shift reads, "Psych nurse was advised of resident's episodes of . . . . . staff to encourage fluids." On 2/2/13 the observation note reads, "(7-3) Resident complained of loose stools. Resident did not eat breakfast/lunch Resident's . . . . sugar 58. Staff educated resident to drink fluids." On . . . . the observation note reads, "(3-11) Resident . . . . . sugar remains at 58... Resident refuses to eat/drink. Resident very . . . . Sent resident out to Sarasota Memorial Hospital per PA." The facility's documentation of . . . . . administration shows the resident was given 36 units of Lantus on . . . . with a . . . . . sugar of 58. The resident had not eaten breakfast and	A 010		

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A 010	Continued From page 6 had The resident was hospitalized at 4:54 p.m. on and spent the night in the hospital with An interview was conducted with Resident #3 at 11:00 a.m. on She was asked how much she takes everyday. She stated, I take 33 units in the morning and 20 units at night. She was asked if she remembered going to the hospital in She stated she did not remember. She was asked what happened in the morning when you get your She stated the staff takes my sugar and they dial in the and I inject it. She was asked if she had a low sugar who would make the decision not to take She stated, "The nurses I guess." She was asked if the staff tell her what her sugar is when they take it in the morning and night. She stated, "They don't tell me what my sugar is. They give me the and I inject what they give me." The medical doctor who treated the resident on is the same medical doctor who signed her 1823 assessment on stating the resident needed her medications administered (by skilled staff). The medical doctor's note on discharge from the hospital reads, "At the time of emergency transport her sugar was 55 and she was given a half amp of D50. On arrival in the emergency after some evaluation her sugar was noted to be 68.... Given her I recommend that she have medication assistance at the ALF....Given the relative danger of versus I recommend we decrease Lantus to 10 units every 12 hours and monitor."	A 010		

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A 010	Continued From page 7 An interview was conducted with the Medical Doctor via telephone on at 1:15 p.m. He stated he would want the facility to call him for a sugar of 40 or below. He stated he want the resident to eat food if the sugar was below 60 before she had her Lantus Injection. He stated his major concern was he thought because of the residents declining mental status and eyesight she could no longer administer her own medication. He stated, "I told the social worker at Sarasota Memorial Hospital twice she (Resident #3) could not self administer her own medications." The doctor was told of the situation of a medication technician giving 36 units of Lantus to the resident when her sugar was 58 with the resident not having eaten. He stated, "That is an issue." An interview was conducted with the ALF Administrator on at 1:30 p.m. He was told of the concern for the resident being hospitalized due to hypoglycemia and the continued safety of the resident being in the facility. He stated he was not aware of the issue of medication technicians giving to the residents. He was not aware of Resident #3 being sent to the hospital with on He stated he felt as long as the residents were able to give themselves the injection it was ok. He stated his understanding was staff could dial in the for the residents with pens. On at 11:00 a.m., an interview was conducted with the Home Health Registered Nurse (RN) hired by the facility to evaluate the resident. She stated the resident is not appropriate for the ALF. She stated the resident is not able to care for her She stated she had interviewed all the staff in the facility and none of them knew their limitations and roles with	A 010		

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A 010	Continued From page 8 regard to 2. Resident #1 is a male who moved into the facility on . On admission to the facility the resident had an order for sliding scale coverage with . He was to have coverage before meals and at the hour of sleep. Review of the resident's 1823 assessment shows he has a and he is forgetful. According to the 1823, dated the resident needs assistance with medications. Review of the resident's initial 1823 dated shows no documentation as to whether the resident needs assistance or needs administration of medications. During the initial interview with the resident on 3/7/13 at 11:12 a.m., the resident was observed to be slow. He did not seem capable of understanding his use. He was asked how he received his . He stated, "They put the number of units I need into the flex pen and I give myself the shot. They want to make sure I get the right dose. That's why they do that. I get my sugar checked 4 times daily." At 11:50 a.m., the resident was observed receiving his and coverage. Staff D, an unlicensed staff member, was observed taking the resident's glucometer and holding it to the resident's finger and obtain a reading of 115 after the third attempt. She was observed handing the pen to the resident. The resident was observed not to be able to dial in his one unit dose of coverage. The aide then pulled the pen close to her side and clicked the dial to one unit and handed it to the resident. The resident was observed to inject himself with	A 010		

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A 010	Continued From page 9 the dosage given by the aide. An interview was conducted with Staff D on [redacted] at 10:00 a.m. She verified she had obtained the resident glucose and that she had dialed in the [redacted] dosage to the pen. She stated she sometimes had to do that for the resident. In interviews with staff and the Administrator there had not been a nurse on staff at the facility since [redacted] of 2012. It is clear from observation, record review and interview the resident had not been able to self-administer his own [redacted] for some time before that date. 3. Observation of Resident #7 on [redacted] at 9:45 a.m., revealed the resident in her [redacted] in a wheelchair. A full leg brace from the top of the resident's left thigh down to the bottom of her left leg was in place. During this observation, the resident was asked if she puts the leg brace on by herself or if she receives assistance. She stated, "They help me put my brace on my left leg." She referred to "They" as the CNA's at the ALF. She stated, "We don't have a registered nurse here. My leg brace goes on some mornings early when I go to breakfast but otherwise, it's a busy [redacted] there's a lot of people around. I wear my brace in the morning...I wear the brace most of the day." When asked how she removes the brace, she stated, "One of the same people who is on duty that hour (in the evening) removes my brace for me. They also put my stockings on. These are the white elastic ones (pointing). The same people who help with the brace help with my stockings." Observation on [redacted] at 11:48 a.m., revealed	A 010		

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A 010	Continued From page 10 the resident wheeling herself out toward the dining . A CNA bent down next to her and adjusted the strap on her left leg brace. During an interview on at 1:33 p.m., with the same CNA observed adjusting the strap on the resident's left leg brace, she stated, "I'm not sure if I can help her, it would be good to know but I put it on, make sure it fits right, there are two spots near her knee (as indicators for aligning the brace). She has a diagram booklet that she got when she was in rehab that I use. And then she fastens it. I help her with her D's (elastic stockings) too." The CNA explained the resident went out to ER (Emergency for and While she was there it was determined that she needed to go to rehab. The CNA stated, "While she was there, I guess they found a crack or in her knee. She (Resident #7) followed up with the doctor who determined she needed a brace." Review on of Resident #7's demographic information sheet documented the resident was originally admitted to the facility on A review of the most recent 1823 Health Assessment signed by the physician for the date of documents the resident with , previous left total knee replacement and with left knee strain. Under the "Physical or sensory limitations section" of this assessment, the resident is to wear a "Brace" to left leg when out of bed. Her level of assistance required for	A 010		

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A 010	Continued From page 11 ambulation was not assessed; the section was left blank. The section of the assessment requesting the level of assistance the resident requires with medication was checked under "Needs medication administration." There is no physician's orders for the application or removal of the elastic stockings. Review of the "Resident Observation Log" completed by the facility staff dated documented the resident "Wasn't feeling well. was seen by an RN that happened to be on the second floor. She stated the resident wasn't oriented and was weak. She stated that she might be or have a more serious issue. Suggested she (illegible) send to hospital. Physician's Assistant (PA) was contacted and he said to send her to hospital. Administrator and family was notified." Review of the facility's current licensure status lists the facility as a "Standard" license. The facility does not have a limited nursing license. As stipulated by Florida statutes, "A facility with a limited nursing license may provide the following nursing services in addition to any nursing service permitted under a standard license pursuant to Section 429.255, F.S.: (k) Caring for casts, braces and . An interview was conducted with the Administrator of the facility on at 2:45 p.m. He confirmed he is responsible for the oversight of the wellness center. He acknowledged the facility's "Standard" licensure; however, was not aware the CNA's were placing the brace on the resident's leg (which is a nursing service) for which the facility did not hold the proper licensure.	A 010		

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A 010	Continued From page 12	A 010		

He was not aware the resident's physician indicated the resident required medication administration (which is a nursing service) and failed to ensure the criteria for continued residency related to Resident #7 was met.

An interview was conducted with the Medical Doctor via telephone on [redacted] at 1:15 p.m. He stated he would want the facility to call him for a [redacted] sugar of 40 or below. He stated he want the resident to eat food if the [redacted] sugar was below 60 before she had her Lantus injection. He stated his major concern was he thought because of the residents declining mental status and eyesight she could no longer administer her own medication. He stated, "I told the social worker at Sarasota Memorial Hospital twice she (Resident #3) could not self administer her own medications." The doctor was told of the situation of a medication technician giving 36 units of Lantus to the resident when her [redacted] sugar was 58 with the resident not having eaten. He stated, "That is an issue."

An interview was conducted with the ALF Administrator on [redacted] at 1:30 p.m. He was told of the concern for the resident being hospitalized due to [redacted] and the continued safety of the resident being in the facility. He stated he was not aware of the issue of medication technicians giving [redacted] to the residents. He was not aware of Resident #3 being sent to the hospital with [redacted] on [redacted]. He stated he felt as long as the residents were able to give themselves the injection it was ok. He stated his understanding was staff could dial in the [redacted] for the residents with [redacted] pens.

An interview was conducted with the Administrator on [redacted] at 11:00 a.m. He was

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A 010	Continued From page 13 asked how he would evaluate residents coming into the facility and how would he continually evaluate the appropriateness of residents while they were in the facility. He stated he relied on the medical doctors and the 1823 to evaluate the residents. He was asked if he had a policy regarding evaluating resident's appropriateness for the facility. He stated he had been working on a tool form two weeks prior to the survey regarding evaluating residents. He stated he had no current policy at this time. He then stated he had meetings every 2 weeks with Home health nurses who provide skilled nursing for the residents. He stated he relied on those meetings to inform him if of the status of the residents. In an interview with the Marketing Director on [redacted] at 12:00 p.m., he stated the facility had not implemented the New Evaluation Form as of yet. He stated Staff E, a CNA, had been working on writing the form. Review of the "Alderman Oaks New Resident Evaluation Form" shows #17 on the form as an evaluation of [redacted] coming into the facility. It reads, "17. Are they [redacted] If so can they push down their plunger on their [redacted] pen without assistance?" There is no further evaluation of the [redacted] resident noted on the form. Class III	A 010		
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	A 030		

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A 030	Continued From page 14 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 comptaint. (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 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	A 030		

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A 030	Continued From page 15	A 030		

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 [redacted] 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 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 [redacted] and neglect.
(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.

