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
	AL11965330	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA OAKS ASSISTED LIVING	1013 EAST GIBSON STREET ARCADIA, FL 34266

(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 Two Complaint Surveys, CCR# 2013002380 and CCR#2013001667 were conducted at Arcadia Oaks Assisted Living Facility on through The following is a description of non-compliance:	A 000		
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		

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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	A 010		

This Statute or Rule is not met as evidenced by:
Based on record review observation and interview, the facility failed to discharge 1 (Resident #7) of 7 residents sampled who can no longer assist with her Activities of Daily (ADLs).

The findings include:

On . at 12:20 p.m., Resident #7 was observed sitting in her wheelchair in the small dining . . . . . Resident #7 remained motionless, she did not attempt to feed herself. A staff member fed Resident #7. At 1:36 p.m., of the same day, Staff E and Staff B rolled Resident #7 into her . . . . . A sign was observed above Resident #7's bed. The sign read, "Please remember to rotate Resident #7 every [two] hours (picture taken)." At approximately 1:37 p.m., Staff E and B were observed transferring Resident #7 from her wheelchair to her bed. Staff E bent over and lifted Resident #7 out of the wheelchair, while Staff B lifted Resident #7 from behind. Resident #7's feet did not touch the ground during the transfer. Resident #7 remained motionless throughout the transfer process. Staff E and B were observed changing Resident #7's adult brief immediately after the transfer. Staff B rolled Resident #7 onto her right side while Staff E wiped Resident #7's bottom, then Staff E rolled Resident #7 onto her left side while staff B replaced Resident #7's bed . . . Staff E pulled a new adult brief over Resident #7's feet, between her legs and onto her bottom. Resident #7 was motionless the throughout the entire process. Resident #7 was not observed assisting in her ADLs.

On . . at 4:15 p.m., an interview was conducted with Staff D. Staff D stated Resident

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A 010	Continued From page 3 #7 is, .I weight and could not assist in her transfers." On . at 1:28 p.m., Staff B was interviewed. Staff B explained they would not put Resident #7 on the toilet, because the resident would ...l off of the toilet. Staff B continued by saying, "I am going to tell you the truth; we have to do everything (all ADLs) for [Resident #7]." On . Resident #7's physician was interviewed. He confirmed Resident #7 needs, "Total care" with ADLs. On . an offsite record review reveled the facility has a standard licenses. Class III	A 010		
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	AZ827		

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AZ827	Continued From page 4	AZ827		

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.

(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

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AZ827	Continued From page 5	AZ827		

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, observations and interviews, the facility allowed unlicensed staff to provide services to 4 (Residents #6, #7, #8, and #9) of 9 residents observed for which the facility does not have a specialty license to provide.

The findings include:

1. On , a pre-survey record search revealed the facility has a standard license.

2. On , Resident #6's record was reviewed. The record revealed a physician's order dated on for two (2) liters of continuous

3. On , Resident #7's record was reviewed. The record revealed a physician's order dated on for two (2) liters of continuous

4. On , a review of Resident #8's record revealed a physician's order for two (2) liters of continuously through a nasal cannula.

5. On , Resident #9's record was reviewed. The record revealed Resident #9 was admitted to the facility on with an external bag.

On at 12:19 p.m., Staff B was observed changing Resident #8's tank in the small dining Staff B checked Resident #8's

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AZ827	Continued From page 6	AZ827		

level then removed a large tank from the back of Resident #8's wheelchair and replaced it with a new tank. Staff A turned Resident #8's on and set the level to two liters.

On at approximately 12:30 p.m., Staff A was observed changing the tanks for Residents #6 and #7. Staff A replaced the tanks for both resident and set both tanks to two liters of .

On at 9:45 a.m., Staff D and Staff F were observed assisting Resident #9 in the . Staff F disconnected Resident #9's bag from Resident #9's stomach area. Staff D retrieved a new wafer and bag for Resident #9. Staff D cut a hole in the center of the wafer. Staff E entered the relieved Staff F. Staff E verbally prompted Resident #9 to clean around the hole in her stomach with a wipe. After seeing Resident #9 was unable to properly clean around the area, Staff E grabbed a few wipes and cleaned around the whole in Resident #9's stomach. Staff D placed a new adhesive wafer around the hole in Staff D's stomach. Staff D attached the bag to the wafer on Resident #9's stomach. Staff D placed a clamp at the end of the bag.

