

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911942	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED _____
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NAME OF PROVIDER OR SUPPLIER ROYAL PALM RET CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 AARON STREET PORT CHARLOTTE, FL 33952
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A 000	Initial Comments These are the results of an unannounced Biennial and Limited Nursing Service (LNS) survey conducted _____ through _____ at Royal Palm Retirement Centre, a Assisted Living Facility (ALF) in Port Charlotte, Florida. There was a complaint survey conducted as part of the Biennial survey with 1 allegation which was substantiated without deficiency. The census at the time of the survey was 73 residents. The following is a description of the non compliance:	A 000		
A 008	58A-5.0181(2) FAC Admissions - Health Assessment (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a face-to-face medical examination completed by a licensed health care provider, as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days prior to the individual's admission to a facility pursuant to Section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations; 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living; 3. Any nursing or _____ services required by the individual; 4. Any special diet required by the individual; 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication; 6. Whether the individual has signs or symptoms of a communicable _____ which is likely to be	A 008		

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6600

DWO511

If continuation sheet 1 of 149

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A 008	Continued From page 1 transmitted to other residents or staff. 7. A statement on the day of the examination that, in the opinion of the examining licensed health care provider, the individual's needs can be met in an assisted living facility; and 8. The date of the examination, and the name, signature, address, phone number, and license number of the examining licensed health care provider. The medical examination may be conducted by a currently licensed health care provider from another state. (b) A medical examination completed after the resident's admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, 2010. The form is hereby incorporated by reference. A faxed copy of the completed form is acceptable. A copy of AHCA Form 1823 may be obtained from the Agency Central Office or its website at www.fdhc.state.fl.us/MCHQ/Long_Term_Care/ <http://www.fdhc.state.fl.us/MCHQ/Long_Term_Care/> Assisted_living/pdf/AHCA_Form_1823%.pdf. The form must be completed as follows: 1. The resident's licensed health care provider must complete all of the required information in Sections 1, Health Assessment, and 2, Self-Care and General Oversight Assessment. a. Items on the form that may have been omitted by the licensed health care provider during the examination do not necessarily require an additional face-to-face examination for completion. b. The facility may obtain the omitted information either verbally or in writing from the licensed health care provider. c. Omitted information received verbally must be documented in the resident's record, including	A 008			

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A 008	Continued From page 2 the name of the licensed health care provider, the name of the facility staff recording the information and the date the information was provided. 2. The facility administrator, or designee, must complete Section 3 of the form, Services Offered or Arranged by the Facility, or may use electronic documentation, which at a minimum includes the elements in Section 3. This requirement does not apply for residents receiving: a. Extended congregate care (ECC) services in facilities holding an ECC license; b. Services under community living support plans in facilities holding limited mental health licenses; c. Medicaid assistive care services; and d. Medicaid waiver services. (c) Any information required by paragraph (a) that is not contained in the medical examination report conducted prior to the individual's admission to the facility must be obtained by the administrator within 30 days after admission using AHCA Form 1823. (d) Medical examinations of residents placed by the department, by the Department of Children and Family Services, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.426, F.S., and this rule. (f) Any orders for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility issued by the licensed health care provider conducting the medical examination may be attached to the health assessment. A licensed health care	A 008			

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A 008	Continued From page 3 provider may attach a _____ order for residents who do not wish _____ to be administered in the case of _____ or (g) A resident placed on a temporary emergency basis by the Department of Children and Family Services pursuant to Section 415.105 or 415.1051, F.S., shall be exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement shall be entered on the facility's admission and discharge log and counted in the facility census; a facility may not exceed its licensed capacity in order to accept a such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Administrator or his designee are signing Section 3 of the 1823 Health Assessment Form on 1 (Resident #1) of 3 resident records reviewed. The findings include: A record review conducted _____ on the resident record of Resident #1 revealed that Section 3 on the AHCA form 1823 which lists services offered or arranged by the facility for the resident was signed by Staff H, a Resident Assistant. The regulation states Section 3 on the AHCA form 1823 must be signed by the administrator or designee	A 008			

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A 008	Continued From page 4 In an interview on _____ at approx. 11:00 a.m. with the facility Administrator, he stated "My designee to sign Section 3 of the AHCA 1823 form is the current Resident Care Supervisor. Prior to her arrival it was (Staff I) the previous Resident Care Supervisor." Class _____	A 008			
A 025	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual. (c) General awareness of the resident ' s whereabouts. The resident may travel independently in the community. (d) Contacting the resident ' s health care provider and other appropriate party such as the resident ' s family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication	A 025			

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A 025	Continued From page 5 administration, or other changes which resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide adequate nursing supervision in providing care for 4 dependent residents (Residents #7, #8, #9 and #10) of 4 dependent surveyed, by monitoring as ordered by the medical doctor, holding medications as ordered by the medical doctor, notifying the medical doctor of critically low and high sugars, and failing to monitor food intake after administering. This resulted in Resident #8 being hospitalized on 5 separate occasions for hyper- and and having emergency medical technicians administer glycogen to save his life on 3 separate occasions, having Resident #9 being hospitalized for and the immediate potential injury for 4 (Residents #7, #8, #9, and #10) residents reviewed. 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	A 025			

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A 025	Continued From page 6 _____ 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 _____ can be caused by the resident taking _____ and not eating. The complications of _____ 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, _____ 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 _____ 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	A 025			

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A 025	Continued From page 7 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 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: After 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 of training in assisting residents with medications and do not have the training or knowledge base to make judgments in critical care decisions 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	A 025			

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A 025	Continued From page 8 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 #8 was admitted to the Facility on _____ with a diagnosis of _____, and _____ The facility in which the resident resides has a Limited Nursing Services (LNS) license. Also, after reviewing the medical record, Resident #8 had Home Health Services ordered so that he received weekly assessments from a licensed nurse. Review of the Resident Condition Log (RCL) dated _____ shows, "(Resident #8) is a new resident...He is a _____. He gets his sugar taken 4 x's a day. He has to be reminded of his meals and meds." On _____ at 11:30 a.m., Staff B, a medication technician, was observed administering an _____ to Resident #8 in the 5th floor dining room. She was observed to prepare the lancet in the pen for the resident. The resident then was observed to prick his finger with the lancet after being cued by Staff B. Staff B was then observed to pick up the glucometer and obtain the _____ sample from the resident's finger. The resident was observed to be clearly _____ and unable to understand the process of his _____. Staff B never told the resident his _____ result. In an interview with Staff B on _____ at 11:35 a.m., she confirmed she had performed the	A 025		

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A 025	Continued From page 9 resident's She confirmed the resident suffered from and was not able to understand when or why he received She was then asked how the resident receives administration. She stated, "I turn the dial to 25 units each morning and Resident #8 injects the dosage himself." She was asked if the resident would be able to tell her not to give the medication to him because his sugar was to low? She stated, "I don't think any of residents on this floor know what they are taking." She was asked how would she know when his sugar was to low and to hold his She stated, we have parameters from the Licensed Practical Nurse Supervisor to notify her if his sugar is less than 40 or greater than 400." She then showed the surveyor this had been written above the resident's daily documentation. An interview was conducted with Resident #8 on at 1:20 p.m. The resident was observed at the time of the interview to be and oriented to self only. When asked if he received assistance with his medications at the facility he stated, "I don't know." He was then asked how he gets every morning from the staff? He stated, I don't know. I don't take He was asked if he gets his sugar checked on a daily basis? He stated, No, they don't check my sugar. I don't get An interview was conducted with the supervising LPN on at 3:40 p.m. She stated she had only been working at the facility since of 2013. She was asked how Resident #8 receives from the staff. She stated they bring it to him and he does everything for himself. She was then told Staff B stated she turn the dial of pen to 25 for the resident each morning. The supervisor was also told Staff B was observed	A 025		

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A 025	Continued From page 10 obtaining an _____ from the resident at 11:30 a.m. She seemed to be surprised and stated, "Staff have been told they can't administer _____ She was then asked about Resident #8's _____. She confirmed the resident was _____ and unable to make judgments regarding his _____ care. She was then asked how medical technicians with 4 hours of training would be able to make decisions in the resident's care that would be critical enough to cause _____. She stated, "I see what you're saying." Review of Resident #8's RCL dated _____ shows, "(Resident #8) was sent out _____ sugar was very low 20. Was found slumped over in chair drooling and unable to drink." Review of the recorded _____ dated _____ shows the resident's _____ sugar at 6:30 a.m. was 47. There was no documentation any interventions were performed for this critically low _____ sugar in the RCL. Review of the Medication Observation Review (MOR) shows the resident received 30 units of _____ at 7:00 a.m. on _____. An incident report dated _____ and timed 10:45 a.m., shows, "While calling floors for lunch Resident #8 was found sweating and drooling, _____ sugar was 20. Not responding. Attempted to give orange juice couldn't get him to swallow. Called 911." On the same form, under the heading "Facility comments (recommendations and/or steps to avoid recurrence of incident)" a Resident Assistant _____ documented, "Returned next day. Sugars are being monitored and recorded. Resident being checked several times a day."	A 025			

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A 025	Continued From page 11 She signed and dated her note on The LPN Supervisor signed and dated the form with no documentation from a licensed staff member. There is no documentation the resident's medical doctor was informed the resident was given with a sugar of 47. There is no documentation the resident's medical doctor or the resident's family was informed the resident was hospitalized with When the resident returned from the hospital on the medical doctor ordered, "Change AM to 24 units. AC (before meals) and HS (hour of sleep) with high dosage coverage." Review of the medication list on the 1823 dated shows, "Hold if sugar is less than 120." Review of Resident #8's MOR shows unlicensed staff continued to document administration after There was no documentation the hospital physician was notified to clarify his order of "High dose coverage." The medical record shows no coverage (sliding scale) initiated for this resident after the order. There is no documentation of contacting the medical doctor until Review of the physician's orders shows a change in coverage on The order reads, "Lantus 15 units every PM." Review of the Sugar Checks" record dated shows the resident's sugar was 106. Review of the MOR, the was changed from 24 units in the AM to 20 units	A 025			

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A 025	Continued From page 12 in the AM on Review of the physician's orders show no recorded order to change the dosage for The resident was given 20 units of at 7:00 a.m. on The MOR clearly reads, "Hold if sugar below 120, start" Review of the physician's orders shows no change in the parameters for holding the Review of the Communication form dated shows a home health Registered Nurse (RN) had evaluated the resident on and noted his sugar was 106. There is no documentation there was any concern from the home health nurse the resident had been given which should have been held according to the medical doctor's order. The RN notes, ... has episodes of Fasting Sugar was 106 today. Instructed Patient on regime." Review of the "Sugar Checks" Record shows on at 10:30 a.m., the resident's sugar was 55. There is no documentation in the RCL any interventions were performed for the resident's low blood Review of the same record shows on 6/27 3:30 p.m., no accuchecks performed as ordered. Review of the RCL dated 6/27 timed, "3-11:30 PM" shows, "Went up to check on (Resident #8) around 6 PM. He was lying in bed shaking uncontrollably and making no sense verbally. Stated he fell had a laceration on his left arm. We called 911. He went to Peace River. Family was called." The note is not signed. Review of the "Incident Report" dated 6/27 timed at 6:00 p.m., shows, "Resident #8 found lying in the bed shaking uncontrollably and not making much sense when he spoke. He	A 025		

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A 025	Continued From page 13 also had a laceration on his left arm." Review of the report shows the . . . who completed the incident report was the same . . . who wrote the RCL note on . . . At the bottom of the incident report an unlicensed staff member documents, "Resident is still in the hospital. Will follow up with Infinity Home Health Care upon return." She dates her note . . . The acting LPN supervisor signs the incident report and dates it on . . . Review of the hospital record written by the hospital physician and dated . . . reads, "I talked to the nursing staff and they told that they were given the history that he was walking at the ALF and he . . . down and probably became . . . and when . . . was called and he was found to be . . . There was no documentation the medical doctor was notified the resident was given . . . even though it was supposed to hold. There is no documentation the medical doctor was notified an . . . had not been done at 3:30 p.m. as ordered. There is no documentation the family was notified the resident was sent to the hospital for . . . There is no investigation on the incident report. There are no recommendations from a licensed staff member to avoid a recurrence of the incident. The patient returned to the facility from the hospital on . . . Review of the Form 1823 dated . . . shows under . . . behavioral status: . . . Under Nursing Treatments the form reads, "Infinity Home Health."	A 025			

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A 025	Continued From page 14 Review of the MOR showed unlicensed staff continued to administer after Review of the RCL dated I timed "6:30-3" shows, "(Resident #8's) sugar has been low even though he has eaten his meals." Another note dated written after 7/25, timed 7:30 a.m., reads, "(Resident #8) blood 32 when I checked it gave him orange juice. He did not want to drink it asked (RA) call 911. EMT's came they gave him sugar IV checked his sugar it was 24. After the hivey (IV?) was 168. They left. (Resident #8) was eating banana he had orange juice and peanut butter and jelly." The note is not signed by the RA the note. The note is initiated by the acting LPN supervisor. Review of the Blood check record shows the resident had his blood checked twice by the RA at 6:30 a.m. Review of the MOR shows blood were being checked before and after meals. Review of the physician's orders show no order to take accuchecks and after meals. The accuchecks this time remained AC (before meals) and HS (hour of sleep), hold novolog blood less than 120." Review of the MOR shows the resident received insulin 7:00 a.m. This would be 30 minutes before the resident was found with a low blood There is no way to tell from the documentation if the higher blood recorded at 6:30 a.m. were before or after the resident had received IV Review of the medical record shows no incident report was completed on is no documentation the medical doctor was notified the resident's blood was 32 and EMS to administer glycogen IV save the resident's	A 025			

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A 025	Continued From page 15 life. There is no documentation the resident's family member was notified of this critical issue. Review of the physician's orders show the resident is not seen by a medical doctor until The "Medical Appointment Information" note shows the medical doctor discontinues the and orders Lantus 20 units twice a day. There is no clarification from a nurse noted as to holding the for a sugar of 120. There is no change noted to the The order remains AC (before meals) and HS (hour of sleep). Review of the record shows . . . 's checking the resident's sugar 5 and 6 times daily without an order from the medical doctor. Review of the RCL timed "6:30 to 3" and dated shows, ... found (Resident #8) slumped over in his chair and not responsive. 911 was called and they took his sugar which was 12. They proceeded to give him a shot which brought his sugar up to 167. didn't feel it was necessary to take him to the hospital. 's tried to give him his lunch and drinks to keep his sugar up. 's continue to check on him throughout the day. also spoke to (resident's wife) to let her know what was happening. Incident report filled out. (Resident #8) did eat a bowl of ice cream, cranberry juice and half his lunch meal." Review of "Sugar Checks" form shows on the resident's sugar was taken twice at 6:30 a.m. His sugar is recorded as There is no documentation any intervention was done by any staff member to prevent critically low Review of the MOR shows Resident #8 received 20 units of Lantus at 7:00 a.m., even though his	A 025		

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A 025	Continued From page 16 sugar was abnormally low. An "Incident Report" dated _____ and timed 11:25 a.m. reads, "Resident was unable to respond. _____ went to resident's _____ found resident slumped over in chair and unable to respond. 911 was called and they came. Took his _____ sugar which was 12. They proceeded to give him a shot and brought his sugar up to 162. _____ felt it was not necessary to take him to the hospital. _____'s gave resident a lunch tray and made sure he was doing fine." On the bottom of the form another _____ documents, "Resident good after received shot. _____ keep eye on sugars and report to his home health and Dr. Butler office." The note is dated _____. The incident is signed by the Supervising LPN on _____. There is no documentation the resident's medical doctor was notified the day the incident occurred. There is no documentation the medical doctor or the family were told the resident was given _____ by a _____ when the resident had an abnormally low _____ sugar. There is no investigation noted on the incident report as to why the resident had a _____ sugar of 12. There are no recommendations from licensed staff to prevent the same issue from occurring again. A "Patient Service Update" sent to the physician from the Home Health Nurse and dated _____ reads, "Patient saw VA (Veterans Administration) MD last week. The following changes were made: Discontinued Prandin and _____ flex pen. Lantus was changed from 15 units at night to Lantus 20 units _____ 2 times daily.... Patient had episode of _____ this weekend. _____ reported _____ sugar of 12. Today's fasting _____ sugar was 54. Attached is the glucose log. Please advise." The physician responds, "Give Lantus in AM same dose	A 025		

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A 025	Continued From page 17 continue to monitor." The order from the doctor is not clear as to how he wants the ... given. In looking at the order it appears he wants the resident to just have AM Lantus at the same dosage the VA had ordered. The order is not acceptable and should have been clarified by a nurse. Review of the MOR on ... shows no change in the order for Lantus noted. An "Incident Report" timed 7:30 a.m. and dated ... reads, "Resident did not come down went to check on him. Wasn't acting right. Checked his ... sugar it was 32. 911 called for resident. He was unable to drink orange juice. ... came gave him ... sugar. Then it was 160 and left." On the bottom of the incident report another ... writes, "EMT gave ... sugar to resident and got sugars up. Resident didn't go to the hospital. Resident was able to go to dining ... eat lunch and dinner and did well rest of the day. Home Health was notified. The note is dated ... The form is signed by the supervising LPN on ... There was no investigation on the incident report as to why the resident was found to have a ... sugar of 32. There is no documentation the resident's doctor was notified the resident had ... There are no recommendations listed on the incident report to prevent further incidents to occur. Review of the Home Health Communication form dated ... reads, "... sugars are still very unstable. Extremely important that staff makes sure he eats all his meals and has a snack at night before bed (Unknown) aware of ... sugars and is monitoring closely." The note is signed by an RN. There is no documentation in the resident's record the facility staff ever followed	A 025			

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A 025	Continued From page 18 the advice of the licensed home health nurse to monitor the residents food intake. Review of the _____ Sugar Check dated _____ shows at 6:30 a.m. the _____ documented three separate _____ sugars taken. There is no time noted as to when the _____ sugars were taken. The _____ sugars recorded are _____ Review of the MOR shows the resident received 20 units of Lantus _____ at 7:00 a.m. There is no documentation as to if the resident received _____ before he was found with a _____ sugar of 32. No investigation is documented by the Facility or the Home Health Nurse. Review of the Physician's orders shows the resident's _____ was changed on _____. The new order was Lantus 20 units _____ every AM and 15 units _____ every PM. No parameters are attached to the order, which would leave an untrained, unlicensed staff with the decision on when to give the _____ if it was abnormally low. Review of the RCL dated _____ and timed "6-3" reads, "(Resident #8) didn't wake for breakfast but did take his meds. (Resident #8) sent to hospital low _____ sugar." An "Incident Report" dated _____ with a time of 11:00 a.m. reads, "Resident found on the floor Rq (unknown) side of bed. Resident took _____ sugar was very low. Resident unable to move at the time." The LPN supervisor documents on the same date, "Resident Sent 911 to be evaluated." There is no documentation the resident's medical doctor was notified at the time the resident was transported to the hospital. The form clearly reads, "Describe Exactly what happened; Why; What causes were." There is no investigation	A 025			