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A 030	Continued From page 16 (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 attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a [illegible]th 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.	A 030		

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A 030	Continued From page 17 (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 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, interview and observation, the facility denied 3 (Residents #1, #3, and #7) of 11 residents reviewed of their right to appropriate health care by allowing unlicensed staff to administer , for 2 (Resident #1, and #2) residents and care for a leg brace for 1 (Resident #7) resident resulting in the hospitalization of 1 (Resident #3) resident and the	A 030		

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A 030	Continued From page 18 immediate potential injury for 3 (Residents #1, #3, and #7) residents. The findings include: According to the American [illegible] Association (ADA,) [illegible] is a chronic illness that requires continuing medical care and ongoing patient self-management education and support to prevent acute complications and to reduce the risk of long-term complications. [illegible] care is [illegible] and requires multifactorial risk reduction strategies beyond [illegible] control." A resident in an ALF (Assisted Living Facility) who is [illegible] dependant and who self-administers or receives assistance with medications must be able to understand the [illegible] of their [illegible] and be able to make critical judgments related to its treatment. There are 2 major concerns with the [illegible] residents having both acute and long term effects. The first is [illegible] (low [illegible] sugar). A [illegible] sugar 60 or less is considered [illegible] can be caused by the resident taking [illegible] and not eating. The complications of [illegible] if untreated include tremor, visual [illegible], acute [illegible] state, muscle [illegible], reduced levels of [illegible], vegetative state, [illegible] and [illegible]. The [illegible] state caused by low [illegible] sugar levels could lead a resident to become [illegible] and hallucinate. In this state the resident would be unable to make a concise judgment about care and would be totally dependent upon a caregiver to obtain medical assistance.	A 030	Tag A 030 CORRECTIVE ACTION The Corrective Action for Tag A 010 will assure that Alderman Oaks is appropriate for all of our assisted living residents. All staff who supervise the self-administration of meds and the administrator of Alderman Oaks will take the Department of Elder Affairs Assistance with Self-Administration of Medications in Assisted Living Facility class and shall be instructed in the application of 58A – 5.0181 (4). They shall be instructed to bring any concerns about appropriate placement to the Administrator and make sure the Administrator is informed in writing of significant changes in the health of any resident.	4/30/13

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A 030	Continued From page 19 The second concern with ... is ... (high ... sugar). ... can be caused by a resident not getting enough ... or eating too many simple sugars. According to the American ... Association, "... can be a serious problem if you don't treat it, so it's important to treat as soon as you detect it. If you fail to treat ... a condition called ... coma) could occur. ... develops when your body doesn't have enough ... Without ..., your body can't use glucose for fuel, so your body breaks down fats to use for energy." "When your body breaks down fats, waste products called ketones are produced. Your body cannot tolerate large amounts of ketones and will try to get rid of them through the ... Unfortunately, the body cannot release all the ketones and they build up in your ..., which can lead to ketoacidosis. Ketoacidosis is life-threatening and needs immediate treatment." The long term effects of ... include ..., limb amputation, and kidney failure. According to the Mayo Clinic, "Your doctor sets your target ... sugar range. For many people who have ... target levels are: Fasting at least eight hours (fasting ... sugar level) - between 90 and 130 mg/dL (5 and 7 mmol/L) Before meals - between 70 and 130 mg/dL (4 and 7 mmol/L) One to two hours after meals - lower than 180 mg/dL (10 mmol/L)" Medication technicians in an ALF receive 4 hours	A 030	All med techs and the Administrator will complete the Med training before ... 2013. We are in the process of trying to schedule this training to take place before the end of ... 2013. The AHCA tags concerning supervision of meds were discussed at our ... 2013 health care staff meeting so that none would be repeated. Licensed staff were contracted to meet AHCA health concerns on ... 2013 at the direction of the surveyors, as soon as the concerns were brought to our attention and shall continue until all AHCA safety concerns are fully addressed and satisfied. All aspects of the above including the Med training will be completed by ... 2013. One resident of concern has been placed in another facility. The Doctor of a second resident (with ... concerns) is in the process of changing his regimen to oral medications. The Doctor of the third resident of concern has removed the order for a brace on her knee.	

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A 030	Continued From page 20	A 030		

of training in assisting residents with medications and do not have the knowledge base to make judgments in critical care decision for the dependent resident. For a resident to be appropriate for assistance with care they would have to be able to make all decisions regarding the care of the process. Medication technicians would be able to bring the resident their equipment, remind them of the time medications are due and record the sugar levels obtained by the resident when they test themselves. It is not within the technician's scope of practice to do glucose testing, draw up and make judgments regarding care.

An pen is a device used to draw doses of The device has a container of with a re-capable needle on one end and a plunger attached to a dial at the other end. Accurate unit doses of are obtained by twisting the dial to the proper dosage and drawing the plunger of the pen. The needle is then injected and the plunger is pushed to inject the dose of dialed into the pen. It is a device used to simplify the drawing up of into a syringe.

1. Resident #3 is a female who moved into the facility on 7/30/12. Review of the observation log notes on 7/30/12 the Licensed Practitioner Nurse (LPN) working for the facility at the time noted, "Resident arrived at 1 AM with husband to community. Resident alert with at all times."

An interview was conducted with the Administrator on at 11:00 a.m. He stated there had been a LPN working at the facility as a supervisor of healthcare. According to the

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A 030	Continued From page 21 Administrator there has not been a nurse on staff at the facility for 2 to 3 months. During an interview with Staff B at 10:45 a.m. on [redacted], she stated the LPN had not worked at the facility since [redacted] of 2012. Review of the resident's Form 1823 (resident health assessment) dated [redacted] shows the medical doctor wanted the resident to have her medications administered. Administration of medications is performed by licensed persons (such as RN or LPN). The doctor documented on the form the resident suffers from memory loss. On 8/10/12 a Certified Nursing Assistant (CNA) noted in the resident observation log, "Staff communicated to Dr. XX as to whether he wished resident to perform [redacted] glucose level) as she is on [redacted] and 2 [redacted] medications. As of PM no response." The resident had an order for Lantus [redacted] 36 units every am and 20 units every PM. She was receiving this dosage via an [redacted] pen injector. There was no order from a medical doctor found in the resident's record for the resident to self-administer [redacted] Review of the facilities forms Indicate a Medication Administration Record (MAR) for [redacted] of 2012 shows [redacted] before meals twice daily, once before breakfast and supper. The times written on the MAR show 8:00 a.m. and 5:00 p.m. when the [redacted] were obtained. The documentation in the month of [redacted] begins on [redacted]. On separate sheets of untitled paper the facility documented [redacted] readings 2 to 3 times daily from [redacted]. On [redacted] no order for [redacted] could be found in the resident's chart.	A 030		

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A 030	Continued From page 22	A 030		

Review of the medical record showed a Fax sheet dated . It is addressed to a Physician's Assistant and reads, "We need an updated 1823 for Resident #3. Our files show her old doctor checked the box "Needs Medication Administration." We assist Resident #3 with self administraion." On the bottom of the fax is written, "This is important as medication administration is skilled nursing." The fax has the name of a CNA on staff listed as a contact person. The resident had a 1823 dated 2/5/13 filled out by the Physician's Assistant (PA). The form shows the resident can have assistance with self-administration of medications.

An interview was conducted with the PA by phone on at 3:00 p.m. He stated he felt medication assistance was assisting with and assisting the resident with their insulin pens. He was not aware the facility did not have a nurse on staff to assist the resident with her . He stated, "We never heard anything from them (the ALF) so we assumed they were able to provide the care."

The resident was observed in her her son on at 1:15 p.m. She was observed to have a condition in her right eye that caused excessive tearing and redness. Her bottom right eyelid was observed to droop downward. She was observed to be pleasant but slightly She was unable to answer some questions without the assistance of her son. She was also observed to be frail and slow to move.

During an interview with the resident at that time she was asked if she knew what medications she was taking. She stated she was not aware what she was taking. She stated, "They hand them to

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A 030	Continued From page 23	A 030		

me they don't tell me what they are." The resident was asked about receiving injections. She stated, "They (Staff) make the adjustment about how many units I can take and I do the injection."

An interview was conducted with Staff A on at 9:21 a.m. She stated she sometimes would have to dial in the amount of the resident was receiving.

An interview was conducted with Staff D at 10:00 a.m. on She stated she would sometimes dial in doses for the resident.

On an observation note reads, "Sugar 52 in AM apple sauce with banana. Ordered breakfast tray for am need to eat feels by lunch. 5 PM staff assisted her to dinner." There is no documentation as to who wrote the note in the log. The note, by its content and style of writing, shows an untrained person wrote it. Review of the facility's documentation of administration shows the resident received 36 units of Lantus with a sugar of 52. There is no documentation the was held or the medical doctor was notified before giving this resident

On an unsigned note reads, "Very agitated and refused to come to supper." The facilities documentation of administration shows the resident refused to have her sugar tested and she was given 20 units of Lantus

On an observation note written by an LPN on staff with the facility at that time reads, sugar 48 at PM. Orange juice and banana given to increase sugar level. 5:20 PM

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A 030	Continued From page 24 sugar 98... Staff re-educated to monitor all resident's meals closely to prevent event. Staff understood teachings." There is no documentation the resident's medical doctor was ever notified. The MAR shows the resident received 20 units of Lantus at 8:00 p.m. on the night of 8/23/12. There is no documentation a sugar was obtained before administering the medication. An accepted nursing standard of practice would be to obtain a sugar before administering that amount of to a resident with known On the observation note reads, "Very on 3-11 shift ate 20% of dinner." There is no further documentation on On the observation record reads, "Resident #3 wandered into another resident's On the observation record reads, "Resident all night long and very agitated. Resident #3 thought it was morning and wanted breakfast for supper even after med staff explained the time and meal." On Staff B documents in the observation record, "Resident seen by psych nursing. Nurse advised that resident's are probably due to and that her is caused by low Review of the facilities documentation of administration forms shows the resident had a glucose level of 56 on The form shows she was given orange juice. There is no documentation of the low sugar in the observation record.	A 030		

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(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 25 An interview was conducted with Staff B on [redacted] at 10:00 a.m., she stated she was the one who obtained the resident's [redacted] glucose that morning. She stated she did not recheck the [redacted] or notify the medical doctor before giving the resident 36 units of Lantus. On [redacted] the unsigned observation note for the 7-3 shift reads, "Psych nurse was advised of resident's episodes of [redacted] staff to encourage fluids." On 2/2/13 the observation note reads, (7-3) Resident complained of loose stools. Resident did not eat breakfast/lunch Resident's [redacted] sugar 58. Staff educated resident to drink fluids. On [redacted] the observation note reads, (3-11) Resident [redacted] sugar remains at 58... Resident refuses to eat/drink. Resident very [redacted]. Sent resident out to Sarasota Memorial Hospital per PA.. The facility's documentation of [redacted] administration shows the resident was given 36 units of Lantus on [redacted] with a [redacted] sugar of 58. The resident had not eaten breakfast and had [redacted]. The resident was hospitalized at 4:54 p.m. on [redacted], and spent the night in the hospital with [redacted]. An interview was conducted with Resident #3 at 11:00 a.m. on [redacted]. She was asked how much [redacted] she takes everyday. She stated, I take 33 units in the morning and 20 units at night. She was asked if she remembered going to the hospital in [redacted]. She stated she did not remember. She was asked what happened in the	A 030		

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morning when you get your . She stated the staff takes my sugar and they dial in the and I inject it. She was asked if she had a low sugar who would make the decision not to take . She stated, "The nurses I guess." She was asked if the staff tell her what her sugar is when they take it in the morning and night. She stated, "They don't tell me what my sugar is. They give me the and I inject what they give me."

The medical doctor who treated the resident on is the same medical doctor who signed her 1823 assessment on stating the resident needed her medications administered (by skilled staff.) The medical doctor's note on discharge from the hospital reads, "At the time of emergency transport her sugar was 55 and she was given a half amp of D50. On arrival in the emergency after some evaluation her sugar was noted to be 68.....Given her I recommend that she have medication assistance at the ALF....Given the relative danger of Hyperglycemia versus I recommend we decrease Lantus to 10 units every 12 hours and monitor."