On at approximately 12:21 p.m., Staff B was interviewed. Staff B stated Residents #6, #7, and #9 cannot manage or maintain their own tanks. She states the facility staff changes the tanks for these residents. Staff B confirmed she is not a nurse.

On at approximately 12:37 p.m., Staff A was interviewed. Staff A confirmed she is not a nurse. Staff A also stated when she prepare

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AZ827	Continued From page 7	AZ827		

resident who cannot manage their for bed, she takes the tank off the wheelchair and adjust the level to 0 (zero) liters. She continued by saying she puts the residents on their respective concentrator and when they get up in the morning the she adjust the tank back to 2 (two) liters of

On at 12:37 p.m., Staff C was interviewed. Staff C admitted to assisting Residents #6, #7 and #8 with their Staff C confirmed she is not a licensed nurse.

On at 12:45 p.m., the Administrator was interviewed. The Administrator confirmed she allows unlicensed staff members to assist residents with their tanks and concentrators. The Administrator confirmed she has a Standard Assisted Living Facility Licenses without a specialty license. She also confirmed the facility does not have licensed staff providing care and services in this facility.

On at approximately 4:15 p.m., Staff D was interviewed. Staff D described cleaning caring for Resident #9's bag and Staff D stated, "We have to take it [the bag] off, we remove it [the wafers] from around the hole in her stomach." Staff D stated [the facility staff] clean the area around the and replace the wafer and the bag." Staff D stated Resident #9 cannot connect her bag without assistance. She added, "Resident #9 can't really get it [her bag] back on the whole like she needs to."

On at 4:40 p.m., Resident #9 was interviewed. Resident #9 stated the staff changes her bag and cleans around her open for her.

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AZ827	Continued From page 8	AZ827		

Unclassified

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Arcadia Oaks Assisted Living
1013 East Gibson Street
Arcadia, FL 34266

RE: REVISED

Dear Administrator:

Enclosed you will find the REVISED State (3020) Form showing tag A165 has been dropped.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

Enclosure: Revised State (3020) Form

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

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

PRINTED: 04/23/2013
FORM APPROVED

Agency for Health Care Administration

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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 | (X6) DATE

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A 010	Continued From page 2	A 010	Resident #7 was discharged to a skilled nursing facility.	4/26/13

This Statute or Rule is not met as evidenced by:
Based on record review observation and interview, the facility failed to discharge 1 (Resident #7) of 7 residents sampled who can no longer assist with her Activities of Daily (ADLs).

The findings include:

On 4/10/13 at 12:20 p.m., Resident #7 was observed sitting in her wheelchair in the small dining . . . . Resident #7 remained motionless, she did not attempt to feed herself. A staff member fed Resident #7. At 1:36 p.m., of the same day, Staff E and Staff B rolled Resident #7 into her . . . . A sign was observed above Resident #7's bed. The sign read, "Please remember to rotate Resident #7 every [two] hours (picture taken)." At approximately 1:37 p.m., Staff E and B were observed transferring Resident #7 from her wheelchair to her bed. Staff E bent over and lifted Resident #7 out of the wheelchair, while Staff B lifted Resident #7 from behind. Resident #7's feet did not touch the ground during the transfer. Resident #7 remained motionless throughout the transfer process. Staff E and B were observed changing Resident #7's adult brief immediately after the transfer. Staff B rolled Resident #7 onto her right side while Staff E wiped Resident #7's bottom, then Staff E rolled Resident #7 onto her left side while staff B replaced Resident #7's bed pad, ... E pulled a new adult brief over Resident #7's feet, between her legs and onto her bottom. Resident #7 was motionless the throughout the entire process. Resident #7 was not observed assisting in her ADLs.

On 4/09/13 at 4:15 p.m., an interview was conducted with Staff D. Staff D stated Resident

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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	A 165	Letter to appeal A165 sent 5/16/13 to AHCA Supervisor for review.	