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A 025	Continued From page 19 noted on the incident report as to why the resident was having a low _____ sugar. Review of the resident's Blood _____ Checks on 4/30 _____ at 10:30 a.m., the resident had a blood _____ of 31. There are no documented interventions noted for this critically low blood _____ Review of the medical record shows the resident was admitted to the hospital with a diagnosis of hypoglycemia _____ spent 6 days in the hospital. Review of the discharge records on _____ insulin _____ discontinued when the resident was discharged from the hospital. Review of the "Blood _____ Checks" for the month of May _____ the resident's blood _____ were abnormally high for several days when he was discharged. The first blood _____ taken was 403 when the resident returned to the facility on _____ I was recorded at 7:00 - 9:00 p.m. The resident's Blood _____ was recorded as 467 on _____ Blood _____ was recorded as 558 on _____ was recorded as 542 on 5/10 _____ is no documentation the resident's medical doctor was notified of these critically abnormal blood _____ until 5/10 _____ "Patient Service Update" sent by the Home Health Agency to the medical doctor on 5/10 _____ "Patient's diabetic _____ were discontinued by hospital Blood _____ are as follows: _____ 5/10/1 _____ Please advise." The nurse filling out the form writes an order of Metformin _____ MG _____ pill by mouth twice daily. On the side of the paper the medical doctor writes, "?" Underneath the question mark he writes, "Already on Metformin _____ mg 1 pill by mouth twice daily and Lantus."	A 025		

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A 025	Continued From page 20 This note shows the medical doctor was not made aware the resident was sent to the Hospital on _____ and discharged on _____ without _____ medications until _____. Review of the medical record shows the resident was sent to the Hospital and evaluated on _____. The medical record shows he was seen for _____ and Chronic _____. There is no documentation the resident's family was made aware that he was sent to the Hospital. There is no documentation in the RCL and no incident report was completed. Review of the _____ "Sugar Checks" show on _____ Resident #8's _____ sugar was 508. The record shows the resident was hospitalized from _____ to _____. Review of an incident report dated _____ and timed 6:45 a.m. reads, "Checked resident _____ sugar and it was 508. resident went to Peace River for Eval." The Incident report is signed by the supervising LPN. An interview was conducted with the Supervising LPN at 4:10 p.m. on _____. She was asked if the resident had any symptoms when he was sent out. She stated, "No." She was asked if the medical doctor was notified of the resident's _____ sugar? She stated, "No, we had no coverage so I sent him to the hospital so they could get his _____ sugar down." She was asked about the abnormally high _____ sugars on _____ and _____. She stated, "They were not reported to me." She was asked how often she looks at the resident's _____. She stated, "I never look at them. The doctor sees them when he comes." She was asked how often the medical doctor sees the resident? She stated, "About once a month."	A 025			

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A 025	Continued From page 21 Review of the admission note from the hospital dated _____ reads, "Third hospital visit since _____ with issues related to his _____ sugar. The patient has had two admissions with low _____ sugars and _____ sugars in the 21 range, though he has been taken off scheduled _____. Apparently there was much _____ lying around at the facility and the patient had a series of this according to the personal that saw the situation. The patient's _____ sugar was over 500 unless he was sent to the Emergency _____ admission for uncontrolled _____. the patient is demented and has numerous other medical problems, but has not been safe to put on scheduled _____ because he becomes _____ on some. He has apparently been on sliding scale _____." Review of the Discharge Summary written by the hospital physician and dated _____ reads, "Apparently, at the _____ unit I am told that there are a number of cupcakes available and the patient had several and was found with a _____ sugar of 500." Review of physician's orders dated _____ reads, _____ before meals breakfast, lunch, and dinner, at bedtime and 2 AM. Restart Lantus _____ 6 units _____ PM 25 units _____ AM." There is no physician's signature on the order. Review of the MOR shows the order was started on _____. Review of the _____ Sugar Checks for the month of _____ 2013 shows 2 AM _____ sugars were not done on _____ or _____. On _____ The resident's 2 AM _____ sugar was 38. No interventions are recorded for this critically low _____ sugar."	A 025			

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A 025	Continued From page 22 At 6:30 on _____ Resident #8's _____ sugar is recorded as 40. Review of the MOR shows on _____ at 7:00 a.m., the resident was administered 25 units of Lantus _____ Review of RCL dated _____ reads, "(Resident #8's) _____ sugar was 40 when he came out ate breakfast 1 pancake cup of coffee cup of OJ. He had _____ A "Communication Form" dated _____ reads, "Fasting _____ Sugar was 44-at 10:30 AM 88. No 2 AM _____ sugar recorded times 2 days. Spoke with (LPN supervisor) about this matter". Review of RCL dated _____ reads, "Visiting Nurse saw (Resident #8) was wondering why nobody is checking 2 AM _____ sugar. His _____ sugar was 44 at 6:30 AM." Review of the _____ 2013 _____ Sugar Checks" show the only 2:00 a.m. _____ was obtained on _____ Even after LPN supervisor was made aware of the situation. Review of the 1823 dated _____ shows the resident's _____ status to be "Alert and oriented x's 1 (to person,) _____ and forgetful." Under Nursing Treatments on the same form is documented, _____ Which would mean a nurse would be required to provide the services requested. Review of the MOR show unlicensed staff still continued to administer _____ after _____ An interview was conducted with the resident's medical doctor by phone at 3:00 p.m. on _____ When he was told the _____ \s were making decisions in the resident's _____ care management he stated, "I have standing orders for that." He was then told on _____ an _____	A 025		

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A 025	Continued From page 23 gave the resident when he had sugar of 47 and by 11:00 a.m. the resident had a sugar of 20 and had to be hospitalized. The physician stated, "That's not good." He was unable to confirm when he was notified the resident had a low sugars during each hospitalization and critical event. He stated, "I'm not going to lie to you. I would not be able to say." He was asked if he knew the limitations of's? He stated he thought they were trained to take care of residents with dependence. He stated as far as he knew the previous LPN supervisor was administering to the residents. An interview was conducted with the LPN supervisor on at 4:10 p.m. She stated, "We don't take standing orders here from doctors." 2. Resident #9 is a white male who was admitted to the Facility on He has a history of and Review of the residents form 1823, dated shows the resident has poor eyesight. The resident receives N 60 units, every morning. Review of the MOR show unlicensed staff providing care for the resident. The MOR shows there are no high and low parameters ordered for this resident's sugar. Review of an "Incident report" dated and timed 12:30 PM reads, "Son has (Resident #9) at the dentist office. Brought back. Resident became unstable. Unable to walk, speak, or respond to verbal commands. Resident was checked out by nurse and Home Health nurse. 911 called." On the bottom of the form which had	A 025			

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A 025	Continued From page 24 a heading of "(Recommendations and/or steps to avoid reoccurrence of incident)", the _____ writes, "Came back same day with low sugar. Son is taking to MD." The form is signed and dated by the LPN supervisor on _____. There is no documentation as to why the resident had a low _____ sugar. There is no documentation the medical doctor was notified the resident was critically _____ enough to go to the hospital. Review of the _____ "Sugar Checks" shows on _____ the resident's fasting _____ sugar was 70. Review of the MOR on _____ shows the resident received 60 units of _____ N _____ at 7:00 AM. There is no documentation the _____ ensured the resident ate something before the he was sent to the dentist office. On _____ the resident's fasting _____ sugar was 60. The MOR show the resident was given 60 units of _____ with no interventions. On _____ the residents fasting _____ sugar was documented as 49. He was given 60 units of _____ with no interventions. On _____ the resident's _____ sugar was documented as 54. The resident was given 60 units of _____ with no interventions. On _____ the resident's _____ sugar was 55. The resident was given 60 units of _____ with no interventions. On _____ the resident's _____ sugar was 48. The resident was given 60 units of _____ with no intervention. In each of these instances the medication should have been held and the medical doctor notified before giving _____. 3. Resident #7 is a(n) _____ white female who was admitted to the facility on _____. She has a history of _____ Mellites, and _____.	A 025			

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A 025	Continued From page 25 She receives _____ with sliding scale coverage. She needs her _____ sugars checked three times daily. Review of Section 3 of the 1823 dated _____ shows unlicensed staff are assisting the resident with medications and _____ sugar checks. An interview was conducted with Resident #7 at 2:05 p.m. on _____. She was asked how she gets her _____ sugar checked. She stated, "I go down to the nurses' station on the 1st floor and they take my _____ and check my sugar. They then dial in my _____ dosage and they give me a shot of _____ in my abdomen." She was asked if she was sure the staff injects her with her _____ She stated, "I can't do it myself. They do it for me." She did not know how much _____ she took every day. 4. Resident #10 is a _____ white female who was admitted to the Facility _____. The resident has _____ and receives _____ N _____ 26 units, in the AM and 20 units in the PM _____. She also receives _____ coverage for _____ sugars above 151. Review of section 3 of the 1823 dated _____ show unlicensed staff are providing assistance with medications. An interview was conducted with Resident #10 at 1:20 p.m. on _____. The resident was asked how long she had lived at the facility. She stated, "I moved here about a year ago. I am legally _____. When my eyes got worse I could no longer give myself _____. When asked what staff do for her when she gets her medication she stated, "I go to the medicine _____ times a day. They take my _____ sugar because I can't read the machine. They dial in the amount of _____ I need and I inject myself. I'm not able to read the	A 025			

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A 025	Continued From page 26 pen I'm legally An interview was conducted with Staff C at 3:30 p.m. on She confirmed she put in the dosage for Resident #10. She stated, "Yes, (Resident #10 has a problem because she can't see. I help her turn in the dosage. The residents who take will get aggravated at us if we don't do it. They want us to put in the dosage." She was then explained the danger of administering and making decisions for a resident on when to give and how much to give to a resident. She then stated, "I learned more today than I learned during the whole medication class." An interview was conducted with the Administrator on at 11:30 a.m. He stated he was not aware unlicensed staff were administering to residents. He stated he was aware Resident #8 had been sent to the hospital on several occasions for low and high sugar. During the interview he still seemed unaware unlicensed staff could not make critical decisions regarding care. He stated, "If they have a parameter can they assist with Class I	A 025			
A 030	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Council shall be posted in full view in a freely accessible resident area, and included in the	A 030			

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A 030	Continued From page 27 admission package provided pursuant to Rule 58A-5.0181, F.A.C. (b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456. (d) The statewide toll-free telephone number of the Florida _____ Hotline " 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents. (e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility's policies with respect to such issues, for example, as resident responsibilities, the facility's _____ and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements. (f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be	A 030			

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A 030	Continued From page 28 responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law. (g) The facility shall provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility shall not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there shall be, at a minimum, an accessible telephone on each floor of each building where residents reside. (h) Pursuant to Section 429.41, F.S., the use of physical _____ shall be limited to half-bed rails, and only upon the written order of the resident's physician, who shall review the order biannually, and the consent of the resident or the resident's representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical _____ 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from _____ and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate	A 030			

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A 030	Continued From page 29 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 room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Access to adequate and appropriate health care consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless,	A 030		

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A 030	Continued From page 31 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 insulin _____ and who self-administers or receives assistance with medications must be able to understand the complexities of their disease _____ be able to make critical judgments related to its treatment. There are 2 major concerns with the diabetic _____ having both acute and long term effects. The first is Hypoglycemia. Blood _____ A blood _____ 60 or less is considered Hypoglycemia. _____ be caused by the resident taking insulin _____ not eating. The complications of Hypoglycemia _____ untreated include tremor, visual impairment, _____ confusion _____ muscle weakness, _____ levels of consciousness, _____ state, cardiac _____ death. _____ confusion _____ caused by low blood _____ levels could lead a resident to become delusional _____ 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 diabetes _____	A 030			

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A 030	Continued From page 32 ... (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 ... 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 ... 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: After 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 of training in assisting residents with medications and do not have the training or knowledge base to make judgments in critical care decisions for the ... dependent ... resident. For a	A 030		

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A 030	Continued From page 33 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 #8 was admitted to the Facility on _____ with a diagnosis of _____, and _____ The facility in which the resident resides has a Limited Nursing Services (LNS) license. Also, after reviewing the medical record, Resident #8 had Home Health Services ordered so that he received weekly assessments from a licensed nurse. Review of the RCL (Resident Condition Log) dated _____ shows, "(Resident #8) is a new resident...he is a _____. He gets his sugar taken 4 times a day. He has to be reminded of	A 030			

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A 030	Continued From page 34 his meals and meds." On at 11:30 a.m., Staff B, a medication technician, was observed administering an to Resident #8 in the 5th floor dining She was observed to prepare the lancet in the pen for the resident. The resident then was observed to prick his finger with the lancet after being cued by Staff B. Staff B was then observed to pick up the glucometer and obtain the sample from the resident's finger. The resident was observed to be clearly and unable to understand the process of his Staff B never told the resident his result. In an interview with Staff B on 11:35 a.m., she confirmed she had performed the resident's She confirmed the resident suffered from and was not able to understand when or why he received She was then asked how the resident receives administration. She stated, "I turn the dial to 25 units each morning and Resident #8 injects the dosage himself." She was asked if the resident would be able to tell her not to give the medication to him because his sugar was to low? She stated, "I don't think any of residents on this floor know what they are taking." She was asked how would she know when his sugar was to low and to hold his She stated, We have parameters from the Licensed Practical Nurse Supervisor to notify her if his sugar is less than 40 or greater than 400." She then showed the surveyor this had been written above the resident's daily documentation. An interview was conducted with Resident #8 on at 1:20 p.m. The resident was observed at the time of the interview to be and oriented to self only. When asked if he received	A 030			

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A 030	Continued From page 35 assistance with his medications at the facility he stated, "I don't know." He was then asked how he gets _____ every morning from the staff? He stated, I don't know. I don't take _____. He was asked if he gets his _____ sugar checked on a daily basis? He stated, No, they don't check my _____ sugar. I don't get _____. An interview was conducted with the supervising LPN on _____ at 3:40 p.m. She stated she had only been working at the facility since _____ of 2013. She was asked how Resident #8 receives _____ from the staff. She stated they bring it to him and he does everything for himself. She was then told Staff B stated she turn the dial of _____ pen to 25 for the resident each morning. The supervisor was also told Staff B was observed obtaining an _____ from the resident at 11:30 a.m. She seemed to be surprised and stated, "Staff have been told they can't administer _____." She was then asked about Resident #8's _____. She confirmed the resident was _____ and unable to make judgments regarding his _____ care. She was then asked how medical technicians with 4 hours of training would be able to make decisions in the resident's care that would be critical enough to cause _____. She stated, "I see what you're saying." Review of Resident #8's RCL dated _____ shows, "(Resident #8) was sent out _____ sugar was very low 20. Was found slumped over in chair drooling and unable to drink." Review of the recorded _____ on _____ shows the resident's _____ sugar at 6:30 a.m. was 47. There is no documentation any interventions were performed for this critically low _____ sugar in the RCL.	A 030			

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A 030	Continued From page 36 Review of the Medication Observation Review (MOR) shows the resident received 30 units of _____ at 7:00 a.m. on _____. An incident report dated _____ and timed 10:45 a.m. shows, "While calling floors for lunch Resident #8 was found sweating and drooling, _____ sugar was 20. Not responding. Attempted to give orange juice couldn't get him to swallow. Called 911." On the same form, under the heading "Facility comments (recommendations and/or steps to avoid reoccurrence of incident)" a Resident Assistant _____ documented, "Returned next day. Sugars are being monitored and recorded. Resident being checked several times a day." She signed and dated her note on _____. The LPN Supervisor signed and dated the form with no documentation from a licensed staff member. There is no documentation the resident's medical doctor was informed the resident was given _____ with a _____ sugar of 47. There is no documentation the resident's medical doctor or the resident's family was informed the resident was hospitalized with _____. When the resident returned from the hospital on _____ the medical doctor ordered, "Change AM _____ to _____ 24 units. _____ AC (before meals) and HS (hour of sleep) with high dosage coverage." Review of the medication list on the 1823 dated _____ shows, "Hold _____ if _____ sugar is less than 120." Review of Resident #8's MOR shows unlicensed staff continued to document _____ administration	A 030			

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A 030	Continued From page 37 after _____ There was no documentation the hospital physician was notified to clarify his order of "High dose _____ coverage." The medical record shows no _____ coverage (sliding scale) initiated for this resident after the _____ order. There is no documentation of contacting the medical doctor until _____. Review of the physician's orders shows a change in _____ coverage on _____. The order reads, "Lantus 15 units _____ every PM." Review of the _____ "Sugar Checks" record dated _____ shows the resident's _____ sugar was 106. Review of the MOR The _____ was changed from 24 units in the AM to 20 units in the AM on _____. Review of the physician's orders show no recorded order to change the _____ dosage for _____. The resident was given 20 units of _____ at 7:00 a.m. on _____. The MOR clearly reads, "Hold if _____ sugar below 120, start _____." Review of the physician's orders shows no change in the parameters for holding the _____. Review of the Communication form dated _____ shows a home health RN had evaluated the resident on _____ and noted his _____ sugar was 106. There is no documentation there was any concern from the home health nurse the resident had been given _____ which should have been held according to the medical doctor's order. The RN notes, _____ has episodes of _____ Fasting _____ Sugar was 106 today. Instructed Patient on _____ regime." Review of the _____ "Sugar Checks" Record shows on _____, at 10:30 a.m., the resident's	A 030		

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A 030	Continued From page 38 ... sugar was 55. There is no documentation in the RCL any interventions were performed for the resident's low ... sugar. Review of the same record shows on ... at 3:30 p.m. no ... was performed as ordered. Review of the RCL dated ... and timed, "3-11:30 PM" shows, "Went up to check on (Resident #8) around 6 PM. He was lying in bed shaking uncontrollably and making no sense verbally. Stated he ... and had a laceration on his left arm. We called 911. He went to Peace River. Family was called." The note is not signed. Review of the "Incident Report" dated ... and timed at 6:00 p.m., shows, "Resident #8 found lying in the bed shaking uncontrollably and not making much sense when he spoke. He also had a laceration on his left arm." Review of the report shows the ... who completed the incident report was the same ... who wrote the RCL note on ... At the bottom of the incident report an unlicensed staff member documents, "Resident is still in the hospital. Will follow-up with Infinity Home Health Care upon return." She dates her note ... The acting LPN supervisor signs the incident report and dates it on ... Review of the hospital record written by the hospital physician and dated ... reads, "I talked to the nursing staff and they told that they were given the history that he was walking at the ALF and he ... down and probably became ... and when ... was called and he was found to be ... There was no documentation the medical doctor was notified the resident was given ... even though it was supposed to held.		A 030		