An interview was conducted with the Medical Doctor via telephone on at 1:15 p.m. He stated he would want the facility to call him for a sugar of 40 or below. He stated he want the resident to eat food if the sugar was below 60 before she had her Lantus injection. He stated his major concern was he thought because of the residents declining mental status and eyesight she could no longer administer her own medication. He stated, "I told the social worker at Sarasota Memorial Hospital twice she (Resident #3) could not self administer her own medications." The doctor was told of the situation

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A 030	Continued From page 27 of a medication technician giving 36 units of Lantus to the resident when her sugar was 58 with the resident not having eaten. He stated, "That is an issue." An interview was conducted with the ALF Administrator on at 1:30 p.m. He was told of the concern for the resident being hospitalized due to and the continued safety of the resident being in the facility. He stated he was not aware of the issue of medication technicians giving to the residents. He was not aware of Resident #3 being sent to the hospital with on . He stated he felt as long as the residents were able to give themselves the injection it was ok. He stated his understanding was staff could dial in the for the residents with pens. In an interview with the Administrator at 5:30 p.m. on , he stated he had obtained a nurse to administer to the resident on a daily basis. He stated this would continue until the resident was placed in another facility. The Administrator was asked to what extent the resident's family had been notified of the incident which had occurred when the resident was hospitalized for He stated he was sure the family was not notified the resident of the full extent of the issue. He stated, "I can assure you I will personally notify the family immediately." On at 11:00 a.m., an interview was conducted with the Home Health RN hired by the facility to evaluate the resident. She stated the resident is not appropriate for the ALF. She stated the resident is not able to care for her She stated she had interviewed all the staff in the facility and none of them knew their limitations and roles with regard to	A 030		

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2. Resident #1 is a male who moved into the facility on . On admission to the facility the resident had an order for sliding scale coverage with . He was to have coverage before meals and at the hour of sleep.

Review of the resident's 1823 assessment shows he has a and he is forgetful. According to the 1823, dated , the resident needs assistance with medications. Review of the resident's Initial 1823 dated shows no documentation as to whether the resident needs assistance or needs administration of medications.

During the initial interview with the resident on at 11:12 a.m., the resident was observed to be slow. He did not seem capable of understanding his use. He was asked how he received his He stated, "They put the number of units I need into the flex pen and I give myself the shot. They want to make sure I get the right dose. That's why they do that. I get my sugar checked 4 times daily."

At 11:50 a.m., the resident was observed receiving his and coverage. Staff D, an unlicensed staff member, was observed taking the resident's glucometer and holding it to the resident's finger and obtain a reading of 115 after the third attempt. She was observed handing the pen to the resident. The resident was observed not to be able to dial in his one unit dose of coverage. The aide then pulled the pen close to her side and clicked the dial to one unit and handed it to the resident. The resident was observed to inject himself with the dosage given by the aide.

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An interview was conducted with Staff D on at 10:00 a.m. She verified she had obtained the resident glucose and that she had dialed in the dosage to the pen. She stated she sometimes had to do that for the resident.

Review of the MAR shows the resident self administers his own . There is no documentation of being given on the MAR. There is a separate untitled form that shows staff documenting coverage and Lantus administration. These forms show on several days the resident missed coverage in and . Review of the forms show no coverage given at night for sugars from 130-230. The residents sliding scale reads 100-150=1 unit, 151-200=3 units, 201-250=5 units, 251-300=7 units,301-350=9 units, 351-400=11 units. The resident sugar was greater than 100 on every reviewed from . There was no follow up with a medical doctor documented as to why the resident was not receiving coverage at the hour of sleep.

On and the resident received no Lantus in in the PM as ordered. There is no documentation in the resident's record as to why he didn't receive these doses of medication.

An interview was conducted with the Resident #1 at 12:00 p.m. on . He stated, "I've been taking for ten years. I take 4 shots a day." He was asked what was the dosage of he took everyday. He stated, "It depends upon how much I needed." He was asked

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how much ____ he would get if his ____ sugar was 150. He stated, "I'm not sure. I usually hand the ____ to staff and she tells me how much I need to take. I stick my self with a pen and get ____. They take the machine and get the ____ off my finger. They tell me what my ____ sugar is and then they dial in the number on the ____ and hand me the syringe. I feel I need the help they give me, it's like a little insurance policy to me to make sure I get the right dose of ____." He stated, "I understand the people giving me ____ are not nurses. I do not know what kind of training they have." He was asked what he thought was a low ____ sugar he stated, "I'm not sure but the nurses will tell me." He was asked if he thought the people taking his ____ sugar was nurses he stated, "They're supposed to be." He was asked if there was something that caused him not to be able to do his own ____ sugar. He stated, "My eyes are not as good as they use to be. It's hard to see the ____ to dial it in."

At 1:00 PM on ____ the Administrator was informed of the surveyor's concern for the resident's safety at the facility. The administrator was unaware of the extent that his staff was administering ____ to the resident. He stated he thought the staff could dial in the ____ pen for the residents.

3. Observation of Resident #7 on ____ at 9:45 a.m., revealed the resident in her ____ in a wheelchair. A full leg brace from the top of the resident's left thigh down to the bottom of her left leg was in place. During this observation, the resident was asked if she puts the leg brace on by herself or if she receives assistance. She stated, "They help me put my brace on my left leg." She referred to "They" as the CNAs at the ALF. She stated, "We don't have a registered

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A 030	Continued From page 31 nurse here. My leg brace goes on some mornings early when I go to breakfast but otherwise, it's a busy [illegible] there's a lot of people around. I wear my brace in the morning...I wear the brace most of the day" When asked how she removes the brace, she stated, "One of the same people who is on duty that hour (in the evening) removes my brace for me. They also put my stockings on. These are the white elastic ones (pointing). The same people who help with the brace help with my stockings." Observation on [illegible] at 11:48 a.m., revealed the resident wheeling herself toward the dining [illegible]. A CNA bent down next to her and adjusted the strap on her left leg brace. During an interview on [illegible] at 1:33 p.m., with the same CNA observed adjusting the strap on the resident's left leg brace, she stated, "I'm not sure if I can help her, it would be good to know but I put it on, make sure it fits right, there are two spots near her knee (as indicators for aligning the brace). She has a diagram booklet that she got when she was in rehab that I use. And then she fastens it. I help her with her [illegible] (elastic stockings) too." The CNA explained the resident went out to ER (Emergency [illegible]) for [illegible] and While she was there it was determined that she needed to go to rehab. The CNA stated, "While she was there, I guess they found a crack or [illegible] in her knee. She (Resident #7) followed up with the [illegible] doctor who determined she needed a brace." Review on [illegible] of Resident #7's demographic information sheet documented the resident was originally admitted to the facility on [illegible]	A 030		

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A 030	Continued From page 32 A review of the most recent 1823 Health Assessment signed by the physician for the date of documents the resident with previous left total knee replacement and with left knee strain. Under the "Physical or sensory limitations section" of this assessment, the resident is to wear a "Brace" to left leg when out of bed. Her level of assistance required for ambulation was not assessed; the section was left blank. The section of the assessment requesting the level of assistance the resident requires with medication was checked under "Needs medication administration." There is no physician's orders for the application or removal of the elastic stockings. Review of the "Resident Observation Log" completed by the facility staff dated documented the resident "Wasn't feeling well, was seen by an RN that happened to be on the second floor. She stated the resident wasn't oriented and was weak. She stated that she might be or have a more serious issue. Suggested she (illegible) send to hospital. PA was contacted and he said to send her to hospital. Administrator and family was notified." Review of the facility's current licensure status lists the facility as a "Standard" license. The facility does not have a limited nursing license. As stipulated by Florida statutes, "A facility with a limited nursing license may provide the following nursing services in addition to any nursing service permitted under a standard license pursuant to Section 429.255, F.S.: (k) Caring for casts, braces and An interview was conducted with the Administrator of the facility on at 2:45 p.m.	A 030		

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A 030	Continued From page 33 He confirmed he is responsible for the oversight of the wellness center. He acknowledged the facility's "Standard" licensure; however, was not aware the CNAs were placing the brace on the resident's leg (which is a nursing service) for which the facility did not hold the proper licensure. He was not aware the resident's physician indicated the resident required medication administration (which is a nursing service) and failed to ensure the criteria for continued residency related to Resident #7 was met. The facility failed to ensure the appropriate nursing service was being provided to the resident related to the application of the left leg brace. An improperly fitted leg brace can potentially contribute to development of , leg or knee instability, risk of potential for , improper alignment of the knee joint and potential loss of adequate mobility of the left extremity. Class I	A 030		
A 052	58A-5.0185(3) FAC Medication - Assistance with Self-Admin (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) For facilities which provide assistance with self-administered medication, either: a nurse; or an unlicensed staff member, who is at least , trained to assist with self-administered medication in accordance with Rule 58A-5.0191, F.A.C., and able to demonstrate to the administrator the ability to accurately read and interpret a prescription label, must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S.	A 052		

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(b) Assistance with self-administration of medication includes verbally prompting a resident to take medications as prescribed, retrieving and opening a properly labeled medication container, and providing assistance as specified in Section 429.256(3), F.S. In order to facilitate assistance with self-administration, staff may prepare and make available such items as water, juice, cups, and spoons. Staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, shall not be returned to the container.
(c) Staff shall observe the resident take the medication. Any concerns about the resident ' s reaction to the medication shall be reported to the resident ' s health care provider and documented in the resident ' s record.
(d) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:
1. The health care provider may prescribe a medication schedule which coincides with the resident ' s presence in the facility;
2. The medication container may be given to the resident or a friend or family member upon leaving the facility, with this fact noted in the resident ' s medication record;
3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident ' s medication record; or
4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging;
(e) Pursuant to Section 429.256(4)(h), F.S., the term " competent resident " means that the

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A 052	Continued From page 35 resident is cognizant of when a medication is required and understands the purpose for taking the medication. (f) Pursuant to Section 429.256(4)(i), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (4) Assistance with self-administration does not include: (a) Mixing, converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications through intermittent positive pressure breathing machines or a (d) Administration of medications by way of a tube inserted in a cavity of the body. (e) Administration of preparations. (f) Irrigations or debriding agents used in the treatment of a skin condition. (g) or preparations. (h) Medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident. (i) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. This Statute or Rule is not met as evidenced by:	A 052		

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A 052	Continued From page 36 Based on observation, the facility failed to properly assist 1 (Resident #12) of 5 residents observed who required assistance with self-administration of medications. The Certified Nursing Assistant (CNA) failed to remain with the resident while self-administering his medications and failed to assist the resident with his medications according to the physician's orders. The findings include: 1. Observation on at 8:34 a.m., revealed a CNA pull medications for Resident #12 out of the medication cart. The medications, 325 mg., 81 mg. chew, Glimepride 1 mg., 30 mg., 25 mg. (1/2 tab), 20 mg., CL 10 meq. Rivastigmine 4.5 mg. 2.5 mg., Torsemide 5 mg., and Vit 1,000 mg., were prepackaged by the pharmacy and inside a small plastic container. She then pulled a packet of Prevalite and a container of out of the cart. The CNA donned a pair of gloves, gathered the medications, Prevalite and and walked into the side kitchen off of the second floor dining ..... The CNA retrieved two tall empty glasses and a water pitcher as well as container of Boost supplement and walked over to the resident who was seated at the dining drinking coffee. She poured the into the top of the cap and then placed it into a tall glass. She then opened the Prevalite, poured it into the other tall glass and poured water into the Prevalite mixture and mixed it with a plastic spoon. She placed the Prevalite liquid in front of the resident. She poured chocolate Boost into the mixture, mixed it with a spoon and placed it in front of the resident.	A 052	Tag A 052 CORRECTIVE ACTION Alderman Oaks has an agreement with a Florida Licensed Consultant Pharmacist to evaluate Alderman Oaks' complete medication system, assess the technique of each staff providing medication assistance, and outlining a plan of correction. This same consultant will teach the Department of Elder Affairs Assistance with Self-Administration of Medication in an Assisted Living Facility class which all Alderman Oaks' staff supervising self-administration of meds and the Administrator will take. This consultant group, Senior Care Consultant Group, LLC, will also provide, at minimum, onsite quarterly consultations. This agreement is for one year and will continue until discontinuation is approved by the Agency. Random monitoring will be conducted by the Licensed Pharmacist used by Alderman Oaks (he is also a med trainer).	