Agency for Health Care Administration

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	AL11965330	A. BUILDING: _____ B. WING _____	04/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA OAKS ASSISTED LIVING	1013 EAST GIBSON STREET ARCADIA, FL 34266

(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 165	Continued From page 4 resident ' s condition and results in: 1. 2. [illegible] or spinal damage; 3. Permanent 4. [illegible] or [illegible] of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her 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. (6) [illegible] neglect, or [illegible] 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	A 165		

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A 165	Continued From page 5	A 165		

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. 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;

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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 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 2005, 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 file a one day incident report for 1 (Resident #10) of 3 residents reviewed who were found at the facility.

The findings include:

A review Resident #10's incident report revealed Resident #10 was observed face down on the floor on 4/06/12 shortly after 8:00 a.m., was performed and the resident was pronounced at the facility.

On an interview was conducted with

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Staff D. Staff D stated on 4/0(approximately 7:45 a.m., she went to Resident #10's rooms ...wake him up and remind him to come to breakfast. Staff D recalled the resident told her he would be out after he used the bathroom. ....'D stated she noticed Resident #10 did not come down for breakfast, so she went to his room ..... him face down on the floor without a pulse. Staff D stated she alerted her supervisor.

On 4/0(4:55 a.m., the Administrator was interviewed. She confirmed a one day incident report was not filed for this resident.

Class IV

408.812, FS Unlicensed Activity AZ827

(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

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AZ827	Continued From page 8 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. (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 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.	AZ827		

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AZ827	Continued From page 9 (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, observations and interviews, the facility allowed unlicensed staff to provide services to 4 (Residents #6, #7, #8, and #9) of 9 residents observed for which the facility does not have a specialty license to provide. The findings include: 1. On , a pre-survey record search revealed the facility has a standard license. 2. On 4/09/13, Resident #6's record was reviewed. The record revealed a physician's order dated on 4/01/12 for two (2) liters of continuous 3. On , Resident #7's record was reviewed. The record revealed a physician's order dated on 4/13/11 for two (2) liters of continuous 4. On , a review of Resident #8's record revealed a physician's order for two (2) liters of continuously through a nasal cannula. 5. On 4/09/13, Resident #9's record was reviewed. The record revealed Resident #9 was admitted to the facility on 1/11/05 with an external bag. On , at 12:19 p.m., Staff B was observed changing Resident #8's tank in the small dining . Staff B checked Resident #8's level then removed a large tank from the back of Resident #8's wheelchair and	AZ827	Resident #6 has received verbal cues and is able to manage his oxygen. Resident #7 was discharged to a skilled nursing facility. 4/26/13 Resident #8 was discharged to a skilled nursing facility. 4/26/13 Resident #9 receives assistance by a nurse the family hired to manage the colostomy a daily basis. 5/13/13	

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AZ827	Continued From page 10 replaced it with a new tank. Staff A turned Resident #8's on and set the level to two liters. On at approximately 12:30 p.m., Staff A was observed changing the tanks for Residents #6 and #7. Staff A replaced the tanks for both resident and set both tanks to two liters of On at 9:45 a.m., Staff D and Staff F were observed assisting Resident #9 in the Staff F disconnected Resident #9's bag from Resident #9's stomach area. Staff D retrieved a new wafer and bag for Resident #9. Staff D cut a hole in the center of the wafer. Staff E entered the relieved Staff F. Staff E verbally prompted Resident #9 to clean around the hole in her stomach with a wipe. After seeing Resident #9 was unable to properly clean around the area, Staff E grabbed a few wipes and cleaned around the whole in Resident #9's stomach. Staff D placed a new adhesive wafer around the hole in Staff D's stomach. Staff D attached the bag to the wafer on Resident #9's stomach. Staff D placed a clamp at the end of the bag. On 4/09/13 at approximately 12:21 p.m., Staff B was interviewed. Staff B stated Residents #6, #7, and #9 cannot manage or maintain their own tanks. She states the facility staff changes the tanks for these residents. Staff B confirmed she is not a nurse. On at approximately 12:37 p.m., Staff A was interviewed. Staff A confirmed she is not a nurse. Staff A also stated when she prepare resident who cannot manage their for bed, she takes the tank off the wheelchair	AZ827	Resident #9 is not on oxygen.	

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AZ827	Continued From page 11	AZ827		

and adjust the level to 0 (zero) liters. She continued by saying she puts the residents on their respective concentrator and when they get up in the morning the she adjust the tank back to 2 (two) liters of .