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A 030	Continued From page 39 There is no documentation the medical doctor was notified an _____ had not been done at 3:30 p.m., as ordered. There is no documentation the family was notified the resident was sent to the hospital for _____. There is no investigation on the incident report. There are no recommendations from a licensed staff member to avoid a recurrence of the incident. The patient returned to the facility from the hospital on _____. Review of the Form 1823 dated _____ shows under _____ behavioral status: _____ Under Nursing Treatments the form reads, "Infinity Home Health." Review of the MOR showed unlicensed staff continued to administer _____ after _____ Review of the RCL dated _____ and timed "6:30-3" shows, "(Resident #8's) sugar has been low even though he has eaten his meals." Another note dated _____ and, written after _____ and, timed 7:30 a.m., reads, "(Resident #8) _____ Sugar 32 when I checked it. Gave him orange juice. He did not want to drink it asked _____ to call 911. EMT's came they gave him sugar _____ they checked his sugar it was 24. After the hivey _____ it was 168. They left. (Resident #8) was eating banana he had orange juice and peanut butter and jelly." The note is not signed by the _____ completing the note. The note is initiated by the acting LPN supervisor. Review of the _____ Sugar check record shows the resident had his _____ sugar checked twice by the _____ at 6:30 a.m. Review of the MOR shows _____ sugars were being checked before and after meals. Review of the physician's orders	A 030			

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A 030	Continued From page 40 show no order to take _____ before and after meals. The _____ at this time remained AC (before meals) and HS (hour of sleep), hold _____ for _____ sugar less than 120." Review of the MOR shows the resident received _____ at 7:00 a.m. This would be 30 minutes before the resident was found with a low _____ sugar. There is no way to tell from the documentation if the higher _____ sugars recorded at 6:30 a.m. were before or after the resident had received _____ glycogen. Review of the medical record shows no incident report was completed on _____. There is no documentation the medical doctor was notified the resident's _____ sugar was 32 and _____ had to administer glycogen _____ to save the resident's life. There is no documentation the resident's family member was notified of this critical issue. Review of the physician's orders show the resident is not seen by a medical doctor until _____. The "Medical Appointment Information" note shows the medical doctor discontinues the _____ and orders Lantus _____ 20 units twice a day. There is no clarification from a nurse noted as to holding the _____ for a _____ sugar of 120. There is no change noted to the _____. The order remains _____ AC (before meals) and HS (hour of sleep). Review of the _____ record shows _____'s checking the resident's _____ sugar 5 and 6 times daily without an order from the medical doctor. Review of the RCL timed "6:30 to 3" and dated _____ shows, _____ found (Resident #8) slumped over in his chair and not responsive. 911 was called and they took his _____ sugar which was 12. They proceeded to give him a shot which brought his _____ sugar up to 167. _____ didn't	A 030			

Agency for Health Care Administration

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A 030	Continued From page 41 feel it was necessary to take him to the hospital. ... tried to give him his lunch and drinks to keep his ... sugar up. ... continue to check on him throughout the day. ... also spoke to (resident's wife) to let her know what was happening. Incident report filled out. (Resident #8) did eat a bowl of ice cream, cranberry juice and half his lunch meal." Review of ... "Sugar Checks" form shows on the resident's ... sugar was taken twice at 6:30 a.m. His ... sugar is recorded as ... There is no documentation any intervention was done by any staff member to prevent critically low ... Review of the MOR shows Resident #8 received 20 units of Lantus ... at 7:00 a.m., even though his sugar was abnormally low. An "Incident Report" dated ... and timed 11:25 a.m. reads, "Resident was unable to respond. ... went to resident's ... found resident slumped over in chair and unable to respond. 911 was called and they came. Took his ... sugar which was 12. They proceeded to give him a shot and brought his sugar up to 162. ... felt it was not necessary to take him to the hospital. ... gave resident a lunch tray and made sure he was doing fine." On the bottom of the form another ... documents, "Resident good after received shot. ... keep eye on sugars and report to his home health and Dr. Butler office." The note is dated ... The incident is signed by the Supervising LPN on ... There is no documentation the resident's medical doctor was notified the day the incident occurred. There is no documentation the medical doctor or the family were told the resident was given ... by a ... when the resident had an abnormally low ... sugar. There is no investigation noted on	A 030		

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A 030	Continued From page 42 the incident report as to why the resident had a sugar of 12. There are no recommendations from licensed staff to prevent the same issue from occurring again. A "Patient Service Update" sent to the physician from the Home Health Nurse and dated reads, "Patient saw Veterans Administration (VA) MD last week. The following changes were made: "Discontinued Prandin and flex pen. Lantus was changed from 15 units at night to Lantus 20 units 2 times daily.... Patient had episode of this weekend. reported sugar of 12. Today's fasting sugar was 54. Attached is the glucose log. Please advise." The physician responds, "Give Lantus in AM same dose continue to monitor." The order from the doctor is not clear as to how he wants the given. In looking at the order it appears he wants the resident to just have AM Lantus at the same dosage the VA had ordered. The order is not acceptable and should have been clarified by a nurse. Review of the MOR on shows no change in the order for Lantus noted. An "Incident Report" timed 7:30 a.m. and dated reads, "Resident did not come down went to check on him. Wasn't acting right. Checked his sugar it was 32. 911 called for resident. He was unable to drink orange juice. came gave him sugar. Then it was 160 and left. On the bottom of the incident report another writes, "EMT gave sugar to resident and got sugars up. Resident didn't go to the hospital. Resident was able to go to dining eat lunch and dinner and did well rest of the day. Home Health was notified. The note is dated The form is signed by the supervising LPN on	A 030			

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A 030	Continued From page 43 There was no investigation on the incident report as to why the resident was found to have a sugar of 32. There is no documentation the resident's doctor was notified the resident had . There are no recommendations listed on the incident report to prevent further incidents to occur. Review of the Home Health Communication form dated . reads, "sugars are still very unstable. Extremely important that staff makes sure he eats all his meals and has a snack at night before bed. (Unknown) aware of sugars and is monitoring closely." The note is signed by an RN. There is no documentation in the resident's record the facility staff ever followed the advice of the licensed home health nurse to monitor the residents food intake. Review of the . Sugar Check dated . shows at 6:30 a.m., the documented three separate sugars taken. There is no time noted as to when the sugars were taken. The sugars recorded are . Review of the MOR shows the resident received 20 units of Lantus at 7:00 a.m. There is no documentation as to if the resident received before he was found with a sugar of 32. No investigation is documented by the Facility or the Home Health Nurse. Review of the Physician's orders shows the resident's was changed on . The new order was Lantus 20 units every AM and 15 units every PM. No parameters are attached to the order, which would leave an untrained, unlicensed staff with the decision on when to give the if it was abnormally low.	A 030			

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A 030	Continued From page 44 Review of the RCL dated _____ and timed "6-3" reads, "(Resident #8) didn't wake for breakfast but did take his meds. (Resident #8) sent to hospital low _____ sugar." An "Incident Report" dated _____ with a time of 11:00 a.m. reads, "Resident found on the floor Rq (unknown) side of bed. Resident took _____ sugar was very low. Resident unable to move at the time." The LPN supervisor documents on the same date, "Resident Sent 911 to be evaluated." There is no documentation the resident's medical doctor was notified at the time the resident was transported to the hospital. The form clearly reads, "Describe Exactly what happened; Why; What causes were." There is no investigation noted on the incident report as to why the resident was having a low _____ sugar. Review of the resident's _____ Sugar Checks on _____ show at 10:30 a.m., the resident had a _____ sugar of 31. There are no documented interventions noted for this critically low _____ sugar. Review of the medical record shows the resident was admitted to the hospital with a diagnosis of _____ and spent 6 days in the hospital. Review of the discharge records on _____ shows _____ was discontinued when the resident was discharged from the hospital. Review of the _____ Sugar Checks" for the month of _____ shows the resident's _____ sugars were abnormally high for several days when he was discharged. The first _____ sugar taken was 403 when the resident returned to the facility on _____ and was recorded at 7:00 - 9:00 p.m. The resident's _____ sugar was recorded as 467 on _____		A 030		

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A 030	Continued From page 45 Blood was recorded as 558 on was recorded as 542 on 5/1C is no documentation the resident's medical doctor is notified of these critically abnormal blood until 5/1C "Patient Service Update" sent by the Home Health Agency to the medical doctor on 5/1C "Patient's diabetic were discontinued by hospital Blood are as follows: 5/10/1 Please advise." The nurse filling out the form writes an order of Metformin MG 1 pill by mouth twice daily. On the side of the paper the medical doctor writes, "2" Underneath the question mark he writes, "Already on Metformin mg 1 pill by mouth twice daily and Lantus." This note shows the medical doctor was not made aware the resident was sent to the Hospital on 4/3C discharged on Diabetic until 5/1C of the medical record shows the resident was sent to the Hospital and evaluated on 5/1C medical record shows he was seen for Hyperglycemia Chronic Dementia. is no documentation the resident's family was made aware that he was sent to the Hospital. There is no documentation in the RCL and no incident report was completed. Review of the "Blood Checks" show on 5/1C #8's blood was 508. The record shows the resident was hospitalized form 5/1C 5/1E of an incident report dated 5/1C timed 6:45 a.m. reads, "Checked resident blood and it was 508. Resident went to Peace River for Eval." The Incident report is signed by the supervising LPN.	A 030			

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A 030	Continued From page 46 An interview was conducted with the Supervising LPN at 4:10 p.m. on _____. She was asked if the resident had any symptoms when he was sent out. She stated, "No." She was asked if the medical doctor was notified of the resident's sugar? She stated, "No, we had no coverage so I sent him to the hospital so they could get his _____ sugar down." She was asked about the abnormally high _____ sugars on _____ and _____. She stated, "They were not reported to me." She was asked how often she looks at the resident's _____. She stated, "I never look at them. The doctor sees them when he comes." She was asked how often the medical doctor sees the resident? She stated, "About once a month." Review of the admission note from the hospital dated _____ reads, "Third hospital visit since _____ with issues related to his _____ sugar. The patient has had two admissions with low _____ sugars and _____ sugars in the 21 range, though he has been taken off scheduled _____. Apparently there was much _____ lying around at the facility and the patient had a series of this according to the personal who saw the situation. The patient's _____ sugar was over 500 unless he was sent to the Emergency _____ admission for uncontrolled _____. The patient is demented and has numerous other medical problems, but has not been safe to put on scheduled _____ because he becomes _____ on some. He has apparently been on sliding scale _____." Review of the Discharge Summary written by the hospital physician and dated _____ reads, "Apparently, at the _____ unit I am told that there are a number of cupcakes available and the patient had several and was found with a _____"	A 030			

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A 030	Continued From page 47 sugar of 500." Review of physician's orders dated _____ reads, before meals breakfast, lunch, and dinner, at bedtime and 2:00 a.m. Restart Lantus _____ 6 units _____ PM 25 units _____ AM." There is no physician's signature on the order. Review of the MOR shows the order was started on _____ Review of the _____ Sugar Checks for the month of "2013" shows 2:00 a.m., _____ sugars were not done on _____ or On _____ The resident's 2 AM sugar was 38. No interventions are recorded for this critically low _____ sugar. At 6:30 on _____ Resident #8's _____ sugar is recorded as 40. Review of the MOR shows on _____ at 7:00 a.m., the resident was administered 25 units of Lantus _____ Review of RCL dated _____ reads, "(Resident #8's) _____ sugar was 40 when he came out ate breakfast 1 pancake cup of coffee cup of OJ. He had _____ A "Communication Form" dated _____ reads, "Fasting _____ Sugar was 44-at 10:30 AM 88. No 2 AM _____ sugar recorded times 2 days. Spoke with (LPN supervisor) about this matter". Review of RCL dated _____ reads, "Visiting Nurse saw (Resident #8) was wondering why nobody is checking 2 AM _____ sugar. His _____ sugar was 44 at 6:30 AM." Review of the _____ 2013 _____ Sugar Checks" show the only 2:00 a.m. _____ was obtained on _____. Even after LPN supervisor was made aware of the situation.	A 030			

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A 030	Continued From page 48 Review of the 1823 dated _____ shows the resident's _____ status to be "Alert and oriented x's 1 (to person, _____) and forgetful." Under Nursing Treatments on the same form is documented, _____ Which would mean a nurse would be required to provide the services requested. Review of the MOR show unlicensed staff still continued to administer _____ after _____ An interview was conducted with the resident's medical doctor by phone at 3:00 p.m. on _____ he was told the RA _____ were making decisions in the resident's diabetic _____ management he stated, "I have standing orders for that." He was then told on 6/14 _____ RA _____ the resident insulin _____ he had blood _____ of 47 and by 11:00 a.m. the resident had a blood _____ of 20 and had to be hospitalized. The physician stated, "That's not good." He was unable to confirm when he was notified the resident had a low blood _____ during each hospitalization and critical event. He stated, "I'm not going to lie to you. I would not be able to say." He was asked if he knew the limitations of RA _____. He stated he thought they were trained to take care of residents with insulin _____ He stated as far as he knew the previous LPN supervisor was administering insulin _____ the residents. An interview was conducted with the LPN supervisor on _____ 4:10 p.m.. She stated, "We don't take standing orders here from doctors." 2. Resident #9 is a 90 _____ male who was admitted to the Facility on _____ has a history of Diabetes _____ Dementia.	A 030			

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A 030	Continued From page 49 Review of the residents form 1823, dated shows the resident has poor eyesight. The resident receives N 60 units, every morning. Review of the MOR show unlicensed staff providing care for the resident. The MOR shows there are no high and low parameters ordered for this resident's sugar. Review of an "Incident report" dated and timed 12:30 p.m. reads, "Son has (Resident #9) at the dentist office. Brought back. Resident became unstable. Unable to walk, speak, or respond to verbal commands. Resident was checked out by nurse and Home Health nurse. 911 called." On the bottom of the form which had a heading of "(Recommendations and/or steps to avoid reoccurrence of incident)", the writes, "Came back same day with low sugar. Son is taking to MD." The form is signed and dated by the LPN supervisor on . There is no documentation as to why the resident had a low sugar. There is no documentation the medical doctor was notified the resident was critically enough to go to the hospital. Review of the "Sugar Checks" shows on the resident's fasting sugar was 70. Review of the MOR on shows the resident received 60 units of N at 7:00 a.m. There is no documentation the ensured the resident ate something before the he was sent to the dentist office. On the resident's fasting sugar was 60. The MOR show the resident was given 60 units of with no interventions. On the residents fasting sugar was	A 030			

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A 030	Continued From page 50 documented as 49. He was given 60 units of _____ with no interventions. On _____ the resident's _____ sugar was documented as 54. The resident was given 60 units of _____ with no interventions. On _____ the resident's sugar was 55. The resident was given 60 units of _____ with no interventions. On _____ the resident's _____ sugar was 48. The resident was given 60 units of _____ with no intervention. In each of these instances the medication should have been held and the medical doctor notified before giving _____. 3. Resident #7 is a _____ white female who was admitted to the facility on _____. She has a history of _____ Mellites, and, _____ She receives _____ with sliding scale coverage. She needs her _____ sugars checked three times daily. Review of Section 3 of the 1823 dated _____ shows unlicensed staff are assisting the resident with medications and _____ sugar checks. An interview was conducted with Resident #7 at 2:05 p.m. on _____. She was asked how she gets her _____ sugar checked. She stated, "I go down to the nurses' station on the 1st floor and they take my _____ and check my sugar. They then dial in my _____ dosage and they give me a shot of _____ in my abdomen." She was asked if she was sure the staff injects her with her _____. She stated, "I can't do it myself. They do it for me." She did not know how much _____ she took every day. 4. Resident #10 is a _____ white female who was admitted to the Facility _____. The resident has _____ and receives _____ N _____ 26 units, in the AM and 20 units in the PM	A 030			

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A 030	Continued From page 51 She also receives _____ coverage for _____ sugars above 151. Review of section 3 of the 1823 dated _____ show unlicensed staff are providing assistance with medications. An interview was conducted with Resident #10 at 1:20 p.m. on _____. The resident was asked how long she had lived at the facility. She stated, "I moved here about a year ago. I am legally _____ When my eyes got worse I could no longer give myself _____. When asked what staff do for her when she gets her medication she stated, "I go to the medicine _____ times a day. They take my _____ sugar because I can't read the machine. They dial in the amount of _____ I need and I inject myself. I'm not able to read the _____ pen I'm legally _____ An interview was conducted with Staff C at 3:30 p.m. on _____. She confirmed she put in the dosage for Resident #10. She stated, "Yes, (Resident #10 has a problem because she can't see. I help her turn in the dosage. The residents who take _____ will get aggravated at us if we don't do it. They want us to put in the dosage." She was then explained the danger of administering _____ and making decisions for a resident on when to give and how much _____ to give to a resident. She then stated, "I learned more today than I learned during the whole medication class." An interview was conducted with the Administrator on _____ at 11:30 a.m. He stated he was not aware unlicensed staff were administering _____ to residents. He stated he was aware Resident #8 had been sent to the hospital on several occasions for low and high _____ sugar. During the interview he still seemed	A 030			

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A 030	Continued From page 52 unaware unlicensed staff could not make critical decisions regarding _____ care. He stated, "If they have a parameter can they assist with _____ Class I	A 030			
A 032	58A-5.0182(8) FAC Resident Care - Elopement Standards (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement shall be identified so staff can be alerted to their needs for support and supervision. 1. As part of its resident elopement response policies and procedures, the facility shall make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff attention shall be directed towards residents assessed at high risk for elopement, with special attention given to those with _____ and related _____ assessed at high risk. 2. At a minimum, the facility shall have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The photo identification shall be made available for the file within 10 calendar days of admission. In the event a resident is assessed at risk for elopement subsequent to admission, photo identification shall be made available for the file within 10 calendar days after a determination is made that the resident is at risk for elopement. The photo identification may be taken by the facility or provided by the resident or resident's family/caregiver. (b) Facility Resident Elopement Response	A 032			