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A 052	Continued From page 37 While stirring the powder medications, she explained what she was doing. She then read the tablet medications off to the resident. Resident #12 requested she pour his medications out of the package and onto a napkin. She honored his request; however, removed the from the rest of the pills and explained to the resident that it was being held for today. The resident then picked the medications up from the napkin and began self administering them. The CNA gathered the empty packets, picked up the water pitcher while observing the resident self administer his medications. While he was not yet finished administering his medications or drinking the fluid mixtures, she walked away from the resident and into the kitchen wear she discarded the packets, and then walked out of the dining She removed her gloves and sanitized her hands. Resident #12 remained in the dining with the mixture, Prevallte drink and 2 pills in front of him. The CNA failed to remain with the resident and observe him take all of his medications. Upon review of the medication label, Medication Observation Record (MOR) and physician's orders, the CNA was to give the Prevalite mix "Before" the resident's breakfast and observation revealed she gave the mixture "After" his breakfast while he was finishing his coffee. Class III	A 052	The Consultant's training and complete review of procedures of staff will be completed by 31, 2013 (a request for this time frame has been included in the cover letter accompanying this response to AHCA tags). We are trying to schedule this training so that it will be completed before the end of 2013. Procedural concerns brought up by AHCA in this survey being addressed have already been reviewed with staff and it is believed that Alderman Oaks' staff currently supervises self-administration of meds according to State requirements.	4/30/13
A 053	58A-5.0185(4) FAC Medication - Administration	A 053		

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
	AL11964447	A. BUILDING: _____ B. WING _____	03/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDERMAN OAKS RETIREMENT CENTE	727 HUDSON AVENUE SARASOTA, FL 34236

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A 053	Continued From page 38 (4) MEDICATION ADMINISTRATION. (a) For facilities which provide medication administration a staff member, who is licensed to administer medications, must be available to administer medications in accordance with a health care provider ' s order or prescription label. (b) Unusual reactions or a significant change in the resident ' s health or behavior shall be documented in the resident ' s record and reported immediately to the resident ' s health care provider. The contact with the health care provider shall also be documented in the resident ' s record. (c) Medication administration includes the conducting of any examination or testing such as glucose testing or other procedure necessary for the proper administration of medication that the resident cannot conduct himself and that can be performed by licensed staff. (d) A facility which performs clinical laboratory tests for residents, including glucose testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Part I of Chapter 483, F.S. A valid copy of the State Clinical Laboratory License and the CLIA Certificate must be maintained in the facility. A state license or CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a State Clinical Laboratory License or a CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents ' own equipment. Information about the State Clinical Laboratory License and CLIA Certificate is available from the Clinical Laboratory Licensure Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone	A 053		

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A 053	Continued From page 39 (850)487-3109. This Statute or Rule is not met as evidenced by: Based on record review, interview and observation, the facility allowed unlicensed staff to administer ... to 2 (Residents #1 and Resident #3) of 3 residents reviewed resulting in the hospitalization of 1 (Resident #3) resident for hypoglycemia and the immediate potential danger for 2 (Residents #1 and #3) residents related to ... and ... with a potential for kidney failure, ... and ... The findings include: According to the American ... Association (ADA) ... is a chronic illness that requires continuing medical care and ongoing patient self-management education and support to prevent acute complications and to reduce the risk of long-term complications. ... care is ... and requires multifactorial risk reduction strategies beyond ... control." A resident in an Assisted Living Facility (ALF) who is ... dependent and who self-administers or receives assistance with medications must be able to understand the ... of their ... and be able to make critical judgments related to its treatment. There are 2 major concerns with the residents having both acute and long term effects. The first is ... (low ... sugar). A ... sugar 60 or less is considered ... Hypoglycemia can be caused by the resident taking ... and not eating. The	A 053	Tag A 053 CORRECTIVE ACTION It is currently Alderman Oaks' policy to not admit residents who require med administration as alleged from the 1823 form and the nurse evaluation. One gentleman currently resides at Alderman Oaks that surveyors alleged was being administered ... by Alderman Oak's staff. Alderman Oaks' has contracted for licensed nurses to administer his ... temporarily by direction of the surveyors. All Assisted Living Resident 1823's are reviewed and signed by the Administrator. Very careful attention shall be applied to the evaluation of the Doctor on the 1823 concerning the med administration or supervision of administration. Any concerns shall be immediately addressed with the signing Doctor as clarification is often needed.	4/30/13

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A 053	Continued From page 40 complications of Hypoglycemia if untreated include tremor, visual , acute state, muscle , reduced levels of , vegetative state, , and . The state caused by low sugar levels could lead a resident to become and hallucinate. In this state the resident would be unable to make a concise judgment about care and would be totally dependent upon a caregiver to obtain medical assistance. The second concern with is (high sugar). can be caused by a resident not getting enough or eating too many simple sugars. According to the American Association, "Hyperglycemia can be a serious problem if you don't treat it, so it's important to treat as soon as you detect it. If you fail to treat hyperglycemia, a condition called Ketoacidosis could occur. develops when your body doesn't have enough . Without , your body can't use glucose for fuel, so your body breaks down fats to use for energy. When your body breaks down fats, waste products called ketones are produced. Your body cannot tolerate large amounts of ketones and will try to get rid of them through the . Unfortunately, the body cannot release all the ketones and they build up in your , which can lead to . Ketoacidosis is life-threatening and needs immediate treatment." The long term effects of include , limb amputation, and kidney failure. According to the Mayo Clinic, "Your doctor sets	A 053		

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A 053	Continued From page 41 your target [illegible] sugar range. For many people who have [illegible] target levels are: Fasting at least eight hours (fasting [illegible] sugar level) - between 90 and 130 mg/dL (5 and 7 mmol/L) Before meals - between 70 and 130 mg/dL (4 and 7 mmol/L) One to two hours after meals - lower than 180 mg/dL (10 mmol/L)." Medication technicians in an ALF receive 4 hours of training in assisting residents with medications and do not have the knowledge base to make judgments in critical care decision for the [illegible] dependent [illegible] resident. For a resident to be appropriate for assistance with [illegible] care they would have to be able to make all decisions regarding the care of the [illegible] process. Medication technicians would be able to bring the resident their equipment, remind them of the time medications are due, and record the [illegible] sugar levels obtained by the resident when they test themselves. It is not within the technician's scope of practice to do [illegible] glucose testing, draw up [illegible] and make judgments regarding [illegible] care. An [illegible] pen is a device used to draw doses of [illegible]. The device has a container of [illegible] with a re-capable needle on one end and a plunger attached to a dial at the other end. Accurate unit doses of [illegible] are obtained by twisting the dial to the proper dosage and drawing the plunger of the pen. The needle is then injected [illegible] and the plunger is pushed to inject the dose of [illegible] dialed into the pen. It is a device used to simplify the drawing up of [illegible] into a syringe. 1. Resident #3 is a [illegible] female who	A 053		

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A 053	Continued From page 42 moved into the facility on [redacted]. Review of the observation log notes on [redacted] the Licensed Practitioner Nurse (LPN) working for the facility at the time noted, "Resident arrived at 1 AM with husband to community. Resident alert with [redacted] at all times." An Interview was conducted with the Administrator on 3/11/12 at 11:00 a.m. He stated there had been an LPN working at the facility as a supervisor of healthcare. According to the administrator there has not been a nurse on staff at the facility for two to three months. During an interview with Staff B at 10:45 a.m. on [redacted] she stated the LPN had not worked at the facility since [redacted] of 2012. Review of the resident's Form1823 (resident health assessment) dated 6/4/12 shows the medical doctor wanted the resident to have her medications administered. Administration of medications is performed by licensed persons (such as RN or LPN). The doctor documented on the form the resident suffers from memory loss. On [redacted] a Certified Nursing Assistant (CNA) noted in the resident observation log, "Staff communicated to Dr. XX as to whether he wished resident to perform [redacted] glucose level) as she is on [redacted] and 2 [redacted] medications. As of PM no response." The resident had an order for Lantus [redacted] 36 units every am and 20 units every PM. She was receiving this dosage via an [redacted] pen injector. There was no order from a medical doctor found in the resident's record for the resident to self-administer [redacted]. Review of the facilities forms indicate a Medication Administration	A 053		

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A 053	Continued From page 43 Record (MAR) for of 2012 shows before meals twice daily, once before breakfast and supper. The times written on the MAR show 8:00 a.m. and 5:00 p.m. when the were obtained. The documentation in the month of begins on . On separate sheets of untitled paper the facility documented readings 2 to 3 times daily from . On no order for could be found in the resident's chart. Review of the medical record showed a Fax sheet dated . It is addressed to a Physician's Assistant and reads, "We need an updated 1823 for Resident #3. Our files show her old doctor checked the box "Needs Medication Administration". We assist Resident #3 with self-administration." On the bottom of the fax is written, "This is important as medication administration is skilled nursing." The fax has the name of Staff E, a CNA on staff listed as a contact person. The resident had a 1823 dated filled out by the PA. The form shows the resident can have assistance with self administrationof medications. An interview was conducted with the PA by phone on at 3:00 p.m. He stated he felt medication assistance was assisting with and assisting the resident with their pens. He was not aware the facility did not have a nurse on staff to assist the resident with her . He stated, "We never heard anything from them (the ALF) so we assumed they were able to provide the care." The resident was observed in her her son on at 1:15 p.m. She was observed to have a condition in her right eye that caused	A 053		

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excessive tearing and redness. Her bottom right eyelid was observed to droop downward. She was observed to be pleasant but slightly [illegible] She was unable to answer some questions without the assistance of her son. She was also observed to be frail and slow to move.

During an interview with the resident at that time she was asked if she knew what medications she was taking. She stated she was not aware what she was taking. She stated, "They hand them to me they don't tell me what they are." The resident was asked about receiving [illegible] injections. She stated, "They (Staff) make the adjustment about how many units I can take and I do the injection."

An interview was conducted with Staff A on [illegible] at 9:21 a.m. She stated she sometimes would have to dial in the amount of [illegible] the resident was receiving.

An interview was conducted with Staff D at 10:00 a.m. on [illegible] She stated she would sometimes dial in [illegible] doses for the resident.