On 4/09/13 at 12:37 p.m., Staff C was interviewed. Staff C admitted to assisting Residents #6, #7 and #8 with their . Staff C confirmed she is not a licensed nurse.

On 4/09/13 at 12:45 p.m., the Administrator was interviewed. The Administrator confirmed she allows unlicensed staff members to assist residents with their tanks and concentrators. The Administrator confirmed she has a Standard Assisted Living Facility Licenses without a specialty license. She also confirmed the facility does not have licensed staff providing care and services in this facility.

On at approximately 4:15 p.m., Staff D was interviewed. Staff D described cleaning caring for Resident #9's bag and . Staff D stated, "We have to take it [the bag] off, we remove it [the wafers] from around the hole in her stomach. " Staff D stated [the facility staff] clean the area around the and replace the wafer and the bag." Staff D stated Resident #9 cannot connect her bag without assistance. She added, "Resident #9 can't really get it [her bag] back on the whole like she needs to."

On at 4:40 p.m., Resident #9 was interviewed. Resident #9 stated the staff changes her bag and cleans around her open for her.

Unclassified

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A 000	Initial Comments Two Complaint Surveys, CCR# 2013002380 and CCR#2013001667 were conducted at Arcadia Oaks Assisted Living Facility on ... through ... The following is a description of non-compliance:	A 000		
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 resid... 's record; and	A 010		

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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 ... nsed 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 ... nse 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	A 010	Resident #7 was discharged to a skilled nursing facility. 4/26/13	

This Statute or Rule is not met as evidenced by:
Based on record review observation and interview, the facility failed to discharge 1 (Resident #7) of 7 residents sampled who can no longer assist with her Activities of Daily (ADLs).

The findings include:

On at 12:20 p.m., Resident #7 was observed sitting in her wheelchair in the small dining . . . . Resident #7 remained motionless, she did not attempt to feed herself. A staff member fed Resident #7. At 1:36 p.m., of the same day, Staff E and Staff B rolled Resid . . . #7 into her . . . . A sign was observed above Resident #7's bed. The sign read, "Please remember to rotate Resident #7 every [two] hours (picture taken)." At approximately 1:37 p.m., Staff E and B were observed transferring Resid . . . #7 from her wheelchair to her bed. Staff E bent over and lifted Resident #7 out of the wheelchair, while Staff B lifted Resident #7 from behind. Resident #7's feet did not touch the ground during the transfer. Resident #7 remained motionless throughout the transfer process. Staff E and B were observed changing Resident #7's adult brief immediately after the transfer. Staff B rolled Resident #7 onto her right side while Staff E wiped Resident #7's bottom, then Staff E rolled Resident #7 onto her left side while staff B replaced Resident #7's bed . . . . Staff E pulled a new adult brief over Resident #7's feet, between her legs and onto her bottom. Resident #7 was motionless the throughout the entire process. Resident #7 was not observed assisting in her ADLs.

On at 4:15 p.m., an interview was conducted with Staff D. Staff D stated Resident

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A 010	Continued From page 3 #7 is, ____ weight and could not assist in her transfers." On 4/10/13 at 1:28 p.m., Staff B was interviewed. Staff B explained they would not put Resident #7 on the toilet, because the resident would ____ off of the toilet. Staff B continued by saying, "I am going to tell you the truth; we have to do everything (all ADLs) for [Resident #7]." On 4/11/13, Resident #7's physician was interviewed. He confirmed Resident #7 needs, "Total care" with ADLs. On 4/07/13, an offsite record review revealed the facility has a standard licenses. Class III	A 010		
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 ha... 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	AZ827		

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AZ827	Continued From page 4	AZ827		

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.