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A 032	Continued From page 53 Policies and Procedures. The facility shall develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures shall include: 1. An immediate staff search of the facility and premises; 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities; 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility shall conduct resident elopement drills pursuant to Sections 429.41(1)(a)3. and 429.41(1)(l), F.S. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to identify and assess 1 (Resident #8) of 11 resident's interviewed as an elopement risk. The facility failed to develop adequate policies and procedures to identify staff responsibilities and specific duties when a resident elopes resulting in one resident (Resident # 8) eloping from the facility 4 times and the potential for further resident elopements. The findings include: Resident #8 was admitted to the Facility on _____ with a diagnosis of _____ and _____	A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911942	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ROYAL PALM RET CENTRE

**2500 AARON STREET
PORT CHARLOTTE, FL 33952**

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A 032	Continued From page 54 An interview was conducted with Resident #8 on _____ at 1:35 p.m.. He was found to be _____, alert and oriented to self only. The RCL (Resident Condition Log) dated _____ indicated that Resident was missing. They found him over Winn-Dixie. Keep eye on him often. The "Incident Report" dated _____ and timed 11:00 a.m. reads, "(Resident 8's Name) was missing at lunch time. We looked everywhere couldn't find him. We did _____. He wasn't here. (Two Staff) went to Winn Dixie they came back without him. Then we checked everywhere again. No (Resident #8). (Two Staff) went back to Winn Dixie again. They went to the police station. They saw him sitting. Stated he couldn't find his way back to Royal Palm." The bottom of the incident report reads, "Facility comments /Recommendations and /or Steps to avoid reoccurrence of incident." Under this heading a Resident Assistant _____ writes, "Resident was found and all parties were notified." The supervising LPN signs the report on _____ with no further documentation. There is no documented plan for staff to be aware the resident could elope. There is no documentation the Facility did anything to prevent the resident from eloping again. The RCL dated _____ reads, "(Resident #8) left the building to walk to the bank. One of our employees found him walking and brought him back to Royal Palm. His _____ sugar was taken, it was 35. _____'s gave him something to eat and drink. (Resident #8) felt fine. Retook his _____ sugar again. Family was called and an incident	A 032		

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A 032	Continued From page 55 report was filed out." Review of "Incident Report" dated _____ and timed 2:19 p.m. reads, "I received a call from our housekeeper. She said she saw (Resident #8) on US 41 in Charlotte Harbor by Publix. She was trying to stop him and bring him home. Called (Staff) our driver and asked him to go help with (Resident #8). Also called and reported the incident to (Supervising LPN). (Staff) was able to get him in the car and bring him home. We tested his _____ sugar which was 31 and we gave him food and drinks." The bottom of the incident report reads, "Facility comments/Recommendations and /or Steps to avoid reoccurrence of incident." Under this heading a _____ writes, "All parties notified. Resident's _____ sugar was taken care of when he came back." The Supervising LPN signs the form on _____ without documenting anything. There is no documentation of a plan for staff to identify Resident #8 as an elopement risk. There is no documented plan to prevent Resident #8 from eloping again. A "Communication Form" written by a Home Health RN and dated _____ reads, _____ seen by psych nurse. Remains _____ and disoriented. Does not remember walking down 41 to Publix last week....Unable to make commitment to not leave the building. MSW (Master in Social work) ordered to assist wife in more secure placement. Will meet with wife soon." A "Communication Form" written by the same RN and dated _____ reads, "Patient seen by psych nurse. Remains disoriented and _____ Spoke with wife and advised that Facility would like him to be placed in a locked facility. Advised	A 032			

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A 032	Continued From page 56 that MSW will consult with her." A "Communication Form" written by the same RN and dated _____ reads, "Patient was seen by psych nurse. Patient remains demented...patient does not remember being at the Publix near the bridge. Says he likes to go to the bridge and watch the boats and fisherman. Repeated to him over and over again that he must not ever walk away from the building. Patient agreed not to walk away from Royal Palm. Needs to be constantly reminded and monitored for his presence in the building." There is no documentation in the medical record there was any plan initiated to constantly monitor the resident by the facility staff. A "Communication form" dated _____ reads, "Patient walked to the VFW 2 times today. He is alert but has memory issues and _____ with need to stay on premises." A note in the RCL dated _____ reads (Resident #8) moved to Patient Care Unit (PCU) today." The PCU is located on the 5th floor and is considered a locked unit. Another note in the RCL on _____ reads, "Made his way downstairs, (Staff) brought him back up." No incident report was filled out on _____. No investigation was documented to determine how the resident left the secured unit. No plan to prevent further elopement was documented. An interview was conducted with the Administrator on _____ at 2:30 p.m. He stated there had been no adverse incidents filed for Resident #8 after any of his elopements. He stated he had not felt the resident had been injured or was in any danger. He stated the resident had slowly declined and had to be moved to the locked unit.	A 032			

Agency for Health Care Administration

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A 032	Continued From page 57 Review of the incident reports and home health documentation shows staff were concerned for the resident's safety. The documentation on shows staff going to the police station. The documentation on shows staff is concerned the resident is on Highway 41. Highway 41 is an extremely busy highway. On the resident was transferred to a locked unit, but there is no documentation that family was advised or notified or that the resident's medical doctor had been informed. The Facility "Elopement and Elopement Drills Policy And Procedures" reads, "Upon finding the resident an assessment must be completed and determination made as to whether or not medical assistance is required." An interview was conducted with the Administrator on at 10:00 a.m. He was asked who would have been responsible for assessing a resident's injuries once he was found? He stated the acting Supervising LPN would be responsible. He was then asked where the LPN would document this assessment? He stated, "On the Incident Report." Review of the two incident reports in the resident's medical record shows no documentation from the acting Supervising LPN. On it is documented the resident eloped twice and no incident report was completed. Further review of the "Elopement Policies and Procedures" show no policies regarding: 1. An immediate coordinated staff search of the facility and premises; 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including	A 032			

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A 032	Continued From page 58 specific duties and responsibilities; 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and 4. The continued care of all residents within the facility in the event of an elopement. An interview was conducted with the Administrator on _____ at 10:30 a.m. He was asked how he would determine residents at risk for elopement? He stated he would do so verbally with staff. He stated there are no written lists to keep track of residents at risk. He stated the only resident in the building at risk would be Resident #8. No assessment tools were observed An interview was conducted with the LPN Supervisor at 10:40 a.m. on _____. She was asked who was at risk for elopement. She first stated there were no resident's at risk. She then stated Resident #8 is in a locked unit. She was asked if staff should be aware he had a history of elopement? She then stated Resident #8 was at risk. She confirmed there are 17 other residents in the secured unit. In an interview with Staff D, _____ at 10:45 a.m. on _____, she was asked if any residents were at risk for elopement. She stated, "Everybody in the building is ok right now. No one is at risk." An interview was conducted with Staff B, _____ at 10:50 a.m. on _____. She was asked if any residents were at risk for elopement? She stated, "What is Elopement?" After explaining what elopement was to the staff she stated, "Besides Resident #8 I don't think any of them would do it."	A 032			

Agency for Health Care Administration

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A 032	Continued From page 59 She then stated the supervisors had never discussed who in the building was at risk for elopement since she had started working in the Facility about 3 months ago. Class III	A 032			
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. (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.	A 052			

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A 052	Continued From page 60 (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 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.	A 052			

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A 052	Continued From page 61 (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: Based on observation and interview, the facility failed to read medication labels in the presence of 3 (Residents #12, #13 and #14) of 3 residents surveyed while assisting the resident in self-administration of medication. This resulted in a potential of residents taking the wrong medication, in the wrong amount, at the wrong time. The findings include: 1. At 11:30 a.m. on _____ B, Medication Technician, was observed on the 5th floor at the medication cart. Staff B was observed taking Tramadol _____ MG from the package and placing into a small plastic cup while at the medication cart. She was then observed to walk several feet	A 052			

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A 052	Continued From page 62 to the dining where Resident #12 was sitting. Staff B stated the resident's name and then said, "Here is your pain pill." Staff B failed to read the label of the medication to ensure the resident knew what she was taking, how much medication she was taking, and when the medication was due. In an interview with Staff B at 2:30 p.m. on she confirmed she had not read the label to the resident. 2. At 11:45 a.m. on Staff A was observed at the medication cart on the 1st floor. She was observed removing 0.5 mg and 50 MG from the bubble packs and placing them in a small plastic cup. Staff A was then observed to take the plastic cup to Resident #13 and stated, "Here is your nerve pill and your pill." Staff A failed to read the medication label to Resident #13. 3. At 12:00 p.m. on Staff C, Medication technician, was observed at the 1st floor medication cart. She was observed to take 2 extra-strength from the bubble pack while standing at the medication cart then place them in a small plastic cup. Staff C then took the plastic cup and handed it to Resident #13. Staff B stated, "Here is your The resident was observed to take the medication. Staff C failed to read the medication label to Resident #14. During an interview with Staff C at 3:10 p.m. on she confirmed she had not read the label to the resident. After explaining the difference between assistance with self-administration and administration of medication to Staff C she stated, "I've learned more in here today than I did in the 4 hour medication class."	A 052			

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STREET ADDRESS, CITY, STATE, ZIP CODE

ROYAL PALM RET CENTRE

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PORT CHARLOTTE, FL 33952**

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A 052	Continued From page 63 4. An interview was conducted with the LPN Supervisor at 3:55 p.m. on She confirmed staff should read medication labels to residents before giving medications to them. Class III	A 052		
A 053	58A-5.0185(4) FAC Medication - Administration (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	A 053		

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A 053	Continued From page 64 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 (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 4 (Residents #7, #8, #9 and #10) of 4 residents reviewed resulting in the hospitalization of 2 (Resident #8 and #9) of 4 residents for and and the immediate potential danger for 4 (Residents #7, #8, #9 and #10) of 4 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	A 053			

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A 053	Continued From page 65 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 _____ can be caused by the resident taking _____ and not eating. The complications of _____ 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, _____ 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 _____ occur. Ketoacidosis _____ when your body doesn't have enough insulin. insulin, _____ body can't use glucose for fuel, so your body breaks down fats to use for energy." "When your body breaks down fats, waste	A 053			

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A 053	Continued From page 66 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 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: After 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 of training in assisting residents with medications and do not have the training or knowledge base to make judgments in critical care decisions 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	A 053			

Agency for Health Care Administration

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ROYAL PALM RET CENTRE

**2500 AARON STREET
PORT CHARLOTTE, FL 33952**

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A 053	Continued From page 67 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 #8 was admitted to the Facility on _____ with a diagnosis of _____, and _____ The Facility in which the resident resides has a Limited Nursing Services (LNS) license. Also, after reviewing the medical record, Resident #8 had Home Health Services ordered so that he received weekly assessments from a licensed nurse. Review of the RCL (Resident Condition Log) dated _____ shows, "(Resident #8) is a new resident...He is a _____. He gets his sugar taken 4 x's a day. He has to be reminded of his meals and meds." On _____ at 11:30 a.m. Staff B, a medication technician, was observed administering an _____ to Resident #8 in the 5th floor dining _____. She was observed to prepare the lancet in the pen for the resident. The resident then was observed to prick his finger with the lancet after being cued by Staff B. Staff B was then observed to pick up the glucometer and obtain the _____ sample from the resident's finger. The resident was observed to be clearly _____ and unable to understand the process of his _____. Staff B never told the resident his _____ result. In an interview with Staff B on _____ at 11:35	A 053		

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A 053	Continued From page 68 a.m., she confirmed she had performed the resident's She confirmed the resident suffered from and was not able to understand when or why he received She was then asked how the resident receives administration. She stated, "I turn the dial to 25 units each morning and Resident #8 injects the dosage himself." She was asked if the resident would be able to tell her not to give the medication to him because his sugar was to low? She stated, "I don't think any of residents on this floor know what they are taking." She was asked how would she know when his sugar was to low and to hold his She stated, "We have parameters from the Licensed Practical Nurse Supervisor to notify her if his sugar is less than 40 or greater than 400." She then showed the surveyor this had been written above the resident's daily documentation. An interview was conducted with Resident #8 on at 1:20 p.m. The resident was observed at the time of the interview to be and oriented to self only. When asked if he received assistance with his medications at the facility he stated, "I don't know." He was then asked how he gets every morning from the staff? He stated, "I don't know. I don't take He was asked if he gets his sugar checked on a daily basis? He stated, "No, they don't check my sugar. I don't get" An interview was conducted with the supervising LPN on at 3:40 p.m. She stated she had only been working at the facility since of 2013. She was asked how Resident #8 receives from the staff. She stated they bring it to him and he does everything for himself. She was then told Staff B stated she turn the dial of pen to 25 for the resident each morning. The	A 053			

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A 053	Continued From page 69 supervisor was also told Staff B was observed obtaining an _____ from the resident at 11:30 a.m. She seemed to be surprised and stated, "Staff have been told they can't administer _____." She was then asked about Resident #8's _____. She confirmed the resident was _____ and unable to make judgments regarding his _____ care. She was then asked how medical technicians with 4 hours of training would be able to make decisions in the resident's care that would be critical enough to cause _____. She stated, "I see what you're saying." Review of Resident #8's RCL dated _____ shows, "(Resident #8) was sent out. _____ sugar was very low 20. Was found slumped over in chair drooling and unable to drink." Review of the recorded _____ on _____ shows the resident's _____ sugar at 6:30 a.m. was 47. There is no documentation any interventions were performed for this critically low _____ sugar in the RCL. Review of the Medication Observation Review (MOR) shows the resident received 30 units of _____ at 7:00 AM on _____. An incident report dated _____ and timed 10:45 a.m. shows, "While calling floors for lunch Resident #8 was found sweating and drooling. _____ sugar was 20. Not responding. Attempted to give orange juice couldn't get him to swallow. Called 911." On the same form, under the heading "Facility comments (recommendations and/or steps to avoid reoccurrence of incident)" a Resident Assistant _____ documented, "Returned next day. Sugars are being monitored and recorded."	A 053			

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A 053	Continued From page 70 Resident being checked several times a day." She signed and dated her note on _____. The LPN Supervisor signed and dated the form with no documentation from a licensed staff member. There is no documentation the resident's medical doctor was informed the resident was given _____ with a _____ sugar of 47. There is no documentation the resident's medical doctor or the resident's family was informed the resident was hospitalized with _____. When the resident returned from the hospital on _____, the medical doctor ordered, "Change AM _____ to _____ 24 units. _____ AC (before meals) and HS (hour of sleep) with high dosage coverage." Review of the medication list on the 1823 dated _____ shows, "Hold _____ if _____ sugar is less than 120." Review of Resident #8's MOR shows unlicensed staff continued to document _____ administration after _____. There was no documentation the hospital physician was notified to clarify his order of "High dose _____ coverage." The medical record shows no _____ coverage (sliding scale) initiated for this resident after the _____ order. There is no documentation of contacting the medical doctor until _____. Review of the physician's orders shows a change in _____ coverage on _____. The order reads, "Lantus 15 units _____ every PM." Review of the _____ Sugar Checks" record dated _____ shows the resident's _____ sugar was 106. Review of the MOR The _____	A 053			

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A 053	Continued From page 71 was changed from 24 units in the AM to 20 units in the AM on Review of the physician's orders show no recorded order to change the dosage for The resident was given 20 units of at 7:00 a.m. on The MOR clearly reads, "Hold if sugar below 120, start Review of the physician's orders shows no change in the parameters for holding the Review of the Communication form dated shows a home health RN had evaluated the resident on and noted his sugar was 106. There is no documentation there was any concern from the home health nurse the resident had been given which should have been held according to the medical doctor's order. The RN notes, ... has episodes of Fasting Sugar was 106 today. Instructed Patient on regime." Review of the "Sugar Checks" Record shows on at 10:30 a.m., the resident's sugar was 55. There is no documentation in the RCL any interventions were performed for the resident's low sugar. Review of the same record shows on at 3:30 p.m. no was performed as ordered. Review of the RCL dated and timed, "3-11:30 PM" shows, "Went up to check on (Resident #8) around 6 PM. He was lying in bed shaking uncontrollably and making no sense verbally. Stated he and had a laceration on his left arm. We called 911. He went to Peace River. Family was called." The note is not signed. Review of the "Incident Report" dated and timed at 6:00 p.m., shows, "Resident #8 found lying in the bed shaking uncontrollably	A 053			

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A 053	Continued From page 72 and not making much sense when he spoke. He also had a laceration on his left arm." Review of the report shows the ... who completed the incident report was the same ... who wrote the RCL note on ... At the bottom of the incident report an unlicensed staff member documents, "Resident is still in the hospital. Will follow-up with Infinity Home Health Care upon return." She dates her note ... The acting LPN supervisor signs the incident report and dates it on ... Review of the hospital record written by the hospital physician and dated ... reads, "I talked to the nursing staff and they told that they were given the history that he was walking at the ALF and he ... down and probably became ... and when ... was called and he was found to be ... There was no documentation the medical doctor was notified the resident was given ... even though it was supposed to held. There is no documentation the medical doctor was notified an ... had not been done at 3:30 p.m. as ordered. There is no documentation the family was notified the resident was sent to the hospital for ... There is no investigation on the incident report. There are no recommendations from a licensed staff member to avoid a recurrence of the incident. The patient returned to the facility from the hospital on ... Review of the Form 1823 dated ... shows under ... behavioral status: Under Nursing Treatments the form reads, "Infinity Home Health."	A 053			

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A 053	Continued From page 73 Review of the MOR showed unlicensed staff continued to administer _____ after _____ Review of the RCL dated _____ and timed "6:30-3" shows, "(Resident #8's) sugar has been low even though he has eaten his meals." Another note dated _____ and, written after _____ and, timed 7:30 a.m., reads, "(Resident #8) _____ Sugar 32 when I checked it. Gave him orange juice. He did not want to drink it asked _____ to call 911. EMT's came they gave him sugar _____ they checked his sugar it was 24. After the hivey _____ it was 168. They left. (Resident #8) was eating banana he had orange juice and peanut butter and jelly." The note is not signed by the _____ completing the note. The note is initiated by the acting LPN supervisor. Review of the _____ Sugar check record shows the resident had his _____ sugar checked twice by the _____ at 6:30 a.m. Review of the MOR shows _____ sugars were being checked before and after meals. Review of the physician's orders show no order to take _____ before and after meals. "The _____ at this time remained AC (before meals) and HS (hour of sleep), hold _____ for _____ sugar less than 120." Review of the MOR shows the resident received _____ at 7:00 a.m. This would be 30 minutes before the resident was found with a low _____ sugar. There is no way to tell from the documentation if the higher _____ sugars recorded at 6:30 a.m. were before or after the resident had received _____ glycogen. Review of the medical record shows no incident report was completed on _____. There is no documentation the medical doctor was notified the resident's _____ sugar was 32 and _____ had	A 053		