On [illegible] an observation note reads, "Sugar 52 in AM apple sauce with banana. Ordered breakfast tray for am need to eat feels [illegible] by lunch. 5 PM staff assisted her to dinner." There is no documentation as to who wrote the note in the log. The note, by its content and style of writing, shows an untrained person wrote it. Review of the facility's documentation of [illegible] administration shows the resident received 36 units of Lantus [illegible] with a [illegible] sugar of 52. There is no documentation the [illegible] was held or the medical doctor was notified before giving this [illegible] resident [illegible]

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A 053	Continued From page 45 On : an unsigned note reads, "Very agitated and refused to come to supper." The facilities documentation of : administration shows the resident refused to have her : sugar tested and she was given 20 units of Lantus . On : an observation note written by an LPN on staff with the facility at that time reads, "... sugar 48 at PM. Orange juice and banana given to increase ... sugar level. 5:20 PM : sugar 98... Staff re-educated to monitor all resident's meals closely to prevent : event. Staff understood teachings." There is no documentation the resident's medical doctor was ever notified. The MAR shows the resident received 20 units of Lantus ... at 8:00 p.m. on the night of ... . There is no documentation a ... sugar was obtained before administering the medication. An accepted nursing standard of practice would be to obtain a ... sugar before administering that amount of ... to a resident with known On ... the observation note reads, "Very ... on 3-11 : ate 20% of dinner." There is no further documentation on ... . On ... the observation record reads, "Resident #3 wandered into another resident's ... On ... the observation record reads, "Resident ... all night long and very agitated. Resident #3 thought it was morning and wanted breakfast for supper even after med staff explained the time and meal." On ... Staff B documents in the observation record, "Resident seen by psych nursing. Nurse	A 053		

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A 053	Continued From page 46 advised that resident's [illegible] are probably due to [illegible] and that her [illegible] is caused by low [illegible]. Review of the facilities documentation of [illegible] administration forms shows the resident had a [illegible] glucose level of 56 on [illegible]. The form shows she was given orange juice. There is no documentation of the low [illegible] sugar in the observation record. An interview was conducted with Staff B on 3/8/13 at 10:00 a.m., she stated she was the one who obtained the resident's [illegible] glucose that morning. She stated she did not recheck the [illegible] or notify the medical doctor before giving the resident 36 units of Lantus. On [illegible] the unsigned observation note for the 7-3 shift reads, "Psych nurse was advised of resident's episodes of [illegible] staff to encourage fluids." On [illegible] the observation note reads, "(7-3) Resident complained of loose stools. Resident did not eat breakfast/lunch Resident's [illegible] sugar 58. Staff educated resident to drink fluids." On [illegible] the observation note reads, "(3-11) Resident [illegible] sugar remains at 58... [illegible] refuses to eat/drink. Resident very [illegible] Sent resident out to Sarasota Memorial Hospital per PA." The facility's documentation of [illegible] administration shows the resident was given 36 units of Lantus on [illegible] with a [illegible] sugar of 58. The resident had not eaten breakfast and had [illegible].	A 053		

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A 053	Continued From page 47 The resident was hospitalized at 4:54 p.m. on [redacted] and spent the night in the hospital with [redacted]. An interview was conducted with Resident #3 at 11:00 a.m. on [redacted]. She was asked how much [redacted] she takes everyday. She stated, I take 33 units in the morning and 20 units at night. She was asked if she remembered going to the hospital in [redacted]. She stated she did not remember. She was asked what happened in the morning when you get your [redacted] she stated the staff takes my [redacted] sugar and they dial in the [redacted] and I inject it. She was asked if she had a low [redacted] sugar who would make the decision not to take [redacted]. She stated, "The nurses I guess." She was asked if the staff tell her what her [redacted] sugar is when they take it in the morning and night. She stated, "They don't tell me what my [redacted] sugar is. They give me the [redacted] and I inject what they give me." The medical doctor who treated the resident on [redacted] is the same medical doctor who signed her 1823 assessment on [redacted] stating the resident needed her medications administered (by skilled staff.) The medical doctor's note on discharge from the hospital reads, "At the time of emergency transport her [redacted] sugar was 55 and she was given a half amp of D50. On arrival in the emergency [redacted] after some evaluation her [redacted] sugar was noted to be 68....Given her [redacted] I recommend that she have medication assistance at the ALF....Given the relative danger of [redacted] versus [redacted] I recommend we decrease Lantus to 10 units every 12 hours and monitor." An Interview was conducted with the Medical Doctor via telephone on 3/8/13 at 1:15 p.m. He	A 053		

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stated he would want the facility to call him for a [redacted] sugar of 40 or below. He stated he want the resident to eat food if the [redacted] sugar was below 60 before she had her Lantus injection. He stated his major concern was he thought because of the residents declining mental status and eyesight she could no longer administer her own medication. He stated, "I told the social worker at Sarasota Memorial Hospital twice she (Resident #3) could not self administer her own medications." The doctor was told of the situation of a medication technician giving 36 units of Lantus to the resident when her [redacted] sugar was 58 with the resident not having eaten. He stated, "That is an issue."

An interview was conducted with the ALF Administrator on [redacted] at 1:30 p.m. He was told of the concern for the resident being hospitalized due to hypoglycemia and the continued safety of the resident being in the facility. He stated he was not aware of the issue of medication technicians giving [redacted] to the residents. He was not aware of Resident #3 being sent to the hospital with hypoglycemia on 2/2/13. He stated he felt as long as the residents were able to give themselves the injection it was ok. He stated his understanding was staff could dial in the [redacted] for the residents with [redacted] pens.

In an interview with the Administrator at 5:30 p.m. on [redacted], he stated he had obtained a nurse to administer [redacted] to the resident on a daily basis. He stated this would continue until the resident was placed in another facility.

On [redacted] at 11:00 a.m., an interview was conducted with the Home Health Registered Nurse (RN) hired by the facility to evaluate the resident. She stated the resident is not

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A 053	Continued From page 49 appropriate for the ALF. She stated the resident is not able to care for her [illegible]. She stated she had interviewed all the staff in the facility and none of them knew their limitations and roles with regard to [illegible]. 2. Resident #1 is a [illegible] male who moved into the facility on [illegible]. On admission to the facility the resident had an order for sliding scale [illegible] coverage with [illegible]. He was to have coverage before meals and at the hour of sleep. Review of the resident's 1823 assessment shows he has a [illegible] and he is forgetful. According to the 1823, dated [illegible] the resident needs assistance with medications. Review of the resident's initial 1823 dated 3/2/11 shows no documentation as to whether the resident needs assistance or needs administration of medications. During the initial interview with the resident on [illegible], at 11:12 a.m., the resident was observed to be [illegible] slow. He did not seem capable of understanding his [illegible] use. He was asked how he received his [illegible]. He stated, "They put the number of units I need into the flex pen and I give myself the shot. They want to make sure I get the right dose. That's why they do that. I get my [illegible] sugar checked 4 times daily." At 11:50 a.m., the resident was observed receiving his [illegible] and [illegible] coverage. Staff D, an unlicensed staff member, was observed taking the resident's glucometer and holding it to the resident's finger and obtain a reading of 115 after the third attempt. She was observed handing the [illegible] pen to the resident. The resident was observed not to be able to dial	A 053		

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A 053	Continued From page 50 in his one unit dose of [illegible] coverage. The aide then pulled the pen close to her side and clicked the dial to one unit and handed it to the resident. The resident was observed to inject himself with the dosage given by the aide. An interview was conducted with Staff D on [illegible] at 10:00 a.m. She verified she had obtained the resident glucose and that she had dialed in the [illegible] dosage to the pen. She stated she sometimes had to do that for the resident. Review of the MAR shows the resident self administers his own [illegible] There is no documentation of [illegible] being given on the MAR. There is a separate untitled form that shows staff documenting [illegible] coverage and Lantus administration. These forms show on several days the resident missed coverage in [illegible] and [illegible]. Review of the forms show no coverage given at night for [illegible] sugars from 130-230. The residents sliding scale reads 100-150=1 unit, 151-200=3 units, 201-250=5 units, 251-300=7 units,301-350=9 units, 351-400=11 units. The resident [illegible] sugar was greater than 100 on every [illegible] reviewed from [illegible]. There was no follow up with a medical doctor documented as to why the resident was not receiving coverage at the hour of sleep. On [illegible] and [illegible] the resident received no Lantus in in the PM as ordered. There is no documentation in the resident's record as to why he didn't receive these doses of medication. An interview was conducted with the Resident #1	A 053		

Agency for Health Care Administration

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	AL11964447	A. BUILDING: _____ B. WING _____	03/11/2013

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ALDERMAN OAKS RETIREMENT CENTE	727 HUDSON AVENUE SARASOTA, FL 34236

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A 053	Continued From page 51 at 12:00 p.m. on . He stated, "I've been taking for ten years. I take 4 shots a day." He was asked what was the dosage of he took everyday. He stated, "It depends upon how much I needed." He was asked how much he would get if his sugar was 150. He stated, "I'm not sure. I usually hand the to staff and she tells me how much I need to take. I stick my self with a pen and get They take the machine and get the off my finger. They tell me what my sugar is and then they dial in the number on the and hand me the syringe. I feel I need the help they give me, it's like a little insurance policy to me to make sure I get the right dose of ." He stated, "I understand the people giving me are not nurses. I do not know what kind of training they have." He was asked what he thought was a low sugar he stated, "I'm not sure but the nurses will tell me." He was asked if he thought the people taking his sugar was nurses he stated, "They're supposed to be." He was asked if there was something that caused him not to be able to do his own sugar. He stated, "My eyes are not as good as they use to be. It's hard to see the to dial it in." At 1:00 p.m. on , the Administrator was informed of the surveyor's concern for the resident's safety at the facility. The Administrator was unaware of the extent that his staff was administering to the resident. He stated he thought the staff could dial in the pen for the residents. Class I	A 053		
A 054	58A-5.0185(5) FAC Medication - Records	A 054		

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A 054	Continued From page 52 (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 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 record review and interview the facility failed to keep accurate records for 2 (Residents #1 and #3) of 11 residents reviewed. The findings include: 1. Resident #1 is a male who moved into the facility on On admission to the	A 054	Tag A 054 CORRECTIVE ACTION As detailed in Tag A052 Alderman Oaks has an agreement with a State Licensed Pharmacist Consultant to train all staff who supervise the self-administration of medications and the Administrator to be trained in all med procedures for Assisted Living Facilities. This training will include all medication records. In addition the trainer will observe each staff member as they perform their med duties. After the original training the consultant will check the records and procedures quarterly for at least a year pending AHCA's satisfaction. Random monitoring will be conducted by the Licensed Pharmacist used by Alderman Oaks (he is also a med trainer and will be taking the consultant training as well). This re-training will be completed by 2013 per Tag A 052.	5/31/13

Agency for Health Care Administration

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A 054	Continued From page 53 facility the resident had an order for sliding scale coverage with . He was to have coverage before meals and at the hour of sleep. Review of the resident's 1823 assessment shows he has a and he is forgetful. According to the 1823, dated the resident needs assistance with medications. Review of the resident's initial 1823 dated 3/2/11 shows no documentation as to whether the resident needs assistance or needs administration of medications. The residents medications are recorded on a Medication Administration Record (MAR). On the MAR unlicensed staff are signing they are administering the resident's medications. Review of the MAR shows the resident self administers his own . There is no documentation of being given on the MAR. There is a separate untitled form that shows staff documenting coverage and Lantus administration. These forms show on several days the resident missed coverage in and . Review of the forms show no coverage given at night for sugars from 130-230. The residents sliding scale reads 100-150=1 unit, 151-200=3 units, 201-250=5 units, 251-300=7 units,301-350=9 units, 351-400=11 units. The resident sugar was greater than 100 on every reviewed from . There was no follow up with a medical doctor documented as to why the resident was not receiving coverage at the hour of sleep. On 11/28/12, 12/9/12, and 1/30/13 the	A 054		

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A 054	Continued From page 54	A 054		

resident received no Lantus in in the PM as ordered. There is no documentation in the resident's record as to why he didn't receive these doses of medication.

