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
	AL11968083	A. BUILDING: _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON ASSISTED LIVING	2580 FIRST STREET FORT MYERS, FL 33901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments On a follow-up to a Biennial survey was completed at Avalon Assisted Living. An Increase in Capacity survey was also completed. The previously cited deficiencies were found to be corrected. During the survey process a new deficiency was identified. Under the request for an increase in capacity the following information was noted: The current capacity is 11. The request was for an increase of 4 or a total of 15. The facility has a total of 8 resident . Six have the square feet requirement to accommodate double occupancy. Two had less than the 120 square feet requirement for double occupancy. The total facility capacity would be a maximum of 14. had 195 sq. ft. and could accommodate double occupancy. had 169 sq. ft. and could accommodate double occupancy. had 120 sq. ft. and could accommodate double occupancy There is no had 130 sq. ft. and could accommodate double occupancy. There is no had 100 sq. ft. and can accommodate only a single occupancy. had 112 sq. ft. and can accommodate only a single occupancy. had 126 sq. ft. and could accommodate double occupancy. had 126 sq. ft. and could accommodate double occupancy. The following is a description of non-compliance:	{A 000}		
A 052	58A-5.0185(3) FAC Medication - Assistance with Self-Admin	A 052		

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	AL11968083	A. BUILDING: _____ B. WING _____	R 05/30/2013

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A 052	Continued From page 1 (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 [redacted] 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. (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	A 052		

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A 052	Continued From page 2	A 052		

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 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.

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A 052	Continued From page 3	A 052		

(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:
Based on observation, record review and interview, the facility failed to ensure that "As needed" medications were not administered based on independent judgment of unlicensed staff and at the request of a competent resident for 1 (Resident #5) of 2 sampled residents.

The findings include:

On 5/3(11:50 a.m., Resident #5 was observed sitting in the dining area eating. The resident was alert but confused.

review for Resident #5 found the most current "Resident Health Assessment" (1823) dated 1/1(the resident as having "Advanced dementia." "Cognitive behavioral status" the resident is identified as being "Alert with confusion." resident's record contained a Physician's Order for medication dated 2/2(order is for Lorazepam mg tablet. Take one tablet every 6 hours as needed for agitations (prn). The Medication Observation Record (MOR) for May, documents this medication was provided on May 11, 12, and 24 of 2013.

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A 052	Continued From page 4 On [redacted] at 11:34 a.m., the Office Manager stated unlicensed staff has initialed the MOR indicating the [redacted] 1 mg had been given to the resident on [redacted], 10, 11, 12, and 24 of 2013. The Office Manager stated that when unlicensed staff see Resident #5 "Not acting normal," they call the Administrator who is a Registered Nurse (RN) and she give them the Ok to give Resident #5 the [redacted] 1 mg. The Office Manager stated Resident #5 is [redacted] and does not understand the need for or is able to request the [redacted] medication On [redacted] at 1:30 p.m., the Administrator stated that when the unlicensed staff observe Resident #5 not acting normal, they will call her and she assesses the resident's need based upon the unlicensed staff's observation and will authorized them to provide the prn [redacted] 1 mg to Resident #5. Class III	A 052		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11968083	A. Building B. Wing	5/30/2013

Name of Facility	Street Address, City, State, Zip Code
AVALON ASSISTED LIVING	2580 FIRST STREET FORT MYERS, FL 33901

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix A0030 Reg. # 58A-5.0182(6) FAC; 429.28 LSC		ID Prefix A0050 Reg. # 58A-5.0185(1) FAC LSC		ID Prefix A0078 Reg. # 58A-5.019(2) FAC LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	Johnny HFES	6-4-13	Johnny Alten, HFE II	6-4-13
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: _____

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

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Avalon Assisted Living
2580 First Street
Fort Myers, FL 33901

Dear Administrator:

This letter reports the findings of a follow-up to the Biennial survey with Capacity increase that was conducted on , 2013 by a representative of this office.

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

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

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

Sincerely,

Harold D. Williams
Field Office Manager

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Enclosure: State Form and Revisit Report

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

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