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A 053	Continued From page 74 to administer glycogen . . . to save the resident's life. There is no documentation the resident's family member was notified of this critical issue. Review of the physician's orders show the resident is not seen by a medical doctor until . . . The "Medical Appointment Information" note shows the medical doctor discontinues the . . . and orders Lantus . . . 20 units twice a day. There is no clarification from a nurse noted as to holding the . . . for a . . . sugar of 120. There is no change noted to the . . . The order remains . . . AC (before meals) and HS (hour of sleep). Review of the . . . record shows . . . 's checking the resident's . . . sugar 5 and 6 times daily without an order from the medical doctor. Review of the RCL timed "6:30 to 3" and dated . . . shows, . . . found (Resident #8) slumped over in his chair and not responsive. 911 was called and they took his . . . sugar which was 12. They proceeded to give him a shot which brought his . . . sugar up to 167. . . didn't feel it was necessary to take him to the hospital. . . 's tried to give him his lunch and drinks to keep his . . . sugar up. . . 's continue to check on him throughout the day. . . also spoke to (resident's wife) to let her know what was happening. Incident report filled out. (Resident #8) did eat a bowl of ice cream, cranberry juice and half his lunch meal." Review of . . . "Sugar Checks" form shows on . . . the resident's . . . sugar was taken twice at 6:30 a.m. His . . . sugar is recorded as . . . There is no documentation any intervention was done by any staff member to prevent critically low . . . Review of the MOR shows Resident #8 received 20 units of	A 053			

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A 053	Continued From page 75 Lantus at 7:00 a.m., even though his sugar was abnormally low. An "Incident Report" dated and timed 11:25 a.m. reads, "Resident was unable to respond. went to resident's found resident slumped over in chair and unable to respond. 911 was called and they came. Took his sugar which was 12. They proceeded to give him a shot and brought his sugar up to 162. felt it was not necessary to take him to the hospital. X's gave resident a lunch tray and made sure he was doing fine." On the bottom of the form another documents, "Resident good after received shot. keep eye on sugars and report to his home health and Dr. Butler office." The note is dated The incident is signed by the Supervising LPN on There is no documentation the resident's medical doctor was notified the day the incident occurred. There is no documentation the medical doctor or the family were told the resident was given by a when the resident had an abnormally low sugar. There is no investigation noted on the incident report as to why the resident had a sugar of 12. There are no recommendations from licensed staff to prevent the same issue from occurring again. A "Patient Service Update" sent to the physician from the Home Health Nurse and dated reads, "Patient saw Veterans Administration (VA) MD last week. The following changes were made: Discontinued Prandin and flex pen. Lantus was changed from 15 units at night to Lantus 20 units 2 times daily.... Patient had episode of this weekend. reported sugar of 12. Today's fasting sugar was 54. Attached is the glucose log. Please advise." The physician	A 053			

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A 053	Continued From page 76 responds, "Give Lantus in AM same dose continue to monitor." The order from the doctor is not clear as to how he wants the ... given. In looking at the order it appears he wants the resident to just have AM Lantus at the same dosage the VA had ordered. The order is not acceptable and should have been clarified by a nurse. Review of the MOR on ... shows no change in the order for Lantus noted. An "Incident Report" timed 7:30 a.m. and dated ... reads, "Resident did not come down went to check on him. Wasn't acting right. Checked his ... sugar it was 32. 911 called for resident. He was unable to drink orange juice. ... came gave him ... sugar. Then it was 160 and ... left. On the bottom of the incident report another ... writes, "EMT gave ... sugar to resident and got sugars up. Resident didn't go to the hospital. Resident was able to go to dining ... eat lunch and dinner and did well rest of the day. Home Health was notified. The note is dated ... The form is signed by the supervising LPN on ... There is no investigation on the incident report as to why the resident was found to have a ... sugar of 32. There is no documentation the resident's doctor was notified the resident had ... There are no recommendations listed on the incident report to prevent further incidents to occur. Review of the Home Health Communication form dated ... reads, "... sugars are still very unstable. Extremely important that staff makes sure he eats all his meals and has a snack at night before bed. (Unknown) aware of ... sugars and is monitoring closely." The note is signed by an RN. There is no documentation in the resident's record the facility staff ever followed	A 053			

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A 053	Continued From page 77 the advice of the licensed home health nurse to monitor the residents food intake. Review of the Sugar Check dated shows at 6:30 a.m., the documented three separate sugars taken. There is no time noted as to when the sugars were taken. The sugars recorded are Review of the MOR shows the resident received 20 units of Lantus at 7:00 a.m. There is no documentation as to if the resident received before he was found with a sugar of 32. No investigation is documented by the facility or the Home Health Nurse. Review of the Physician's orders shows the resident's was changed on The new order was Lantus 20 units every AM and 15 units every PM. No parameters are attached to the order, which would leave an untrained, unlicensed staff with the decision on when to give the if it was abnormally low. Review of the RCL dated and timed "6-3" reads, "(Resident #8) didn't wake for breakfast but did take his meds. (Resident #8) sent to hospital low sugar." An "Incident Report" dated with a time of 11:00 a.m. reads, "Resident found on the floor Rq (unknown) side of bed. Resident took sugar was very low. Resident unable to move at the time." The LPN supervisor documents on the same date, "Resident Sent 911 to be evaluated." There is no documentation the resident's medical doctor was notified at the time the resident was transported to the hospital. The form clearly reads, "Describe Exactly what happened; Why; What causes were." There is no investigation	A 053			

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A 053	Continued From page 78 noted on the incident report as to why the resident was having a low _____ sugar. Review of the resident's _____ Sugar Checks on _____ show at 10:30 a.m., the resident had a _____ sugar of 31. There are no documented interventions noted for this critically low _____ sugar. Review of the medical record shows the resident was admitted to the hospital with a diagnosis of _____ and spent 6 days in the hospital. Review of the discharge records on _____ shows _____ was discontinued when the resident was discharged from the hospital. Review of the _____ "Sugar Checks" for the month of _____ shows the resident's _____ sugars were abnormally high for several days when he was discharged. The first _____ sugar taken was 403 when the resident returned to the facility on _____ and was recorded at 7:00 - 9:00 p.m. The resident's _____ sugar was recorded as 467 on _____. His _____ sugar was recorded as 558 on _____. It was recorded as 542 on _____. There is no documentation the resident's medical doctor was notified of these critically abnormal _____ sugars until _____. A "Patient Service Update" sent by the Home Health Agency to the medical doctor on _____ reads, "Patient's _____ meds were discontinued by hospital _____ sugars are as follows: _____ 2/192/558, _____ Please advise." The nurse filling out the form writes an order of _____ 500 MG 1 pill by mouth twice daily. On the side of the paper the medical doctor writes, "?" Underneath the question mark he writes, "Already on _____	A 053		

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PORT CHARLOTTE, FL 33952**

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A 053	Continued From page 79 850 mg 1 pill by mouth twice daily and Lantus." This note shows the medical doctor was not made aware the resident was sent to the Hospital on _____ and discharged on _____ without _____ medications until _____ Review of the medical record shows the resident was sent to the Hospital and evaluated on _____. The medical record shows he was seen for _____ and Chronic _____. There is no documentation the resident's family was made aware that he was sent to the Hospital. There is no documentation in the RCL and no incident report was completed. Review of the _____ "Sugar Checks" show on _____ Resident #8's _____ sugar was 508. The record shows the resident was hospitalized from _____ to _____. Review of an incident report dated _____ and timed 6:45 a.m. reads, checked resident _____ sugar and it was 508. Resident went to Peace River for Eval." The Incident report is signed by the supervising LPN. An interview was conducted with the Supervising LPN at 4:10 p.m. on _____. She was asked if the resident had any symptoms when he was sent out. She stated, "No." She was asked if the medical doctor was notified of the resident's _____ sugar? She stated, "No, we had no coverage so I sent him to the hospital so they could get his _____ sugar down." She was asked about the abnormally high _____ sugars on _____ and _____. She stated, "They were not reported to me." She was asked how often she looks at the resident's _____. She stated, "I never look at them. The doctor sees them when he comes." She was asked how often the medical doctor sees the resident? She stated, "About once a month."	A 053		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911942	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER ROYAL PALM RET CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 AARON STREET PORT CHARLOTTE, FL 33952		
(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 053	Continued From page 80 Review of the admission note from the hospital dated _____ reads, "Third hospital visit since _____ with issues related to his _____ sugar. The patient has had two admissions with low _____ sugars and _____ sugars in the 21 range, though he has been taken off scheduled _____. Apparently there was much _____ lying around at the facility and the patient had a series of this according to the personal who saw the situation. The patient's _____ sugar was over 500 unless he was sent to the Emergency _____ admission for uncontrolled _____. The patient is demented and has numerous other medical problems, but has not been safe to put on scheduled _____ because he becomes _____ on some. He has apparently been on sliding scale _____. Review of the Discharge Summary written by the hospital physician and dated _____ reads, "Apparently, at the _____ unit I am told that there are a number of cupcakes available and the patient had several and was found with a _____ sugar of 500." Review of physician's orders dated _____ reads, _____ before meals breakfast, lunch, and dinner, at bedtime and 2:00 a.m. Restart Lantus _____ 6 units PM 25 units _____ AM." There is no physician's signature on the order. Review of the MOR shows the order was started on _____. Review of the "_____ Sugar Checks for the month of _____ 2013 shows 2:00 a.m. _____ sugars were not done on _____ or _____. On _____ The resident's 2:00 a.m. _____ sugar was 38. No interventions are recorded for this critically low _____ sugar.	A 053			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911942	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
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A 053	Continued From page 81 At 6:30 on _____ Resident #8's _____ sugar is recorded as 40. Review of the MOR shows on _____ at 7:00 a.m., the resident was administered 25 units of Lantus _____. Review of RCL dated _____ reads, "(Resident #8's) _____ sugar was 40 when he came out ate breakfast 1 pancake cup of coffee cup of OJ. He had _____. A "Communication Form" dated _____ reads, "Fasting _____ Sugar was 44-at 10:30 AM 88. No 2:00 a.m. _____ sugar recorded times 2 days. Spoke with (LPN supervisor) about this matter." Review of RCL dated _____ reads, "Visiting Nurse saw (Resident #8) was wondering why nobody is checking 2:00 a.m. _____ sugar. His _____ sugar was 44 at 6:30 AM." Review of the _____ 2013 _____ Sugar Checks" Show the only 2:00 a.m. _____ was obtained on _____. Even after LPN supervisor was made aware of the situation. Review of the 1823 dated _____ shows the resident's _____ status to be "Alert and oriented x's 1 (to person,) _____ and forgetful." Under Nursing Treatments on the same form is documented, _____. Which would mean a nurse would be required to provide the services requested. Review of the MOR show unlicensed staff still continued to administer _____ after _____. An interview was conducted with the resident's medical doctor by phone at 3:00 p.m. on _____. When he was told the _____'s were making decisions in the resident's _____ care management he stated, "I have standing orders	A 053			

Agency for Health Care Administration

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A 053	Continued From page 82 for that." He was then told on _____ an _____ gave the resident _____ when he had _____ sugar of 47 and by 11:00 a.m. the resident had a _____ sugar of 20 and had to be hospitalized. The physician stated, "That's not good." He was unable to confirm when he was notified the resident had a low _____ sugars during each hospitalization and critical event. He stated, "I'm not going to lie to you. I would not be able to say." He was asked if he knew the limitations of _____'s?. He stated he thought they were trained to take care of residents with _____ dependence. He stated as far as he knew the previous LPN supervisor was administering _____ to the residents. An interview was conducted with the LPN supervisor on _____ at 4:10 p.m. She stated, "We don't take standing orders here from doctors." 2. Resident #9 is a _____ white male who was admitted to the Facility on _____. He has a history of _____ and _____. Review of the residents form 1823, dated _____ shows the resident has poor eyesight. The resident receives _____ N _____, 60 units, every morning. Review of the MOR show unlicensed staff providing _____ care for the resident. The MOR shows there are no high and low parameters ordered for this resident's _____ sugar. Review of an "Incident report" dated _____ and timed 12:30 p.m. reads, "Son has (Resident #9) at the dentist office. Brought back. Resident became unstable. Unable to walk, speak, or respond to verbal commands. Resident was checked out by nurse and Home Health nurse.	A 053			

Agency for Health Care Administration

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A 053	Continued From page 83 911 called. On the bottom of the form which had a heading of "(Recommendations and/or steps to avoid reoccurrence of incident)", the . . . writes, "Came back same day with low sugar. Son is taking to MD." The form is signed and dated by the LPN supervisor on There is no documentation as to why the resident had a low sugar. There is no documentation the medical doctor was notified the resident was critically enough to go to the hospital. Review of the Sugar Checks" shows on the resident's fasting sugar was 70. Review of the MOR on shows the resident received 60 units of N at 7:00 a.m. There is no documentation the ensured the resident ate something before he was sent to the dentist office. On the resident's fasting sugar was 60. The MOR show the resident was given 60 units of with no interventions. On the residents fasting sugar was documented as 49. He was given 60 units of with no interventions. On the resident's sugar was documented as 54. The resident was given 60 units of with no interventions. On the resident's sugar was 55. The resident was given 60 units of with no interventions. On the resident's sugar was 48. The resident was given 60 units of with no intervention. In each of these instances the medication should have been held and the medical doctor notified before giving 3. Resident #7 is a white female who was admitted to the facility on She has a history of Mellitus,	A 053			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911942	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ROYAL PALM RET CENTRE

**2500 AARON STREET
PORT CHARLOTTE, FL 33952**

(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 053	Continued From page 84 and She receives _____ with sliding scale coverage. She needs her _____ sugars checked three times daily. Review of Section 3 of the 1823 dated _____ shows unlicensed staff are assisting the resident with medications and _____ sugar checks. An interview was conducted with Resident #7 at 2:05 p.m. on _____. She was asked how she gets her _____ sugar checked. She stated, "I go down to the nurses' station on the 1st floor and they take my _____ and check my sugar. They then dial in my _____ dosage and they give me a shot of _____ in my abdomen." She was asked if she was sure the staff injects her with her _____. She stated, "I can't do it myself. They do it for me." She did not know how much _____ she took every day. 4. Resident #10 is a _____ white female who was admitted to the Facility _____. The resident has _____ and receives _____ N _____ 26 units, in the AM and 20 units in the PM _____. She also receives _____ coverage for _____ sugars above 151. Review of section 3 of the 1823 dated _____ show unlicensed staff are providing assistance with medications. An interview was conducted with Resident #10 at 1:20 p.m. on _____. The resident was asked how long she had lived at the facility. She stated, "I moved here about a year ago. I am legally _____. When my eyes got worse I could no longer give myself _____. When asked what staff do for her when she gets her medication she stated, "I go to the medicine _____ times a day. They take my _____ sugar because I can't read the machine. They dial in the amount of _____ I	A 053		

Agency for Health Care Administration

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A 053	Continued From page 85 need and I inject myself. I'm not able to read the pen I'm legally An interview was conducted with Staff C at 3:30 p.m. on She confirmed she put in the dosage for Resident #10. She stated, "Yes, (Resident #10) has a problem because she can't see. I help her turn in the dosage. The residents who take will get aggravated at us if we don't do it. They want us to put in the dosage." She was then explained the danger of administering and making decisions for a resident on when to give and how much to give to a resident. She then stated, "I learned more today than I learned during the whole medication class." An interview was conducted with the Administrator on at 11:30 a.m. He stated he was not aware unlicensed staff were administering to residents. He stated he was aware Resident #8 had been sent to the hospital on several occasions for low and high sugar. During the interview he still seemed unaware unlicensed staff could not make critical decisions regarding care. He stated, "If they have a parameter can they assist with" Class I	A 053			
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	A 056			

Agency for Health Care Administration

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NAME OF PROVIDER OR SUPPLIER ROYAL PALM RET CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 AARON STREET PORT CHARLOTTE, FL 33952		
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A 056	Continued From page 86 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 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.	A 056			

Agency for Health Care Administration

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A 056	Continued From page 87 (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, 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 and interview, the facility stored expired medication past 30 days and also stored discarded medication greater than 45	A 056			

Agency for Health Care Administration

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A 056	Continued From page 88 days. The findings include: On 11:15 a.m., a bottle of unlabeled Acetaminophen observed in the 5th floor cabinet behind the medication cart. The medication had an expiration date of 2/... ... interview was conducted with Staff B at 11:15 a.m. on ... stated she was not aware what the medications in the cabinet were used for or who they belonged to. She confirmed the medication had been expired longer than 30 days. At 11:45 a.m. on ... bottle of Prostat nutritional supplement was observed in the cabinet in the medication room ... 1st floor. The supplement had a pharmacy label attached to the bottle with an expiration date noted to be 12/1. ... an interview with the LPN supervisor she confirmed the medication was being stored and it had expired 5 months prior to being observed by the surveyor. At 3:50 p.m. on ... unlabeled tube of polysporin ointment was observed in a locked drawer in the nursing office. The medication had an expiration date of 5/... the same drawer a unlabeled tube of silver sulfadiazine 1% cream was observed with an expiration date of 1/... the same drawer a unlabeled bottle of Imodium ... observed to have an expiration date of 3/... bottle of Imodium ... in the same drawer with an expiration date 2/... the same drawer a bottle of medication labeled Mupirocin ... 2% was observed with and expiration	A 056		

Agency for Health Care Administration

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A 056	Continued From page 89 date of _____ An interview was conducted with the LPN supervisor at 3:50 p.m. on _____. She confirmed the medications had been expired longer than 30 days. She stated she had only worked for the facility since ____ of 2013. She stated she was not aware these medications were locked in the drawer in the nursing office. She had no idea why the medications were being stored there. On _____ at 3:50 p.m., a medication labeled Clopidogrel 75 _____ was observed locked in the drawer in the nurse's office. In an interview with the LPN Supervisor on _____ at 11:00 a.m., she stated the resident named on the label was no longer at the facility. She stated she did not know how long the medication had been in the drawer or how long ago the resident had been discharged. She stated the resident was not at the Facility when she started working there in ____ of 2013. Class III	A 056			
A 057	58A-5.0185(8) FAC Medication - Over The Counter (OTC) Products (8) OVER THE COUNTER (OTC) PRODUCTS. For purposes of this subsection, the term OTC includes, but is not limited to, OTC medications, _____, nutritional supplements and nutraceuticals, hereafter referred to as OTC products, which can be sold without a prescription. (a) A stock supply of OTC products for multiple resident use is not permitted in any facility. (b) OTC products, including those prescribed by a licensed health care provider, must be labeled	A 057			