2. Resident #3 is a female who moved into the facility on

Review of the resident's Form1823 (resident health assessment) dated shows the medical doctor wanted the resident to have her medications administered. Administration of medications is performed by licensed persons (such as RN or LPN). The doctor documented on the form the resident suffers from memory loss.

The resident had an order for Lantus 36 units every am and 20 units every PM. She was receiving this dosage via an insulin pen injector. There was no order from a medical doctor found in the resident's record for the resident to self-administer Review of the facilities forms indicate a Medication administration record for of 2012 shows before meals twice daily, once before breakfast and supper. The times written on the MAR show 8:00 a.m. and 5:00 p.m. when the were obtained. The documentation in the month of begins on Review of MAR's from to show no documentation on the MAR of ordered. On separate sheets of untitled paper the facility documented readings 2 to 3 times daily from On 21 times the resident received Lantus insulin there was no documentation of an noted. On no order for could be found in the resident's chart.

An interview was conducted with Staff B on

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A 054	Continued From page 55 [redacted] at 10:00 a.m. She verified there was no order for [redacted] in the medical record. At 11:20 a.m. on [redacted] Staff B showed an order that had been faxed on [redacted] for [redacted] twice daily. In an interview with the Administrator on [redacted] at 5:00 p.m., he verified there was no order for the resident to self-administer medications. Class III	A 054		
A 056	58A-5.0185(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS (a) No prescription drug shall be kept or administered by the facility, including assistance with self-administration of medication, unless it is properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and 2. Identification of each medicinal drug product in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no person other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider shall be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be	A 056		

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A 056	Continued From page 56	A 056		

appropriate for the resident to request the medication and any limitations shall be specified; for example, " as needed for pain, not to exceed 4 tablets per day. " The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, shall be noted in the medication record, or a revised label shall be obtained from the pharmacist.

(d) Any change in directions for use of a medication for which the facility is providing assistance with self-administration or administering medication must be accompanied by a written medication order issued and signed by the resident ' s health care provider, or a faxed copy of such order. The new directions shall promptly be recorded in the resident ' s medication observation record. The facility may then place an " alert " label on the medication container which directs staff to examine the revised directions for use in the MOR, or obtain a revised label from the pharmacist.

(e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident ' s medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed copy of a signed order is acceptable.

(f) The facility shall make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner.

(g) Pursuant to Section 465.0276(5), F.S., and Rule 64F-12.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer ' s packaging, which shall also include the practitioner ' s name,

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A 056	Continued From page 57 the resident ' s name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer ' s labeled package, they shall be kept in a container that bears a label containing the following: 1. Practitioner ' s name; 2. Resident ' s name; 3. Date dispensed; 4. Name and strength of the drug; 5. Directions for use; and 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident ' s health care provider shall provide the resident with a written prescription, or a fax copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, review of physician's orders and interview with the pharmacist, the facility failed to ensure medication were accurately labeled for the correct use of the medication for 3 (Residents #14, #13, and #12) of 5 residents reviewed during self-administration of medications. The findings include: 1. Observation on at 8:00 a.m., revealed the Certified Nursing Assistant (CNA) preparing to assist Resident #14 with self-administration of her medication. Observation revealed 600 w/D" on the label of the medication the resident was supposed to take. Upon reconciliation of the medication with the MOR (Medication Observation Record), the MOR showed 600/400 D as the strength of the medication. The label of the did not match the MOR	A 056	Tag A 056 CORRECTIVE ACTION All medication labeling and order procedures will be addressed by the State Licensed Pharmacist Consultant. Random monitoring will be conducted by the Licensed Pharmacist used by Alderman Oaks (he is also a med trainer). After the original training the consultant will check the records and procedures quarterly for at least a year pending AHCA's satisfaction. This training will be completed by , 2013 per Tag A 052.	5/31/13

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A 056	Continued From page 58 Review of the physician's orders and interview with the pharmacist on at 10:07 a.m., confirmed the resident was to receive D and the label did not match what was ordered. The pharmacist stated she would make the correction. 2. Observation on at 9:27 a.m., revealed the CNA preparing to assist Resident #13 with self-administration of her medications. Observation of the label revealed 200 mg. take 1 tablet by mouth in the morning. However, upon reconciliation of the MOR to the label, the MOR showed 200 mg. take 1 tablet once a day. Interview with the pharmacist on at 10:06 a.m., revealed her most recent order by the physician for the date of reveal 200 mg. take 1 tablet once a day. The label did not match what the physician's orders or MOR indicated for directions for use. 3. Observation on at 8:34 a.m., revealed the CNA preparing to assist Resident #12 with self-administration of his medication. Observation of the label of the medication revealed Glimepride 1 mg. by mouth "Before breakfast." Upon reconciliation with the MOR, the MOR showed the resident to receive Glimepride 1 mg. take 1 tab by mouth "Once daily." Review of the physician's orders for the medication revealed Glimepride 1 mg. tab po AC-before breakfast give with food. During an interview with the pharmacist on at 10:10 a.m., she confirmed the most recent	A 056		

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A 056	Continued From page 59 order she has on file dated 2/4/13 indicates "Glimepride, take 1 tab by mouth once a day." The label did not match the physician's orders or the MOR. Further review of the resident's medication revealed the label of CL 10 meq showed it was to be given "By mouth three times daily"; however, the MOR showed it was to be given three times daily, "Do not crush." Review of the physician's orders confirmed the medication was to be given three times daily, "Do not crush." The label failed to match with the physician's orders and MOR. Class III	A 056		
A 077	58A-5.019(1) FAC Staffing Standards - Administrators Staffing Standards. (1) ADMINISTRATORS. Every facility shall be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of adequate care to all residents as required by Part I of Chapter 429, F.S., and this rule chapter. (a) The administrators shall: 1. Be at least 2. If employed on or after , 1990, have a high school diploma or general equivalency diploma (G.E.D.), or have been an operator or administrator of a licensed assisted living facility in the State of Florida for at least one of the past 3 years in which the facility has met minimum standards. Administrators employed on or after 1995, must have a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background	A 077		

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A 077	Continued From page 60 screening standards pursuant to Section 429.174, F.S.; and 4. Complete the core training requirement pursuant to Rule 58A-5.0191, F.A.C. (b) Administrators may supervise a maximum of either three assisted living facilities or a combination of housing and health care facilities or agencies on a single campus. However, administrators who supervise more than one facility shall appoint in writing a separate " manager " for each facility who must: 1. Be at least and 2. Complete the core training requirement pursuant to Rule 58A-5.0191, F.A.C. (c) Pursuant to Section 429.176, F.S., facility owners shall notify both the Agency Field Office and Agency Central Office within ten (10) days of a change in a facility administrator on the Notification of Change of Administrator, AHCA Form 3180-1006, 2006, which is incorporated by reference and may be obtained from the Agency Central Office. The Agency Central Office shall conduct a background screening on the new administrator in accordance with Section 429.174, F.S., and Rule 58A-5.014, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review, interview and observation, the Administrator allowed unlicensed staff to administer to 2 (Residents #1 and #3) of 3 residents reviewed resulting in the hospitalization of 1 (Resident #3) resident for hypoglycemia and the immediate potential danger for 2 (Residents #1 and #3) residents related to hypoglycemia and with a potential	A 077		

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A 077	Continued From page 61 for kidney failure, and The findings include: 1. Resident #3 is a 92 year old female who moved into the facility on . . . The resident is dependent and takes Lantus twice daily. Review of the resident's Form1823 (resident health assessment) dated shows the medical doctor wanted the resident to have her medications administered. Administration of medications is performed by licensed persons (such as RN or LPN). The doctor documented on the form the resident suffers from memory loss. Review of the medical record showed a Fax sheet dated . It is addressed to a Physician's Assistant and reads, "We need an updated 1823 for Resident #3. Our files show her old doctor checked the box "Needs Medication Administration." We assist Resident #3 with self-administration." On the bottom of the fax is written, "This is important as medication administration is skilled nursing." The fax has the name of Staff E, a CNA on staff listed as a contact person. The resident had a 1823 dated filled out by the PA. The form shows the resident can have assistance with self administrationof medications. An interview was conducted with the PA by phone on at 3:00 p.m. He stated he felt medication assistance was assisting with , and assisting the resident with their pens. He was not aware the facility did not have a nurse on staff to assist the resident with her . He stated, "We never heard anything	A 077	Tag A 077 CORRECTIVE ACTION The Administrator has just reviewed all Florida Assisted Living Law and Rules concerning 58A-5.0181 (4) FAC Admissions – Continued Residency. The Administrator respects AHCA surveyor and supervisor interpretations of what constitutes administration of . The Administrator understands that unlicensed employees can not help residents with braces, or . Alderman Oaks will fully comply with this law. The Administrator plans to take the "Core Training" which is to be held in Sarasota in May and will take the test as soon after that as can be scheduled. Starting 2013 a state licensed nursing home administrator will officially be Administrator of Alderman Oaks until this test can be successfully passed.	5/31/13

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A 077	Continued From page 62 from them (the ALF) so we assumed they were able to provide the care." On ___ the observation note reads, "(7-3) Resident complained of loose stools. Resident did not eat breakfast/lunch Resident's ___ sugar 58. Staff educated resident to drink fluids." On ___ the observation note reads, "(3-11) Resident ___ sugar remains at 58... Resident refuses to eat/drink. Resident very ___. Sent resident out to Sarasota Memorial Hospital per PA." The facility's documentation of ___ administration shows the resident was given 36 units of Lantus on ___ with a ___ sugar of 58. The resident had not eaten breakfast and had ___. The resident was hospitalized at 4:54 p.m. on ___ and spent the night in the hospital with ___. An interview was conducted with Resident #3 at 11:00 a.m. on 3/8/13. She was asked how much ___ she takes everyday. She stated, I take 33 units in the morning and 20 units at night. She was asked if she remembered going to the hospital in ___. She stated she did not remember. She was asked what happened in the morning when you get your ___, she stated the staff takes my ___ sugar and they dial in the ___ and I inject it. She was asked if she had a low ___ sugar who would make the decision not to take ___. She stated, "The nurses I guess." She was asked if the staff tell her what her ___ sugar is when they take it in the morning and night. She stated, "They don't tell me what my ___ sugar is. They give me the ___ and I	A 077		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDERMAN OAKS RETIREMENT CENTE	727 HUDSON AVENUE SARASOTA, FL 34236