(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 [illegible]nses 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

Agency for Health Care Administration

REVISED
May 28, 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965330	A. BUILDING: _____ B. WING _____	04/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA OAKS ASSISTED LIVING	1013 EAST GIBSON STREET ARCADIA, FL 34266

(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
AZ827	Continued From page 5 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, observations and interviews, the facility allowed unlicensed staff to provide services to 4 (Residents #6, #7, #8, and #9) of 9 residents observed for which the facility does not have a specialty license to provide. The findings include: 1. On 4/07/13, a pre-survey record search revealed the facility has a standard license. 2. On , Resident #6's record was reviewed. The record revealed a physician's order dated on for two (2) liters of continuous 3. On , Resident #7's record was reviewed. The record revealed a physician's order dated on for two (2) liters of continuous 4. On , a review of Resident #8's record revealed a physician's order for two (2) liters of continuously through a nasal cannula. 5. On , Resident #9's record was reviewed. The record revealed Resident #9 was admitted to the facility on with an external bag. On at 12:19 p.m., Staff B was observed changing Resident #8's tank in the small dining Staff B checked Resident #8's	AZ827	Resident #6 has received verbal cues and is able to manage his oxygen. 4/19/13 Resident #7 was discharged to a skilled nursing facility. 4/26/13 Resident #8 was discharged to a skilled nursing facility. 4/26/13 Resident #9 receives assistance by a nurse the family hired to manage the colostomy on a daily basis. 5/13/13	

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level then removed a large tank from the back of Resident #8's wheelchair and replaced it with a new tank. Staff A turned Resident #8's on and set the oxygen level to two liters.

On at approximately 12:30 p.m., Staff A was observed changing the tanks for Residents #6 and #7. Staff A replaced the tanks for both resident and set both tanks to two liters of

On 4/10/13 at 9:45 a.m., Staff D and Staff F were observed assisting Resident #9 in the bath. Staff F disconnected Resident #9's colostomy bag from Resident #9's stomach area. Staff D retrieved a new wafer and bag for Resident #9. Staff D cut a hole in the center of the wafer. Staff E entered the relieved Staff F. Staff E verbally prompted Resident #9 to clean around the hole in her stomach with a wipe. After seeing Resident #9 was unable to properly clean around the area, Staff E grabbed a few wipes and cleaned around the whole in Resident #9's stomach. Staff D placed a new adhesive wafer around the hole in Staff D's stomach. Staff D attached the bag to the wafer on Resident #9's stomach. Staff D placed a clamp at the end of the bag.

On 4/09/13 at approximately 12:21 p.m., Staff B was interviewed. Staff B stated Residents #6, #7, and #9 cannot manage or maintain their own tanks. She states the facility staff changes the tanks for these residents. Staff B confirmed she is not a nurse.

Resident #9 is not an oxygen. 4/19/13

On 4/09/13 at approximately 12:37 p.m., Staff A was interviewed. Staff A confirmed she is not a nurse. Staff A also stated when she prepare

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resident who cannot manage their oxygen for bed, she takes the tank off the wheelchair and adjust the level to 0 (zero) liters. She continued by saying she puts the residents on their respective oxygen and when they get up in the morning the she adjust the oxygen back to 2 (two) liters of oxygen.

On 4/0 at 12:37 p.m., Staff C was interviewed. Staff C admitted to assisting Residents #6, #7 and #8 with their oxygen. Staff C confirmed she is not a licensed nurse.

On 4/09/13 at 12:45 p.m., the Administrator was interviewed. The Administrator confirmed she allows unlicensed staff members to assist residents with their oxygen and oxygen concentrators. The Administrator confirmed she has a Standard Assisted Living Facility Licenses without a specialty license. She also confirmed the facility does not have licensed staff providing care and services in this facility.

On 4/0 approximately 4:15 p.m., Staff D was interviewed. Staff D described cleaning caring for Resident #9's colostomy and wound. D stated, "We have to take it [the colostomy off, we remove it [the wafers] from around the hole in her stomach." Staff D stated [the facility staff] clean the area around the wound replace the wafer and the bag." Staff D stated Resident #9 cannot connect her colostomy without assistance. She added, "Resident #9 can't really get it [her colostomy bag] back on the whole like she needs to."

On 4/09/ 4:40 p.m., Resident #9 was interviewed. Resident #9 stated the staff changes her colostomy and cleans around her open wound her.

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May 28, 2013

PRINTED: 05/28/2013
FORM APPROVED

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Unclassified

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Arcadia Oaks Assisted Living
1013 East Gibson Street
Arcadia, FL 34266

Re: CCR #2013002380 and CCR# 2013001667

Dear Administrator:

This letter reports the findings of a Complaint survey that was completed on , 2013 by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after , 2013 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. 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

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
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