Agency for Health Care Administration

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A 057	Continued From page 90 with the resident 's name and the manufacturer 's label with directions for use, or the licensed health care provider 's directions for use. No other labeling requirements are necessary nor should be required. (c) Residents or their representatives may purchase OTC products from an establishment of their choice. (d) A facility cannot require a licensed health care provider 's order for all OTC products when a resident self-administers his or her own medications, or when staff provides assistance with self-administration of medications pursuant to Section 429.256, F.S. A licensed health care provider 's order is required when a licensed nurse provides assistance with self-administration or administration of medications, which includes OTC products. When such an order for an OTC product exists, only the requirements of paragraphs (b) and (c) of this subsection are required. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to label over the counter medications with resident's names and store the OTC's in several areas of the facility. The findings include: On at 11:20 a.m., the following medications were observed locked in the 5th floor medication cabinet of the Facility: OTC Immodium 2 mg caplets OTC with caplets Expiration OTC Fish Oil 100 mg caplets An interview was conducted with Staff B, ... at	A 057			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL19191942	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
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A 057	Continued From page 91 11:20 a.m. on She stated she didn't know why the medications were being stored in the cabinet. She stated she was not aware of who the medications belonged to. During an observation of the medication cart on the 1st floor two large unlabeled bottles of Prostat nutritional supplement was observed. An interview was conducted with the LPN supervisor at 11:20 a.m. on She confirmed the bottles of supplements were unlabeled. At 3:50 p.m. on the following medications OTC medications were found unlabeled and locked in the nursing office desk drawer: OTC Polysporin Ointment, expired 5/2011 OTC expired, ... OTC 10 mg, expired OTC St Joseph in, 81 mg tabs, expired OTC 2 mg., expired Protate SR, 3 bottles, expired OTC HBP, expires OTC caps, expires OTC Liquid Gels, expires 11/2013 OTC PM Liqui-gels, expires OTC expires OTC expires OTC triple expires OTC Equate Relief 25 mg., expires OTC 600 mg/Vit.D, expires OTC Silver 1 % cream, 2 tubes, expires OTC One-a-day 50+, expires OTC Walgreens Pain reliever 500 mg, expires	A 057			

Agency for Health Care Administration

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A 057	Continued From page 92 OTC 150 mg tabs, expires OTC 180 mg, expires OTC 10 mg, expires OTC S, expires During an interview with the LPN supervisor on at 3:50 p.m., she confirmed the medications were being stored unlabeled. She stated she had not been aware the medications were being stored in her office. Class III	A 057			
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 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	A 077			

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NAME OF PROVIDER OR SUPPLIER ROYAL PALM RET CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 AARON STREET PORT CHARLOTTE, FL 33952		
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A 077	Continued From page 93 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 observation, interview and record review, the facility Administrator failed to ensure adequate supervision of all staff and provision of safe, adequate care to all residents living in the facility. The findings include: Due to the Resident Assistants (RAs) managing the resident's _____ status and determining treatment without nursing supervision the resident was at risk for _____	A 077			

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A 077	Continued From page 94 The facility was not aware there was a problem with Resident #8's care, the facility continued to allow the staff to make decisions regarding Resident #8's care. 1. Resident #8 was admitted to the Facility on _____ with a diagnosis of _____ and _____ Review of the RCL (Resident Condition Log) dated _____ shows, "(Resident #8) is a new resident...He is a _____. He gets his sugar taken 4 X's a day. He has to be reminded of his meals and meds." On _____ at 11:30 a.m. Staff B, a medication technician, was observed administering an _____ to Resident #8 in the 5th floor dining _____. She was observed to prepare the lancet in the pen for the resident. The resident then was observed to prick his finger with the lancet after being cued by Staff B. Staff B was then observed to pick up the glucometer and obtain the _____ sample from the resident's finger. The resident was observed to be clearly _____ and unable to understand the process of his _____. Staff B never told the resident his _____ result. In an interview with Staff B at 11:35 a.m., she confirmed she had performed the resident's _____. She confirmed the resident suffered from _____ and was not able to understand when or why he received _____. She was then asked how the resident receives _____ administration. She stated, "I turn the dial to the 25 units and Resident #8 injects the dosage himself." She was asked if the resident would be able to tell her not to give the medication to him because his _____ sugar was to low? She stated,	A 077			

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A 077	Continued From page 95 "I don't think any of residents on this floor know what they are taking." She was asked how would she know when his _____ sugar was to low and to hold his _____. She stated, We have parameters from the Licensed Practical Nurse Supervisor to notify her if his _____ sugar is less than 40 or greater than 400." She then showed the surveyor this had been written above the resident's daily _____ documentation. An interview was conducted with Resident #8 on _____ at 1:20 p.m. The resident was observed at the time of the interview to be _____ and oriented to self only. When asked if he received assistance with his medications at the facility he stated, "I don't know." He was then asked how he gets _____ every morning from the staff? He stated, I don't know. I don't take _____. He was asked if he gets his _____ sugar checked on a daily basis? He stated, No, they don't check my _____ sugar." An interview was conducted with the supervising LPN on _____ at 3:40 p.m. She stated she had only been working at the facility since _____ of 2013. She was asked how Resident #8 receives _____ from the staff. She stated they bring it to him and he does everything for himself. She was then told Staff B stated she turn the dial of _____ pen to 25 for the resident each morning. The supervisor was also told Staff B was observed obtaining an _____ from the resident at 11:30 a.m. She seemed to be surprised and stated, "Staff have been told they can't administer _____. She was then asked about Resident #8's _____. She confirmed the resident was _____ and unable to make judgments regarding his _____ care. She was then asked how medical technicians with 4 hours of training would be able to make decisions in the resident's	A 077			

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A 077	Continued From page 96 care that would be critical enough to cause She stated, "I see what you're saying." Review of Resident #8's RCL dated ... shows, "(Resident #8) was sent out. ... sugar was very low 20. Was found slumped over in chair drooling and unable to drink." Review of the recorded ... on ... shows the resident's ... sugar at 6:30 a.m. was 47. There is no documentation any interventions were performed for this critically low sugar in the RCL. Review of the Medication Observation Review (MOR) shows the resident received 30 units of ... at 7:00 a.m. on ... An incident report dated ... and timed 10:45 a.m. shows, "While calling floors for lunch Resident #8 was found sweating and drooling, sugar was 20. Not responding. Attempted to give orange juice couldn't get him to swallow. Called 911." On the same form, the acting LPN supervisor at the time documented, "Returned next day. Sugars are being monitored and recorded. Resident being checked several times a day." She signed and dated her note on ... There is no documentation the resident's medical doctor was informed the resident was given ... with a ... sugar of 47. There is no documentation the resident's medical doctor or the resident's family was informed the resident was hospitalized with ... When the resident returned from the hospital on ... the medical doctor ordered, "Change AM	A 077			

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A 077	Continued From page 97 _____ to _____ 24 units. _____ AC (before meals) and HS (hour of sleep) with high dosage coverage." Review of the medication list on the 1823 dated _____ shows, "Hold _____ if _____ sugar is less than 120." Review of section 3 of the 1823 dated _____ and signed by the Administrator designee shows medications and _____ sugar checks services were to be provided by Resident Patient Care Staff. There was no documentation the hospital physician was notified to clarify his order of "High dose _____ coverage." The medical record shows no _____ coverage (sliding scale) initiated for this resident after the _____ order. There is no documentation of contacting the medical doctor until _____. Review of the physician's orders shows a change in _____ coverage on _____. The order reads, "Lantus 15 units _____ every PM." Review of the _____ "Sugar Checks" record dated _____ shows the resident's _____ sugar was 106. Review of the MOR The _____ was changed from 24 units in the AM to 20 units in the AM on _____. Review of the physician's orders show no recorded order to change the _____ dosage for _____. The resident was given 20 units of _____ at 7:00 a.m. on _____. The MOR clearly reads, "Hold if _____ sugar below 120, start _____. Review of the physician's orders shows no change in the parameters for holding the _____ Review of the Communication form dated _____ shows a home health Registered Nurse (RN) had	A 077		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ROYAL PALM RET CENTRE

**2500 AARON STREET
PORT CHARLOTTE, FL 33952**

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A 077	Continued From page 98 evaluated the resident on _____ and noted his _____ sugar was 106. There is no documentation there was any concern from the home health nurse the resident had been given _____ which should have been held according to the medical doctor's order. The RN notes, _____ has episodes of _____ Fasting _____ Sugar was 106 today. Instructed Patient on _____ regime." Review of the _____ "Sugar Checks" Record shows on _____ at 10:30 a.m., the resident's _____ sugar was 55. There is no documentation in the RCL any interventions were performed for the resident's low _____ sugar. Review of the same record shows on _____ at 3:30 p.m. no _____ was performed as ordered. Review of the RCL dated _____ and timed, "3-11:30 PM" shows, "Went up to check on (Resident #8) around 6:00 p.m. He was lying in bed shaking uncontrollably and making no sense verbally. Stated he _____ and had a laceration on his left arm. We called 911. He went to Peace River Hospital. Family was called." The note is not signed by the RA _____ of the "Incident Report" dated 6/27. _____ timed at 6:00 p.m., shows, "Resident #8 found lying in the bed shaking uncontrollably and not making much sense when he spoke. He also had a laceration on his left arm." Review of the report shows the RA _____ completed the incident report was the same RA _____ wrote the RCL note on 6/27 _____ the bottom of the incident report an unlicensed staff member documents, "Resident is still in the hospital. Will follow-up with Infinity Home Health Care upon return." She dates her note 6/28. _____ acting LPN supervisor signs the incident report and dates it on 6/28	A 077		

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A 077	Continued From page 99 There was no documentation the medical doctor was notified the resident was given _____ even though it was supposed to held. There was no documentation the medical doctor was notified an _____ had not been done at 3:30 p.m. as ordered. There was no documentation the family was notified the resident was sent to the hospital for _____ There was no investigation on the incident report to show the cause of the resident's hospitalization. The hospital record written by the hospital physician and dated _____ reads, "I talked to the nursing staff and they told that they were given the history that he was walking at the ALF and he _____ down and probably became _____ and when _____ was called and he was found to be _____ The patient returned to the facility from the hospital on _____. Review of the Form 1823 dated _____ shows under _____ behavioral status: Under Nursing Treatments the form reads, "Infinity Home Health." Review of Section 3 of the 1823 and signed by the Administrator's designee shows Resident Patient Care Staff were providing medications and _____ sugar checks. Review of the RCL dated _____ and timed "6:30-3" shows, "(Resident #8's) sugar has been low even though he has eaten his meals." Another note dated _____ and, written after _____ and, timed 7:30 a.m., reads, "(Resident #8) _____ Sugar 32 when I checked it. Gave him orange juice. He did not want to drink it asked to call 911. EM's came they gave him sugar they checked his sugar it was 24. After the	A 077			

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A 077	Continued From page 100 hivey it was 168. They left. (Resident #8) was eating banana he had orange juice and peanut butter and jelly." The note was not signed by the completing the note. The note is initialed by the acting LPN supervisor. Review of the Sugar check record shows the resident had his sugar checked twice by the at 6:30 a.m. Review of the MOR shows sugars were being checked before and after meals. Review of the physician's orders show no order to take before and after meals. The at this time remained AC (before meals) and HS (hour of sleep), hold for sugar less than 120." Review of the MOR shows the resident received at 7:00 a.m. This would be 30 minutes before the resident was found with a low sugar. There is no way to tell from the documentation if the higher sugars recorded at 6:30 a.m. were before or after the resident had received glycogen. Review of the medical record shows no incident report was completed on . There was no documentation the medical doctor was notified the resident's sugar was 32 and had to administer glycogen to save the resident's life. There was no documentation the resident's family member was notified of this critical issue. Review of the physician's orders show the resident was not seen by a medical doctor until . The "Medical Appointment Information" note shows the medical doctor discontinues the and orders Lantus 20 units twice a day. There was no clarification from a nurse noted as to holding the for a sugar of 120. There was no change noted to the . The order remains	A 077			

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A 077	Continued From page 101 AC (before meals) and HS (hour of sleep). Review of the record shows RAs checking the resident's sugar 5 and 6 times daily without an order from the medical doctor. Review of the RCL timed "6:30 to 3" and dated shows, "found (Resident #8) slumped over in his chair and not responsive. 911 was called and they took his sugar which was 12. They proceeded to give him a shot which brought his sugar up to 167. didn't feel it was necessary to take him to the hospital. RAs tried to give him his lunch and drinks to keep his sugar up. RAs continue to check on him throughout the day. also spoke to (resident's wife) to let her know what was happening. Incident report filled out. (Resident #8) did eat a bowl of ice cream, cranberry juice and half his lunch meal." Review of "Sugar Checks" form shows on the resident's sugar was taken twice at 6:30 a.m. His sugar is recorded as . There was no documentation any intervention was done by any staff member to prevent critically low . Review of the MOR shows Resident #8 received 20 units of Lantus at 7:00 a.m., even though his sugar was abnormally low. An "Incident Report" dated and timed 11:25 a.m. reads, "Resident was unable to respond. went to resident's found resident slumped over in chair and unable to respond. 911 was called and they came. Took his sugar which was 12. They proceeded to give him a shot and brought his sugar up to 162. felt it was not necessary to take him to the hospital. gave resident a lunch tray and	A 077			

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A 077	Continued From page 102 made sure he was doing fine." On the bottom of the form another documents, "Resident good after received shot. keep eye on sugars and report to his home health and Dr. Butler office." The note was dated . The incident was signed by the Supervising LPN on . There was no documentation the resident's medical doctor was notified the day the incident occurred. There was no documentation the medical doctor or the family was told the resident was given . by a RA with an abnormally low sugar. There was no investigation noted on the incident report as to why the resident had a sugar of 12. A "Patient Service Update" sent to the physician from the Home Health Nurse and dated . reads, "Patient saw Veterans Administration (VA) MD last week. The following changes were made: Discontinued Prandin and flex pen. Lantus was changed from 15 units at night to Lantus 20 units . 2 times daily.... Patient had episode of this weekend. reported sugar of 12. Today's fasting sugar was 54. Attached is the glucose log. Please advise." The physician responds, "Give Lantus in AM same dose continue to monitor." The order from the doctor is not clear as to how he wants the given. In looking at the order it appears he wants the resident to just have AM Lantus at the same dosage the VA had ordered. The order is not acceptable and should have been clarified by a nurse. Review of the MOR on . shows no change in the order for Lantus noted. An "Incident Report" timed 7:30 a.m. and dated . reads, "Resident did not come down went to check on him. Wasn't acting right. Checked his sugar it was 32. 911 called for resident.	A 077			

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A 077	Continued From page 103 He was unable to drink orange juice. _____ came gave him _____ sugar. Then it was 160 and _____ left. On the bottom of the incident report another _____ writes, "EMT gave _____ sugar to resident and got sugars up. Resident didn't go to the hospital. Resident was able to go to dining _____ eat lunch and dinner and did well rest of the day. Home Health was notified. The note was dated _____. The form was signed by the supervising LPN on _____. There was no investigation on the incident report as to why the resident was found to have a _____ sugar of 32. There was no documentation the resident's doctor was notified the resident had _____. The Home Health Communication form dated _____ reads, "_____ sugars are still very unstable. Extremely important that staff makes sure he eats all his meals and has a snack at night before bed. (Unknown) aware of _____ sugars and is monitoring closely." The note was signed by a RN. Review of the _____ Sugar Check dated _____ shows at 6:30 a.m., the _____ documented three separate _____ sugars taken. There was no time noted as to when the _____ sugars were taken. The _____ sugars recorded were _____. Review of the MOR shows the resident received 20 units of Lantus _____ at 7:00 a.m. There was no documentation as to if the resident received _____ before he was found with a _____ sugar of 32. No investigation was documented by the Facility or the Home Health Nurse. Review of the Physician's orders shows the resident's _____ was changed on _____. The new order was Lantus 20 units _____ every AM and 15 units _____ every PM. No parameters were attached to the order, which	A 077			

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A 077	Continued From page 104 would leave an untrained, unlicensed staff with the decision on when to give the . . . if it was abnormally low. Review of the RCL dated . . . and timed "6-3" reads, "(Resident #8) didn't wake for breakfast but did take his meds. (Resident #8) sent to hospital low . . . sugar." An "Incident Report" dated . . . with a time of 11:00 a.m. reads, "Resident found on the floor Rq (unknown) side of bed. Resident took . . . sugar was very low. Resident unable to move at the time." The LPN supervisor documents on the same date, "Resident Sent 911 to be evaluated." There was no documentation the resident's medical doctor was notified at the time the resident was transported to the hospital. The form clearly reads, "Describe Exactly what happened; Why; What causes were." There was no investigation noted on the incident report as to why the resident was having a low . . . sugar. Review of the resident's . . . Sugar Checks on . . . show at 10:30 a.m., the resident had a . . . sugar of 31. There were no documented interventions noted for this critically low sugar. Review of the medical record shows the resident was admitted to the hospital with a diagnosis of . . . and spent 6 days in the hospital. Review of the discharge records on . . . shows . . . was discontinued when the resident was discharged from the hospital. Review of the . . . Sugar Checks" for the month of . . . shows the resident's . . . sugars were abnormally high for several days when he was discharged. The first . . . sugar taken was	A 077			

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A 077	Continued From page 105 403 when the resident returned to the facility on _____ and was recorded at 7:00 - 9:00 p.m. The resident's _____ sugar was recorded as 467 on _____. His _____ sugar was recorded as 558 on _____. It was recorded as 542 on _____. There was no documentation the resident's medical doctor was notified of these critically abnormal _____ sugars until _____. A "Patient Service Update" sent by the Home Health Agency to the medical doctor on _____ reads, "Patient's _____ meds were discontinued by hospital _____ sugars are as follows: _____ 2/192/558, _____ Please advise." The nurse filling out the form writes an order of _____ 500 MG 1 pill by mouth twice daily. On the side of the paper the medical doctor writes, "?" Underneath the question mark he writes, "Already on _____ 850 mg 1 pill by mouth twice daily and Lantus." This note shows the medical doctor was not made aware the resident was sent to the Hospital on _____ and discharged on _____ without _____ medications until _____. Review of the medical record shows the resident was sent to the Hospital and evaluated on _____. The medical record shows he was seen for _____ and Chronic _____. There is no documentation the resident's family was made aware that he was sent to the Hospital. There was no documentation in the RCL and no incident report was completed. Review of the _____ "Sugar Checks" show on _____ Resident #8's _____ sugar was 508. The record shows the resident was hospitalized form _____ to _____. Review of an incident report dated _____ and timed 6:45 a.m. reads, "Checked resident _____ sugar and it was 508."	A 077			