(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 077	Continued From page 63 inject what they give me." The medical doctor who treated the resident on ... is the same medical doctor who signed her 1823 assessment on ... stating the resident needed her medications administered (by skilled staff) The medical doctor's note on discharge from the hospital reads, "At the time of emergency transport her ... sugar was 55 and she was given a half amp of D50. On arrival in the emergency ... after some evaluation her ... sugar was noted to be 68 ....Given her ... I recommend that she have medication assistance at the ALF....Given the relative danger of ... versus ... I recommend we decrease Lantus to 10 units every 12 hours and monitor." An interview was conducted with the Medical Doctor via telephone on ... at 1:15 p.m. He stated he would want the facility to call him for a ... sugar of 40 or below. He stated he want the resident to eat food if the ... sugar was below 60 before she had her Lantus injection. He stated his major concern was he thought because of the residents declining mental status and eyesight she could no longer administer her own medication. He stated, "I told the social worker at Sarasota Memorial Hospital twice she (Resident #3) could not self administer her own medications." The doctor was told of the situation of a medication technician giving 36 units of Lantus to the resident when her ... sugar was 58 with the resident not having eaten. He stated, "That is an issue." An interview was conducted with the ALF Administrator on ... at 1:30 p.m. He was told of the concern for the resident being hospitalized due to ... and the continued safety of	A 077		

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A 077	Continued From page 64 the resident being in the facility. He stated he was not aware of the issue of medication technicians giving [illegible] to the residents. He was not aware of Resident #3 being sent to the hospital with [illegible] on [illegible]. He stated he felt as long as the residents were able to give themselves the injection it was ok. He stated his understanding was staff could dial in the [illegible] for the residents with [illegible] pens. Review of the Administrators employee file shows he received 24 hours of CORE training in 1997. He had a 2 hour CORE update in 2010. He was trained in assisting with medications 10/4/12 by a pharmacist. He has completed 12 hours of continuing education based on elderly care since [illegible] of 2013. An interview was conducted with the Administrator on [illegible] at 11:00 a.m. He was asked how he would evaluate residents coming into the facility and how would he continually evaluate the appropriateness of residents while they were in the facility. He stated he relied on the medical doctors and the 1823 to evaluate the residents. He was asked if he had a policy regarding evaluating resident's appropriateness for the facility. He stated he had been working on a tool form two weeks prior to the survey regarding evaluating residents. He stated he had no current policy at this time. He then stated he has meetings every 2 weeks with Home health nurses who provide skilled nursing for the residents. He stated he relied on those meeting to inform him if of the status of the residents. In an interview with the Marketing Director on [illegible] at 12:00 p.m., he stated the facility had not implemented the New Evaluation Form as of yet. He stated Staff E, a CNA, had been working	A 077		

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A 077	Continued From page 65 on writing the form. Review of the "Alderman Oaks New Resident Evaluation Form" shows #17 on the form as an evaluation of [redacted] coming into the facility. It reads, "17. Are they [redacted] If so can they push down their plunger on their [redacted] pen without assistance?" There is no further evaluation of the [redacted] resident noted on the form. Class I	A 077		
A 165	429.23 FS; 58A-5.0241 FAC Risk Mgmt & QA; Adverse Incident Report Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, " adverse incident " means: (a) An event over which facility personnel could exercise control rather than as a result of the resident ' s condition and results in: 1. [redacted] 2. [redacted] or spinal damage; 3. Permanent 4. [redacted] or [redacted] of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her	A 165		

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A 165	Continued From page 66 consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility ' s investigation of the incident. (4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility ' s investigation into the adverse incident. (5) , neglect, or must be reported to the Department of Children and Family Services as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident.	A 165		

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A 165	Continued From page 67 The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The Department of Elderly Affairs may adopt rules necessary to administer this section. Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within one (1) business day after the incident on AHCA Form 3180-1024, Assisted Living Facility Initial Adverse Incident Report-1 Day, 2006, and incorporated by reference. The form shall be submitted via electronic mail to riskmgmtps@ahca.myflorida.com; on-line at http://ahca.myflorida.com/reporting/index.shtml; by facsimile to (850)922-2217; or by U.S. Mail to AHCA, Florida Center for Health Information and Policy Analysis, 2727 Mahan Drive, Mail Stop 16, Tallahassee, Florida 32308-5403, telephone (850)412-3731. AHCA Form 3180-1024 is available from the Florida Center for Health Information and Policy Analysis at the address	A 165		

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A 165	Continued From page 68 stated above. The Initial Adverse Incident Report is in addition to, and does not replace, other reporting requirements specified in Florida Statutes. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported under subsection (1) above, the facility shall submit a full report within fifteen (15) days of the incident. The full report shall be submitted on AHCA Form 3180-1025, Assisted Living Facility Full Adverse Incident Report-15 Day, dated 2006, and incorporated by reference. The methods for obtaining and submitting the form are set forth in subsection (1) of this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to report an adverse incident for 1 (Resident #3) of 11 residents reviewed. The findings include: 1. Resident #3 is a female who moved into the facility on . The resident is dependent and takes Lantus twice daily. Review of the resident's Form1823 (resident health assessment) dated shows the medical doctor wanted the resident to have her medications administered. Administration of medications is performed by licensed persons (such as RN or LPN). The doctor documented on the form the resident suffers from memory loss. On the observation note reads, "(7-3) Resident complained of loose stools. Residen:	A 165	Tag A 165 CORRECTIVE ACTION Adverse incident reporting will be reviewed with all med techs. The Administrator has already reviewed the law concerning Adverse Incidents. Alderman Oaks' procedures concerning adverse incidents will be changed in our operating manual to include reporting an Adverse Incident whenever an assisted living resident is sent to a facility for more acute care unless in the Administrator's opinion, the situation very clearly is caused by condition existing before the incident (if in doubt, file report). The procedure shall be changed and re-taught to med tech staff by 2013.	4/30/13

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A 165	Continued From page 69 did not eat breakfast/lunch Resident's sugar 58. Staff educated resident to drink fluids." On the observation note reads, "(3-11) Resident sugar remains at 58... Resident refuses to eat/drink. Resident very Sent resident out to Sarasota Memorial Hospital per PA." The facility's documentation of administration shows the resident was given 36 units of Lantus on with a sugar of 58. The resident had not eaten breakfast and had The resident was hospitalized at 4:54 p.m. on and spent the night in the hospital with An interview was conducted with Resident #3 at 11:00 a.m. on She was asked how much she takes everyday. She stated, I take 33 units in the morning and 20 units at night. She was asked if she remembered going to the hospital in She stated she did not remember. She was asked what happened in the morning when you get your she stated the staff takes my sugar and they dial in the and I inject it. She was asked if she had a low sugar who would make the decision not to take She stated, "The nurses I guess." She was asked if the staff tell her what her sugar is when they take it in the morning and night. She stated, "They don't tell me what my sugar is. They give me the insulin and I inject what they give me." The medical doctor who treated the resident on is the same medical doctor who signed her 1823 assessment on 6/4/12 stating the resident	A 165		

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A 165	Continued From page 70 needed her medications administered (by skilled staff.) The medical doctor's note on discharge from the hospital reads, "At the time of emergency transport her [redacted] sugar was 55 and she was given a half amp of D50. On arrival in the emergency [redacted] after some evaluation her [redacted] sugar was noted to be 68....Given her [redacted] I recommend that she have medication assistance at the ALF....Given the relative danger of [redacted] versus [redacted] I recommend we decrease Lantus to 10 units every 12 hours and monitor." An interview was conducted with the Medical Doctor via telephone on 3/8/13 at 1:15 p.m. He stated he would want the facility to call him for a [redacted] sugar of 40 or below. He stated he want the resident to eat food if the [redacted] sugar was below 60 before she had her Lantus injection. He stated his major concern was he thought because of the residents declining mental status and eyesight she could no longer administer her own medication. He stated, "I told the social worker at Sarasota Memorial Hospital twice she (Resident #3) could not self administer her own medications." The doctor was told of the situation of a medication technician giving 36 units of Lantus to the resident when her [redacted] sugar was 58 with the resident not having eaten. He stated, "That is an issue." An interview was conducted with the ALF Administrator on [redacted] at 1:30 p.m. He was told of the concern for the resident being hospitalized due to [redacted] and the continued safety of the resident being in the facility. He stated he was not aware of the issue of medication technicians giving [redacted] to the residents. He was not aware of Resident #3 being sent to the hospital with [redacted] on [redacted]. He stated	A 165		

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A 165	Continued From page 71 he felt as long as the residents were able to give themselves the injection it was ok. He stated his understanding was staff could dial in the for the residents with pens. Class III	A 165		
A 167	58A-5.025(1) FAC Resident Contracts Resident Contracts. (1) Pursuant to Section 429.24, F.S., prior to or at the time of admission, each resident or legal representative shall execute a contract with the facility which contains the following provisions: (a) A list of the specific services, supplies and accommodations to be provided by the facility to the resident, including limited nursing and extended congregate care services if the facility is licensed to provide such services. (b) The daily, weekly, or monthly rate. (c) A list of any additional services and charges to be provided that are not included in the daily, weekly, or monthly rates, or a reference to a separate fee schedule which shall be attached to the contract. (d) A provision giving at least 30 days written notice prior to any rate increase. (e) Any rights, duties, or of residents, other than those specified in Section 429.28, F.S. (f) The purpose of any advance payments or deposit payments and the refund policy for such advance or deposit payments. (g) A refund policy which shall conform to Section 429.24(3), F.S. (h) A written bed hold policy and provisions for terminating a bed hold agreement if a facility agrees in writing to reserve a bed for a resident who is admitted to a nursing home, health care facility, or facility. The resident or	A 167		

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A 167	Continued From page 72	A 167		

responsible party shall notify the facility in writing of any change in status that would prevent the resident from returning to the facility. Until such written notice is received, the agreed upon daily, weekly, or monthly rate may be charged by the facility unless the resident ' s medical condition, such as the resident ' s being comatose, prevents the resident from giving written notification and the resident does not have a responsible party to act in the resident ' s behalf.

(i) A provision stating whether the organization is affiliated with any religious organization, and, if so, which organization and its relationship to the facility.

(j) A provision that, upon determination by the administrator or health care provider that the resident needs services beyond those the facility is licensed to provide, the resident or the resident ' s representative, or agency acting on the resident ' s behalf, shall be notified in writing that the resident must make arrangements for transfer to a care setting that has services needed by the resident. In the event the resident has no person to represent him, the facility shall refer the resident to the social service agency for placement. If there is disagreement regarding the appropriateness of placement, provisions as outlined in Section 429.26(8), F.S., shall take effect.

(k) A provision that residents must be assessed upon admission pursuant to subsection 58A-5.0181(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4) of that rule.