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A 077	Continued From page 106 resident went to Peace River for Eval." The Incident report was signed by the supervising LPN. An interview was conducted with the Supervising LPN at 4:10 p.m. on _____. She was asked if the resident had any symptoms when he was sent out. She stated, "No." She was asked if the medical doctor was notified of the resident's _____ sugar? She stated, "No, we had no coverage so I sent him to the hospital so they could get his _____ sugar down." She was asked about the abnormally high _____ sugars on _____ and _____. She stated, "They were not reported to me." She was asked how often she looks at the resident's _____. She stated, "I never look at them. The doctor sees them when he comes." She was asked how often the medical doctor sees the resident? She stated, "About once a month." Review of the admission note from the hospital dated _____ reads, "Third hospital visit since _____ with issues related to his _____ sugar. The patient has had two admissions with low _____ sugars and _____ sugars in the 21 range, though he has been taken off scheduled _____ Apparently there was much _____ lying around at the facility and the patient had a series of this according to the personal who saw the situation. The patient's _____ sugar was over 500 unless he was sent to the Emergency _____ admission for uncontrolled _____. the patient is demented and has numerous other medical problems, but has not been safe to put on scheduled _____ because he becomes _____ on some. He has apparently been on sliding scale _____. Review of the Discharge Summary dated _____	A 077			

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A 077	Continued From page 107 reads, "Apparently, at the _____ unit I am told that there are a number of cupcakes available and the patient had several and was found with a _____ sugar of 500." Review of physician's orders dated _____ reads, _____ before meals breakfast, lunch, and dinner, at bedtime and 2:00 a.m. Restart Lantus _____ 6 units PM 25 units _____ AM." There was no physician's signature on the order. Review of the MOR shows the order was started on _____ Review of the _____ Sugar Checks for the month of _____ 2013 shows 2 AM _____ sugars were not done on _____ or _____. On _____ The resident's 2:00 a.m. _____ sugar was 38. No interventions were recorded for this critically low _____ sugar. At 6:30 on _____ Resident #8's _____ sugar was recorded as 40. Review of the MOR shows on _____ at 7:00 a.m., the resident was administered 25 units of Lantus _____. Review of RCL dated _____ reads, "(Resident #8's) _____ sugar was 40 when he came out ate breakfast 1 pancake cup of coffee cup of OJ. He had _____" A "Communication Form" dated _____ reads, "Fasting _____ Sugar was 44-at 10:30 AM 88. No 2 AM _____ sugar recorded times 2 days. Spoke with (LPN supervisor) about this matter." Review of RCL dated _____ reads, "Visiting Nurse saw (Resident #8) was wondering why nobody is checking 2 AM _____ sugar. His _____ sugar was 44 at 6:30 AM." Review of the _____ 2013 _____ Sugar Checks" show the only 2:00 a.m. _____ was obtained on _____. Even after LPN supervisor was made aware of the situation.	A 077			

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A 077	Continued From page 108 Review of the 1823 dated _____ shows the resident's _____ status to be "Alert and oriented x's 1 (to person,) _____ and forgetful." Under Nursing Treatments on the same form is documented, _____ Which would mean a nurse would be required to provide the services requested. An interview was conducted with the resident's medical doctor by phone at 3:00 p.m. on _____. When he was told the RAs were making decisions in the resident's _____ care management he stated, "I have standing orders for that." He was then told on _____ an _____ gave the resident _____ when he had sugar of 47 and by 11:00 a.m., the resident had a sugar of 20 and had to be hospitalized. The physician stated, "That's not good." He was unable to confirm when he was notified the resident had a low _____ sugar. He stated, "I'm not going to lie to you." He was asked if he knew the limitations of RAs? He stated he thought they were trained to take care of residents with dependence. He stated as far as he knew the previous LPN supervisor was administering _____ to the residents. An interview was conducted with the LPN supervisor on _____ 4:10 p.m.. She stated, "We don't take standing orders here." Resident #9 is a 90 _____ male who was admitted to the Facility on _____ has a history of Diabetes _____ Dementia. _____ of the residents form 1823, dated _____ the resident has poor eyesight. The resident receives Humalog _____ insulin, _____ units, every morning.	A 077			

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A 077	Continued From page 109 Review of Section 3 of the 1823 shows medications and _____ sugars are provided by Resident Patient Care Staff. Review of the MOR shows there are no high and low parameters ordered for this resident's _____ sugar. Review of an "Incident report" dated _____ and timed 12:30 PM reads, "Son has (Resident #9) at the dentist office. Brought back. Resident became unstable. Unable to walk, speak, or respond to verbal commands. Resident was checked out by nurse and Home Health nurse. 911 called. The _____ who filled out the form on _____ writes on the bottom of the form, "Came back same day with low sugar. Son is taking to MD." The form is signed and dated by the LPN supervisor on _____. There is no documentation as to why the resident had a low _____ sugar. There is no documentation the medical doctor was notified the resident was critically _____ enough to go to the hospital. Review of the _____ "Sugar Checks" shows on _____ the resident's fasting _____ sugar was 70. Review of the MOR on _____ shows the resident received 60 units of _____ N _____ at 7:00 a.m. There is no documentation the _____ ensured the resident ate something before the he was sent to the dentist office. On _____ the resident's fasting _____ sugar was 60. The MOR show the resident was given 60 units of _____ with no interventions. On _____ the residents fasting _____ sugar was documented as 49. He was given 60 units of _____ with no interventions. On _____ the resident's _____ sugar was documented as 54.	A 077			

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A 077	Continued From page 110 The resident was given 60 units of _____ with no interventions. On _____ the resident's _____ sugar was 55. The resident was given 60 units of _____ with no interventions. On _____ the resident's _____ sugar was 48. The resident was given 60 units of _____ with no intervention. In each of these instances the medication should have been held and the medical doctor notified before giving _____. Resident #7 is a _____ white female who was admitted to the facility on _____. She has a history of _____ Mellitus, and, _____ She receives _____ with sliding scale coverage. She needs her _____ sugars checked three times daily. Review of Section 3 of the 1823 dated _____ shows unlicensed staff are assisting the resident with medications and _____ sugar checks. An interview was conducted with Resident #7 at 2:05 p.m. on _____. She was asked how she gets her _____ sugar checked. She stated, "I go down to the nurses' station on the 1st floor and they take my _____ and check my sugar. They then dial in my _____ dosage and they give me a shot of _____ in my abdomen." She was asked if she was sure the staff injects her with her _____. She stated, "I can't do it myself. They do it for me." She did not know how much _____ she took every day. Resident #10 is a _____ white female who was admitted to the Facility _____. The resident has _____ and receives _____ N 26 units, in the AM and 20 units in the PM _____. She also receives _____ coverage for _____ sugars above 151. Review of section 3 of the 1823 dated _____ show	A 077			

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A 077	Continued From page 111 unlicensed staff are providing assistance with medications. An interview was conducted with Resident #10 at 1:20 p.m. on _____. The resident was asked how she receives her _____, she stated "They give me my shot into my _____ area every day." 2. In an interview _____ at 1:28 p.m. with Resident #7, she stated "I have one pill that helps me sleep, they put it in a separate cup and hand it to me. I put it in my pocket and take it to my _____. I put it on my table. I take it before I go to sleep." In an interview _____ at 5:19 p.m. with Resident #5 she stated, "They give me my sleeping pill in a medicine cup at 4:00 p.m. and I bring it to my _____. I put it on my clock, and I take it at 9:00 p.m." In an interview _____ at 10:00 a.m. with Resident Care Supervisor she stated, "I was not aware of this being done." 3. Interview _____ at 3:00 p.m. with Resident #1 who stated, "I leave my O2 concentrator on at all times because I can't see to turn it on and off, the aides help me with the O2 if I need help, I can't see the gauge to know what the dial is set for." (The aides also help me by putting water into my CPAP machine at night.) In an interview with Executive Administrator (ED) _____ at 11:52 a.m., he stated Resident #1 spoke to him yesterday afternoon and stated she did not need help with her _____. she stated she was _____ about surveyor questions. Surveyor asked if ED thought a resident who has limited	A 077			

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A 077	Continued From page 112 vision can regulate the _____ concentrator, he stated "She said she can." Interview with Resident Care Supervisor (RCS) at 12:05 p.m., who stated Resident #1 told her she can take care of her own _____ RCS Surveyor went to Resident #1's _____ use. Resident was out of building at lunch activity. Resident due back in building at 1:30 p.m. RCS stated she would get surveyor as soon as the resident returned to building so they could task her on her ability to manage her supplemental _____ Interview _____ at 12:14 p.m. with Staff C who stated, "I don't think she would be able to control her _____ concentrator." She stated, "I have never had to help her with it but the aides at night probably help her." "When she takes her pills she puts the pills on a paper towel and feels around for them and we need to be sure she takes them all because she can't see them." Interview _____ at 1:50 p.m. with Executive Director (ED) and Director of Patient Services (DPS), they stated they had brought a magnifying glass to the residents _____ tried to see if Resident #1 could control her O2 concentrator with an assistive device. They verified she was unable to see the ball on the gauge to regulate the liters of supplemental _____ she was receiving. The Administrator and RCD agreed Resident #1 needs assistance with her supplemental _____ and will put her on LNS services for assistance from a nurse with her _____ 4. Review of the incident reports and home health documentation shows staff were concerned for the resident's safety. The documentation on _____ shows staff going to	A 077			

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A 077	Continued From page 113 the police station. The documentation on shows staff is concerned the resident is on Highway 41. Highway 41 is an extremely busy highway. On the resident was transferred to a locked unit, but there is no documentation that family was advised or notified or that the resident's medical doctor had been informed. An interview was conducted with the Administrator on at 2:30 p.m. He stated there had been no adverse incidents filed for Resident #8 after any of his elopements. He stated he had not felt the resident had been injured or was in any danger. He stated the resident had slowly declined and had to be moved to the locked unit. The facility "Elopement and Elopement Drills Policy And Procedures" reads, "Upon finding the resident an assessment must be completed and determination made as to whether or not medical assistance is required." An interview was conducted with the Administrator on at 10:00 a.m. He was asked who would have been responsible for assessing a resident's injuries once he was found? He stated the acting Supervising LPN would be responsible. He was then asked where the LPN would document this assessment? He stated, "On the incident Report." Review of the two incident reports in the resident's medical record shows no documentation from the acting Supervising LPN. On it is documented the resident eloped twice and no incident report was completed. 5. A record review conducted on the resident record of Resident #1 revealed that	A 077			

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A 077	Continued From page 114 Section 3 on the AHCA form 1823 which lists services offered or arranged by the facility for the resident was signed by (Staff H), a Resident Assistant. The regulations require the signature of the administrator of his designee. In an interview with Executive Director . . . at 12:35 p.m., he stated, "My designee to sign the 1823's is the Resident Care Supervisor, it was Staff F prior to the current Resident Care Supervisor. He stated "I was not aware resident assistants were signing the 1823 form." The facility Administrator was not aware of the medical needs of the residents in the facility. He was not aware the . . . staff were managing resident care without the supervision of a nurse. Administrator was not supervising the staff to ensure that adequate, safe medical care was being provided to residents on . . . and . . . in his facility. The Administrator did not ensure a resident at risk for elopement was properly evaluated for elopement risk and not supervised to prevent elopement. He was also not aware resident assistant staff were signing documentation on the AHCA 1823 that specifically requires the signature of the administrator or designee. Class I	A 077			
A 080	58A-5.0191(1) FAC Training - Core & Competency Test Staff Training Requirements and Competency Test. (1) ASSISTED LIVING FACILITY CORE TRAINING REQUIREMENTS AND COMPETENCY TEST.	A 080			

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A 080	Continued From page 115 (a) The assisted living facility core training requirements established by the department pursuant to Section 429.52, F.S., shall consist of a minimum of 26 hours of training plus a competency test. (b) Administrators and managers must successfully complete the assisted living facility core training requirements within 3 months from the date of becoming a facility administrator or manager. Successful completion of the core training requirements includes passing the competency test. The minimum passing score for the competency test is 75%. Administrators who have attended core training prior to 1997, and managers who attended the core training program prior to 1998, shall not be required to take the competency test. Administrators licensed as nursing home administrators in accordance with Part II of Chapter 468, F.S., are exempt from this requirement. (c) Administrators and managers shall participate in 12 hours of continuing education in topics related to assisted living every 2 years as provided under Section 429.52, F.S. (d) A newly hired administrator or manager who has successfully completed the assisted living facility core training and continuing education requirements, shall not be required to retake the core training. An administrator or manager who has successfully completed the core training but has not maintained the continuing education requirements will be considered a new administrator or manager for the purposes of the core training requirements and must: 1. Retake the assisted living facility core training; and 2. Retake and pass the competency test. (e) The fees for the competency test shall not exceed \$200. The payment for the competency	A 080			

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A 080	Continued From page 116 test fee shall be remitted to the entity administering the test. A new fee is due each time the test is taken. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility Administrator failed to ensure he maintained the required continuing education requirements for his position as the facility administrator. The findings include: On . . . at approximately 10:00 a.m., staff record review revealed the facility Administrator had no documentation of any continuing education required for his position as facility Administrator. The Business Manager who assisted with the record review verified she could not find any documentation of continuing education in the administrator ' s staff record. Interview . . . at approximately 11:30 a.m. with the facility Administrator who stated "I was planning to take the classes online but have not done it yet." Class III	A 080			
A 093	58A-5.020(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The Tenth Edition Recommended Dietary Allowances established by the Food and Nutrition Board - National Research Council, adjusted for age, . . . and activity, shall be the nutritional standard used to evaluate meals. Therapeutic	A 093			

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A 093	Continued From page 117 diets shall meet these nutritional standards to the extent possible. A summary of the Tenth Edition Recommended Dietary Allowances, interpreted by a daily food guide, is available from the DOEA Assisted Living Program. (b) The recommended dietary allowances shall be met by offering a variety of foods adapted to the food habits, preferences and physical abilities of the residents and prepared by the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the recommended dietary allowances to be made available to each resident daily by the facility are as follows: 1. Protein: 6 ounces or 2 or more servings; 2. Vegetables: 3 5 servings; 3. Fruit: 2 4 or more servings; 4. Bread and starches: 6 11 or more servings; 5. Milk or milk equivalent: 2 servings; 6. Fats, oils, and sweets: use sparingly; and 7. Water. (c) All regular and therapeutic menus to be used by the facility shall be reviewed annually by a registered dietitian, licensed dietitian/nutritionist, or by a dietetic technician supervised by a registered dietitian or licensed dietitian/nutritionist, to ensure the meals are commensurate with the nutritional standards established in this rule. Portion sizes shall be indicated on the menus or on a separate sheet. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. This review shall be documented in the facility files and include the signature of the reviewer, registration or license number, and date reviewed. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the	A 093		

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A 093	Continued From page 118 preferences of the residents. (d) Menus to be served shall be dated and planned at least one week in advance for both regular and therapeutic diets. Residents shall be encouraged to participate in menu planning. Planned menus shall be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, shall be kept on file in the facility for 6 months. (e) Therapeutic diets shall be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items which enable residents to comply with the therapeutic diet shall be identified on the menus developed for use in the facility. 2. The facility shall document a resident's refusal to comply with a therapeutic diet and notification to the resident's health care provider of such refusal. If a resident refuses to follow a therapeutic diet after the benefits are explained, a signed statement from the resident or the resident's responsible party refusing the diet is acceptable documentation of a resident's preferences. In such instances daily documentation is not necessary. (f) For facilities serving three or more meals a day, no more than 14 hours shall elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals shall be evenly distributed throughout the day with not less than two hours nor more than six hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities,	A 093			

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A 093	Continued From page 119 snacks shall be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food shall be served attractively at safe and palatable temperatures. All residents shall be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, shall be on hand. (h) A 3-day supply of non perishable food, based on the number of weekly meals the facility has contracted with residents to serve, and shall be on hand at all times. The quantity shall be based on the resident census and not on licensed capacity. The supply shall consist of dry or canned foods that do not require refrigeration and shall be kept in sealed containers which are labeled and dated. The food shall be rotated in accordance with shelf life to ensure safety and palatability. Water sufficient for drinking and food preparation shall also be stored, or the facility shall have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on interview, observation and record review, the facility failed to ensure a sufficient amount of eating ware including plate covers and adaptive equipment as needed are available for all residents. The findings include: 1. Observation at 11:38 a.m., in kitchen,	A 093			

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A 093	Continued From page 120 Staff J observed washing plate covers in 3 compartment sink, sitting them in a drying rack for approximately 45 seconds, then shaking them dry in the air. He then brought the stacked plate covers, still wet, to the tray line to be reused. The tray line staff were drying the plate covers with a cloth towel (the same cloth towel was used to dry all plate covers) prior to putting them on the next resident's plate. This practice puts all residents eating in the main dining risk for due to the unsterile plate covers being put on resident's plates. Interview at 11:52 a.m., with kitchen manager, who stated he has 20 plate covers upstairs, (the food is plated and sent upstairs in a warmer for the 5th floor residents) and 15 covers for main dining He stated the 15 plate covers for the main dining washed and sanitized in the 3 compartment sink, dried and reused until all residents in the dining served. When asked if the dishwasher should be shaking the covers in the air to dry them he stated "No that is not the right way to do it, I will talk to him, he gets nervous." When asked why there were not enough plate covers for the number of residents being served he stated AHCA told him it was OK on the last Biennial survey. I informed him I was on the survey and he was told that he could use that method until he could get new plate covers delivered, or he came up with an alternative to using plate covers. He was also told the plate covers must air dry before being reused if that was his interim plan. He stated "It's hard to keep up the inventory of plate covers because they crack and break." Surveyor requested the inventory of plate covers and eating ware that he currently has in the	A 093			

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A 093	Continued From page 121 facility and the invoices for the plate covers the facility has ordered and received since the last AHCA Biennial survey. A copy of the current inventory of eating ware was given to surveyor, the list does not include the plate covers. Surveyor requested inventory of plate covers, however it was never brought to the surveyors. The facility did produce invoices documenting 12 plate covers were ordered on _____, delivered on _____ and 12 plate covers were ordered _____, delivered on _____. No other documentation of invoices was produced. The facility currently has 73 residents and approx. 35 plate covers per interview with kitchen manager _____ at 11:52 a.m. Documentation of China/Silverware inventory dated _____ revealed with a census of 73 residents and a capacity of 164 residents the facility had the following: China: 120 coffee cups, 71 saucers, 113 bread & butter dishes, 105 dinner plates, 24 bouillon cups, and 53 cereal bowls. Glassware available: 12 oz. goblets was 138 and 5oz juice glasses was 53. Flatware: 230 forks, 90 soup spoons, 140 teaspoons and 25 salad forks. The number of the following items was left blank on the inventory form: Salad dish, fruit dish, 14 ounce glass, 8 ounce glass, 7 ounce juice glass and knives. 2. Observation _____ during the lunch meal service revealed all of the residents in the 5th floor dining _____ being served their fluids in styrofoam cups. In an interview _____ at 12:42 p.m., with the kitchen manager he stated "They use styrofoam cups on the 5th floor because it is easier for the residents to use than the regular glasses, the residents were complaining the glasses were too	A 093			