(l) The facility ' s policies and procedures for self-administration, assistance with self-administration and administration of medications, if applicable, pursuant to Rule 58A-5.0185, F.A.C. This also includes provisions regarding over-the-counter (OTC) products

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A 167	Continued From page 73 pursuant to subsection (8) of that rule. (m) The facility ' s policies and procedures related to a properly executed This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility allowed 2 (Residents #15 and #16) residents to occupy beds licensed as Assisted Living Facility (ALF) without a contract. The findings include: After entering the Facility at 9:10 a.m. on 3/6/13, the Administrator explained to the surveyors what beds were licensed as ALF. He stated the rest of the facility were independent residents. Review of the floor plan showed the entire 2nd floor licensed as a ALF. Four ..... were designated on the third floor as ALF ..... #305, #308, #320 and #316. On the first floor of the facility 3 ..... #105, #116 and #117 were designated as ALF ..... During an interview with the Administrator on 3/6/13 at 1:00 p.m., he stated that some independent resident may be living in the ALF ..... He stated the ..... were leased by the residents. He stated they did not have ALF contracts. Review of the facility records show 2 (Residents #15 and #16) hold a lease agreement for two ..... licensed as ALF beds. The ..... are #308 and #316. They is no ALF contract with the residents occupying these	A 167	Tag A 167 CORRECTIVE ACTION Our policy for assigning Assisted Living Beds to Alderman Oaks' apartment shall be modified to assure that independent residents are not contracted for apartments designated with assisted living beds. Alderman Oaks on ..... sent a request to AHCA, Ft. Myers to have bed assignments removed from the two apartments which had bed assignments and independent residents residing in them. On ..... Alderman Oaks ..... endeavored to correct the assignment of beds which were thought to be in violation. It will be our policy to make sure that we have assisted living contracts for those apartments which have assigned beds. This was not our understanding in the past, but we are glad to comply with AHCA.	Completed 4/4/13

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A 167	Continued From page 74 Class	A 167		
AZ827	408.812, FS Unlicensed Activity (1) A person or entity may not offer or advertise services that require licensure as defined by this part, authorizing statutes, or applicable rules to the public without obtaining a valid license from the agency. A licenseholder may not advertise or hold out to the public that he or she holds a license for other than that for which he or she actually holds the license. (2) The operation or maintenance of an unlicensed provider or the performance of any services that require licensure without proper licensure is a violation of this part and authorizing statutes. Unlicensed activity constitutes harm that materially affects the health, safety, and welfare of clients. The agency or any state attorney may, in addition to other remedies provided in this part, bring an action for an injunction to restrain such violation, or to enjoin the future operation or maintenance of the unlicensed provider or the performance of any services in violation of this part and authorizing statutes, until compliance with this part, authorizing statutes, and agency rules has been demonstrated to the satisfaction of the agency. (3) It is unlawful for any person or entity to own, operate, or maintain an unlicensed provider. If after receiving notification from the agency, such person or entity fails to cease operation and apply for a license under this part and authorizing statutes, the person or entity shall be subject to penalties as prescribed by authorizing statutes and applicable rules. Each day of continued operation is a separate offense.	AZ827		

Agency for Health Care Administration

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ALDERMAN OAKS RETIREMENT CENTE	727 HUDSON AVENUE SARASOTA, FL 34236

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AZ827	Continued From page 75 (4) Any person or entity that fails to cease operation after agency notification may be fined $1,000 for each day of noncompliance. (5) When a controlling interest or licensee has an interest in more than one provider and fails to license a provider rendering services that require licensure, the agency may revoke all licenses and impose actions under s. 408.814 and a fine of $1,000 per day, unless otherwise specified by authorizing statutes, against each licensee until such time as the appropriate license is obtained for the unlicensed operation. (6) In addition to granting injunctive relief pursuant to subsection (2), if the agency determines that a person or entity is operating or maintaining a provider without obtaining a license and determines that a condition exists that poses a threat to the health, safety, or welfare of a client of the provider, the person or entity is subject to the same actions and fines imposed against a licensee as specified in this part, authorizing statutes, and agency rules. (7) Any person aware of the operation of an unlicensed provider must report that provider to the agency. This Statute or Rule is not met as evidenced by: Based on record review, interview, and observation the facility allowed unlicensed staff to provide services allowed only with a Limited Nursing Service (LNS) License to 1 (Resident #7) of 11 residents reviewed while possessing a standard Assisted Living Facility (ALF) license resulting in a potential for injury to the resident. The findings include:	AZ827	Tag AZ827 Unlicensed Activity CORRECTIVE ACTION It has never been our intent to break Florida Laws or Rules. The Administrator is re-taking Core Training in . By the end of all med tech staff and the administrator will have re-taken the Med training required by non licensed staff to permit their supervision of the self-administration of meds. At that point (these issues have already been addressed internally) training will have been completed to make sure that Alderman Oaks and staff comply with all assisted living law.	5/31/13

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
	AL11964447	A. BUILDING: _____ B. WING _____	03/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDERMAN OAKS RETIREMENT CENTE	727 HUDSON AVENUE SARASOTA, FL 34236

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AZ827	Continued From page 76 Observation of Resident #7 on [redacted] at 9:45 a.m., revealed the resident in her [redacted] in a wheelchair. A full leg brace from the top of the resident's left thigh down to the bottom of her left leg was in place. During this observation, the resident was asked if she puts the leg brace on by herself or if she receives assistance. She stated, "They help me put my brace on my left leg." She referred to "They" as the CNA's at the ALF. She stated, "We don't have a registered nurse here. My leg brace goes on some mornings early when I go to breakfast but otherwise, it's a busy [redacted] there's a lot of people around. I wear my brace in the morning...I wear the brace most of the day." When asked how she removes the brace, she stated, "One of the same people who is on duty that hour (in the evening) removes my brace for me. They also put my stockings on. These are the white elastic ones (pointing). The same people who help with the brace help with my stockings." Observation on [redacted] at 11:48 a.m., revealed the resident wheeling herself out toward the dining [redacted]. A CNA bent down next to her and adjusted the strap on her left leg brace. During an interview on [redacted] at 1:33 p.m., the same CNA observed adjusting the strap on the resident's left leg brace, she stated, "I'm not sure if I can help her, it would be good to know but I put it on, make sure it fits right, there are two spots near her knee (as indicators for aligning the brace). She has a diagram booklet that she got when she was in rehab that I use. And then she fastens it. I help her with her [redacted] D's (elastic stockings) too." The CNA explained the resident went out to ER (Emergency [redacted] for [redacted] and While she was there it was determined that she needed to go to rehab. The CNA stated, "While she was there, I guess they found a crack or	AZ827		

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	AL11984447	A. BUILDING: _____ B. WING _____	03/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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AZ627	Continued From page 77	AZ827		

in her knee. She (Resident #7) followed up with the doctor who determined she needed a brace."

Review on of Resident #7's demographic information sheet documented the resident was originally admitted to the facility on

A review of the most recent 1823 Health Assessment signed by the physician for the date of documents the resident with previous left total knee replacement and with left knee strain. Under the "Physical or sensory limitations section" of this assessment, the resident is to wear a "Brace" to left leg when out of bed. Her level of assistance required for ambulation was not assessed; the section was left blank. The section of the assessment requesting the level of assistance the resident requires with medication was checked under "Needs medication administration." There is no physician's orders for the application or removal of the elastic stockings.

Review of the "Resident Observation Log" completed by the facility staff dated documented the resident "wasn't feeling well, was seen by an RN that happened to be on the second floor. She stated the resident wasn't oriented and was weak. She stated that she might be or have a more serious issue. Suggested she (illegible) send to hospital. PA (Physician's Assistant) was contacted and he said to send her to hospital. Administrator and family was notified."

Review of the facility's current licensure status lists the facility as a "Standard" license. The facility does not have a limited nursing license. As stipulated by Florida statutes, "A facility with a limited nursing license may provide the following nursing services in addition to any nursing service permitted under a standard license pursuant to Section 429.256, F.S.: (k) Caring for casts,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AZ827	Continued From page 78 braces and splints...." An interview was conducted with the Administrator of the facility on 3/6/13 at 2:45 p.m. He confirmed he is responsible for the oversight of the wellness center. He acknowledged the facility's "Standard" licensure; however, was not aware the CNA's were placing the brace on the resident's leg (which is a nursing service) for which the facility did not hold the proper licensure. He was not aware the resident's physician indicated the resident required medication administration (which is a nursing service) and failed to ensure the services being provided to the resident were within the scope of the CNA's certification and facility current licensure requirements. Unclassified	AZ827		

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Alderman Oaks Retirement Center
727 Hudson Avenue
Sarasota, FL 34236

Dear Administrator:

This letter reports the findings of a state licensure survey that was completed on . 2013 by representatives of this office.

You are directed to provide a plan of correction to the Fort Myers Field Office for the identified deficiencies within ten calendar days of receipt of this faxed report. The plan should be directed to the attention of Mr. Harold Williams, Field Office Manager and mailed to:

Agency for Health Care Administration
Health Quality Assurance, Fort Myers Field Office
2295 Victoria Avenue, Suite 340
Fort Myers, FL 323901
Phone: (239) 335-1315
Fax: (239) 338-2372

The survey resulted in findings of noncompliance with the following areas:

1) A010 Admissions – Continued Residency. Class III

Your Assisted Living facility failed to ensure appropriateness of continued residency for 3 residents resulting in the hospitalization of 1 resident and the continued potential for injury for 3 residents.

2) A 030 Resident Rights. Class I

Your Assisted Living Facility denied residents their right to appropriate health care by allowing unlicensed staff to administer ..... and care for a leg brace. This resulted in the hospitalization of 1 resident and the immediate potential injury for 3 residents.

3) A 0052 Medication – Assistance with self-administration. Class III

Your Assisted Living Facility failed to properly assist 1 resident who required assistance with self-administration of medications. The Certified Nursing Assistant (CNA) failed to remain with the resident while self-administering his medications and failed to assist the resident with his medications according to the physician's orders.

4) A 053 Medication Administration. Class I

Your Assisted Living Facility allowed unlicensed staff to administer to 2 residents resulting in the hospitalization of 1 resident for and the immediate potential danger for 2 residents related to and with a potential for kidney failure, and

5) A 054 Medication – Records. Class III

Your Assisted Living Facility failed to keep accurate medication records for 2 residents.

6) A 056 Medication – Labeling and Orders. Class III

Your Assisted Living Facility failed to ensure medication were accurately labeled for the correct use of the medication for 3 residents reviewed during self-administration of medications.

7) A 077 Staffing Standards – Administrators. Class I

Your Assisted Living Facility Administrator allowed unlicensed staff to administer to 2 residents resulting in the hospitalization of 1 resident for and the immediate potential danger for 2 residents related to and with a potential for kidney failure, and

8) A 165 Risk Management & QA; Adverse Incident report. Class III

to report an adverse incident for 1 (Resident #3) of 11 residents reviewed. to report an adverse incident for 1 resident.

9) A 167 Resident Contracts. Class

Your Assisted Living Facility allowed 2 residents to occupy beds licensed as Assisted Living Facility (ALF) without a contract.

10) Z827 Unlicensed Activity. Unclassified

Your Assisted Living Facility allowed unlicensed staff to provide services allowed only with a Limited Nursing Service (LNS) License to 1 Resident, while possessing a standard Assisted Living Facility (ALF) license resulting in a potential for injury to the resident.

Your plan of correction must include the following:

1) Immediate hiring of a Consultant Pharmacist to evaluate the complete medication system utilized in your facility; assess the technique of each staff providing medication assistance and outlining a plan of correction.

Description of how you plan to address all medication issues identified during the revisit survey and through the consultant process.

Evidence of an agreement for the services of a Pharmacist Consultant who is Florida licensed. The agreement must provide for, at a minimum, onsite, quarterly consultation. The duration of this agreement must be for at least one year. Prior to discontinuation of this consultant's services, the Agency will conduct an onsite inspection to determine if these services must continue.

2) The Administrator and all staff that assist with the self-administration of medications immediately take the Department of Elder Affairs Assistance With Self-Administration of Medications in an Assisted Living Facility class.

3) Immediately determine the eligibility of all residents for continued residency in the facility.

4) Immediately obtain the services of a nurse to administer medications to the residents indicated in citation A053 or immediately move these residents out of the facility to a more appropriate placement.

5) Administrator completes the ALF CORE Training including taking and passing the CORE competency examination. The facility is to remain under third party oversite by a person who is currently eligible to be an Assisted Living Facility Administrator until the current Administrator completes this requirement.

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 surveyors. 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