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A 093	Continued From page 122 heavy." He was asked why the residents who are able to use regular coffee cups and glasses were not being served with regular cups and glasses, he stated, "I was not aware the staff were using the styrofoam cups for all the residents." When asked if adaptive cups were available for residents who can't grip the glasses or coffee cups he stated, "I don't know of any, I do know they have a supply of plastic cups in the 5th floor in the dining that can be used for residents who need a lighter cup." Observation at 1:10 p.m., of the 5th floor cupboard where the eating ware is stored revealed 8 plastic cups in the cupboard. The Resident Assistant (Staff E) in the 5th floor dining "We have used the styrofoam cups for all the residents on the 5th floor since I have been here." Staff E added, "The residents are not all going to be drinking at the same time." The census on the 5th floor unit with mostly residents is currently 17 residents. Staff E stated, "I do not agree the foam cups should be used for everyone." Class III	A 093			
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	A 165			

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A 165	Continued From page 123 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. 2. _____ or spinal damage; 3. Permanent 4. _____ or _____ 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.	A 165			

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A 165	Continued From page 124 (6) _____, 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. 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	A 165			

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A 165	Continued From page 125 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 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 file adverse incident reports for 2 (Residents #8 and #9) of 13 residents surveyed for hypoglycemic events and elopements. The findings include:	A 165	

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A 165	Continued From page 126 1. Resident #8 was admitted to the facility on _____ with a diagnosis of _____ and _____. The facility in which the resident resides has a Limited Nursing Services (LNS) license. Also, after reviewing the medical record, Resident #8 had Home Health Services ordered so that he received weekly assessments from a licensed nurse. Review of the RCL (Resident Condition Log) dated _____ shows, "(Resident #8) is a new resident...He is a _____. He gets his sugar taken 4 x's a day. He has to be reminded of his meals and meds." On _____ at 11:30 a.m., Staff B, a medication technician, was observed administering an _____ to Resident #8 in the 5th floor dining _____. She was observed to prepare the lancet in the pen for the resident. The resident then was observed to prick his finger with the lancet after being cued by Staff B. Staff B was then observed to pick up the glucometer and obtain the _____ sample from the resident's finger. The resident was observed to be clearly _____ and unable to understand the process of his _____. Staff B never told the resident his _____ result. In an interview with Staff B at 11:35 a.m., she confirmed she had performed the resident's _____. She confirmed the resident suffered from _____ and was not able to understand when or why he received _____. She was then asked how the resident receives _____ administration. She stated, "I turn the dial to 25 units each morning and Resident #8 injects the	A 165			

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A 165	Continued From page 127 dosage himself." She was asked if the resident would be able to tell her not to give the medication to him because his _____ sugar was to low? She stated, "I don't think any of residents on this floor know what they are taking." She was asked how would she know when his _____ sugar was to low and to hold his _____. She stated, We have parameters from the Licensed Practical Nurse Supervisor to notify her if his _____ sugar is less than 40 or greater than 400." She then showed the surveyor this had been written above the resident's daily _____ documentation. An interview was conducted with Resident #8 on _____ at 1:20 p.m. The resident was observed at the time of the interview to be _____ and oriented to self only. When asked if he received assistance with his medications at the facility he stated, "I don't know." He was then asked how he gets _____ every morning from the staff? He stated, I don't know. I don't take _____. He was asked if he gets his _____ sugar checked on a daily basis? He stated, No, they don't check my _____ sugar. I don't get _____. An interview was conducted with the supervising LPN on _____ at 3:40 p.m. She stated she had only been working at the facility since _____ of 2013. She was asked how Resident #8 receives _____ from the staff. She stated they bring it to him and he does everything for himself. She was then told Staff B stated she turn the dial of _____ pen to 25 for the resident each morning. The supervisor was also told Staff B was observed obtaining an _____ from the resident at 11:30 a.m. She seemed to be surprised and stated, "Staff have been told they can't administer _____." She was then asked about Resident #8's _____. She confirmed the resident was _____ and unable to make judgments	A 165			

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A 165	Continued From page 128 regarding his _____ care. She was then asked how medical technicians with 4 hours of training would be able to make decisions in the resident's care that would be critical enough to cause _____ She stated, "I see what you're saying." Review of Resident #8's RCL dated _____ shows, "(Resident #8) was sent out. _____ sugar was very low 20. Was found slumped over in chair drooling and unable to drink." Review of the recorded _____ on _____ shows the resident's _____ sugar at 6:30 a.m. was 47. There is no documentation any interventions were performed for this critically low _____ sugar in the RCL. Review of the Medication Observation Review (MOR) shows the resident received 30 units of _____ at 7:00 a.m. on _____ An incident report dated _____ and timed 10:45 a.m. shows, "While calling floors for lunch Resident #8 was found sweating and drooling, _____ sugar was 20. Not responding. Attempted to give orange juice couldn't get him to swallow. Called 911." On the same form, under the heading "Facility comments (recommendations and/or steps to avoid reoccurrence of incident)" a Resident Assistant _____ documented, "Returned next day. Sugars are being monitored and recorded. Resident being checked several times a day." She signed and dated her note on _____. The LPN Supervisor signed and dated the form with no documentation from a licensed staff member. There was no documentation the resident's medical doctor was informed the resident was given _____ with a _____ sugar of 47. There was	A 165			

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A 165	Continued From page 129 no documentation the resident's medical doctor or the resident's family was informed the resident was hospitalized with When the resident returned from the hospital on the medical doctor ordered, "Change AM to 24 units. AC (before meals) and HS (hour of sleep) with high dosage coverage." Review of the medication list on the 1823 dated shows, "Hold if sugar is less than 120." Review of Resident #8's MOR shows unlicensed staff continued to document administration after There was no documentation the hospital physician was notified to clarify his order of "High dose coverage." The medical record shows no coverage (sliding scale) initiated for this resident after the order. There is no documentation of contacting the medical doctor until Review of the physician's orders shows a change in coverage on The order reads, "Lantus 15 units every PM." Review of the "Sugar Checks" record dated shows the resident's sugar was 106. Review of the MOR The was changed from 24 units in the AM to 20 units in the AM on Review of the physician's orders show no recorded order to change the dosage for The resident was given 20 units of at 7:00 a.m. on The MOR clearly reads, "Hold if sugar below 120, start Review of	A 165			

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A 165	Continued From page 130 the physician's orders shows no change in the parameters for holding the Review of the Communication form dated _____ shows a home health Registered Nurse (RN) had evaluated the resident on _____ and noted his _____ sugar was 106. There is no documentation there was any concern from the home health nurse the resident had been given _____ which should have been held according to the medical doctor's order. The RN notes, _____ has episodes of _____ Fasting _____ Sugar was 106 today. Instructed Patient on _____ regime." Review of the _____ "Sugar Checks" Record shows on _____ at 10:30 a.m., the resident's _____ sugar was 55. There was no documentation in the RCL any interventions were performed for the resident's low _____ sugar. Review of the same record shows on _____ at 3:30 p.m. no _____ was performed as ordered. Review of the RCL dated _____ and timed, "3-11:30 PM" shows, "Went up to check on (Resident #8) around 6:00 p.m. He was lying in bed shaking uncontrollably and making no sense verbally. Stated he _____ and had a laceration on his left arm. We called 911. He went to Peace River. Family was called." The note is not signed. Review of the "Incident Report" dated _____ and timed at 6:00 p.m., shows, "Resident #8 found lying in the bed shaking uncontrollably and not making much sense when he spoke. He also had a laceration on his left arm." Review of the report shows the _____ who completed the incident report was the same _____ who wrote the RCL note on _____	A 165			

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A 165	Continued From page 131 At the bottom of the incident report an unlicensed staff member documents, "Resident is still in the hospital. Will follow up with Infinity Home Health Care upon return." She dates her note . . . The acting LPN supervisor signs the incident report and dates it on . . . Review of the hospital record written by the hospital physician and dated . . . reads, "I talked to the nursing staff and they told that they were given the history that he was walking at the ALF and he . . . down and probably became . . . and when . . . was called and he was found to be . . . There was no documentation the medical doctor was notified the resident was given . . . even though it was supposed to held. There is no documentation the medical doctor was notified an . . . had not been done at 3:30 p.m. as ordered. There was no documentation the family was notified the resident was sent to the hospital for . . . There was no investigation on the incident report. There were no recommendations from a licensed staff member to avoid a recurrence of the incident. The resident returned to the facility from the hospital on . . . Review of the Form 1823 dated . . . shows under . . . behavioral status: . . . Under Nursing Treatments the form reads, "Infinity Home Health." Review of the MOR showed unlicensed staff continued to administer . . . after . . . Review of the RCL dated . . . and timed "6:30-3" shows, "(Resident #8's) sugar has been	A 165			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911942	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
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A 165	Continued From page 132 low even though he has eaten his meals." Another note dated _____ and, written after _____ and, timed 7:30 a.m., reads, "(Resident #8) _____ Sugar 32 when I checked it. gave him orange juice. He did not want to drink it asked _____ to call 911. EMT's came they gave him sugar _____ they checked his sugar it was 24. After the hivey _____ it was 168. They left. (Resident #8) was eating banana he had orange juice and peanut butter and jelly." The note is not signed by the _____ completing the note. The note is initiated by the acting LPN supervisor. Review of the _____ Sugar check record shows the resident had his _____ sugar checked twice by the RA at 6:30 a.m. Review of the MOR shows _____ sugars were being checked before and after meals. Review of the physician's orders show no order to take _____ before and after meals. The _____ at this time remained AC (before meals) and HS (hour of sleep), hold _____ for _____ sugar less than 120." Review of the MOR shows the resident received _____ at 7:00 a.m. This would be 30 minutes before the resident was found with a low _____ sugar. There is no way to tell from the documentation if the higher _____ sugars recorded at 6:30 a.m. were before or after the resident had received _____ glycogen. Review of the medical record shows no incident report was completed on _____. There was no documentation the medical doctor was notified the resident's _____ sugar was 32 and _____ had to administer glycogen _____ to save the resident's life. There was no documentation the resident's family member was notified of this critical issue. Review of the physician's orders show the resident was not seen by a medical doctor until _____	A 165			

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A 165	Continued From page 133 The "Medical Appointment Information" note shows the medical doctor discontinues the and orders Lantus 20 units twice a day. There was no clarification from a nurse noted as to holding the for a sugar of 120. There was no change noted to the The order remains AC (before meals) and HS (hour of sleep). Review of the record shows 's checking the resident's sugar 5 and 6 times daily without an order from the medical doctor. Review of the RCL timed "6:30 to 3" and dated shows, ... found (Resident #8) slumped over in his chair and not responsive. 911 was called and they took his sugar which was 12. They proceeded to give him a shot which brought his sugar up to 167. didn't feel it was necessary to take him to the hospital. RAs tried to give him his lunch and drinks to keep his sugar up. RAs continue to check on him throughout the day. also spoke to (resident's wife) to let her know what was happening. Incident report filled out. (Resident #8) did eat a bowl of ice cream, cranberry juice and half his lunch meal." Review of "Sugar Checks" form shows on the resident's sugar was taken twice at 6:30 a.m. His sugar is recorded as There was no documentation any intervention was done by any staff member to prevent critically low Review of the MOR shows Resident #8 received 20 units of Lantus at 7:00 a.m., even though his sugar was abnormally low. An "Incident Report" dated and timed 11:25 a.m. reads, "Resident was unable to	A 165			

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A 165	Continued From page 134 respond. went to resident's I found resident slumped over in chair and unable to respond. 911 was called and they came. Took his sugar which was 12. They proceeded to give him a shot and brought his sugar up to 162. felt it was not necessary to take him to the hospital. 's gave resident a lunch tray and made sure he was doing fine." On the bottom of the form another documents, "Resident good after received shot. keep eye on sugars and report to his home health and Dr. office." The note was dated The incident was signed by the Supervising LPN on There was no documentation the resident's medical doctor was notified the day the incident occurred. There was no documentation the medical doctor or the family were told the resident was given by a when the resident had an abnormally low sugar. There was no investigation noted on the incident report as to why the resident had a sugar of 12. There were no recommendations from licensed staff to prevent the same issue from occurring again. A "Patient Service Update" sent to the physician from the Home Health Nurse and dated reads, "Patient saw Veterans Administration (VA) MD last week. The following changes were made: Discontinued Prandin and flex pen. Lantus was changed from 15 units at night to Lantus 20 units 2 times daily.... Patient had episode of this weekend. reported sugar of 12. Today's fasting sugar was 54. Attached is the glucose log. Please advise." The physician responds, "Give Lantus in AM same dose continue to monitor." The order from the doctor was not clear as to how he wants the given. In looking at the order it appears he wants the resident to just have AM Lantus at the same	A 165			

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A 165	Continued From page 135 dosage the VA had ordered. The order was not acceptable and should have been clarified by a nurse. Review of the MOR on _____ shows no change in the order for Lantus noted. An "Incident Report" timed 7:30 a.m. and dated _____ reads, "Resident did not come down went to check on him. Wasn't acting right. Checked his _____ sugar it was 32. 911 called for resident. He was unable to drink orange juice. _____ came gave him _____ sugar. Then it was 160 and _____ left. On the bottom of the incident report another writes, "EMT gave _____ sugar to resident and got sugars up. Resident didn't go to the hospital. Resident was able to go to dining _____ eat lunch and dinner and did well rest of the day. Home Health was notified. The note is dated _____ The form is signed by the supervising LPN on _____ There was no investigation on the incident report as to why the resident was found to have a _____ sugar of 32. There was no documentation the resident's doctor was notified the resident had _____ There were no recommendations listed on the incident report to prevent further incidents to occur. Review of the Home Health Communication form dated _____ reads, _____ sugars are still very unstable. Extremely important that staff makes sure he eats all his meals and has a snack at night before bed. (Unknown) aware of _____ sugars and is monitoring closely." The note is signed by an RN. There was no documentation in the resident's record the facility staff ever followed the advice of the licensed home health nurse to monitor the residents food intake. Review of the _____ Sugar Check dated _____	A 165			

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A 165	Continued From page 136 shows at 6:30 a.m., the documented three separate _____ sugars taken. There was no time noted as to when the _____ sugars were taken. The _____ sugars recorded are _____ Review of the MOR shows the resident received 20 units of Lantus _____ at 7:00 a.m. There was no documentation as to if the resident received _____ before he was found with a _____ sugar of 32. No investigation is documented by the Facility or the Home Health Nurse. F. Review of the RCL dated _____ and timed "6-3" reads, "(Resident #8) didn't wake for breakfast but did take his meds. (Resident #8) sent to hospital low _____ sugar." An "Incident Report" dated _____ with a time of 11:00 a.m. reads, "Resident found on the floor Rq (unknown) side of bed. Resident took _____ sugar was very low. Resident unable to move at the time." The LPN supervisor documents on the same date, "Resident Sent 911 to be evaluated." There was no documentation the resident's medical doctor was notified at the time the resident was transported to the hospital. The form clearly reads, "Describe Exactly what happened; Why; What causes were." There was no investigation noted on the incident report as to why the resident was having a low _____ sugar. Review of the resident's _____ Sugar Checks on _____ show at 10:30 a.m., the resident had a _____ sugar of 31. There were no documented interventions noted for this critically low _____ sugar. Review of the medical record shows the resident was admitted to the hospital with a diagnosis of _____ and spent 6 days in the hospital. Review of the "Blood _____ Checks" show on	A 165		

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A 165	Continued From page 137 Resident #8's sugar was 508. The record shows the resident was hospitalized form to Review of an incident report dated and timed 6:45 a.m. reads, "Checked resident sugar and it was 508. resident went to Peace River for Eval." The Incident report was signed by the supervising LPN. An interview was conducted with the Supervising LPN at 4:10 p.m. on She was asked if the resident had any symptoms when he was sent out. She stated, "No." She was asked if the medical doctor was notified of the resident's sugar? She stated, "No, we had no coverage so I sent him to the hospital so they could get his sugar down." She was asked about the abnormally high sugars on and She stated, "they were not reported to me." She was asked how often she looks at the resident's She stated, "I never look at them. The doctor sees them when he comes." She was asked how often the medical doctor sees the resident? She stated, "About once a month." Review of the admission note from the hospital dated reads, "Third hospital visit since with issues related to his sugar. The patient has had two admissions with low sugars and sugars in the 21 range, though he has been taken off scheduled Apparently there was much lying around at the facility and the patient had a series of this according to the personal who saw the situation. The patient's sugar was over 500 unless he was sent to the Emergency admission for uncontrolled The patient is demented and has numerous other medical problems, but has not been safe to put on	A 165			

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A 165	Continued From page 138 scheduled because he becomes on some. He has apparently been on sliding scale Review of the Discharge Summary written by the hospital physician and dated reads, "Apparently, at the unit I am told that there are a number of cupcakes available and the patient had several and was found with a sugar of 500." 2. Review of the Resident Condition Log (RCL) dated reads, "(Resident #8) was missing. They found him over Winn-Dixie. Keep eye on him often." Review of "Incident Report" dated and timed 11:00 a.m. reads, "(Resident #8) was missing at lunch time. We looked everywhere couldn't find him. We did" He wasn't here. (Two Staff) went to Winn Dixie they came back without him. Then we checked everywhere again. No (Resident #8). (Two Staff) went back to Winn Dixie again. They went to the police station. They saw him sitting. Stated he couldn't find his way back to Royal Palm." The bottom of the incident report reads, "Facility comments /Recommendations and /or Steps to avoid reoccurrence of incident." Under this heading a Resident Assistant writes, "Resident was found and all parties were notified." The Supervising LPN signs the report on with no further documentation. There was no documented plan for staff to be aware the resident could elope. There was no documentation the Facility did anything to prevent the resident from eloping again.	A 165			

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A 165	Continued From page 139 Review of the RCL dated reads, "(Resident #8) left the building to walk to the bank. One of our employees found him walking and brought him back to Royal Palm. His sugar was taken, it was 35.'s gave him something to eat and drink. (Resident #8) felt fine. Retook his sugar again. Family was called and an incident report was filled out." Review of "Incident Report" dated and timed 2:19 p.m. reads, "I received a call from our housekeeper. She said she saw (Resident #8) on US 41 in Charlotte Harbor by Publix. She was trying to stop him and bring him home. Called (Staff) our driver and asked him to go help with (Resident #8). Also called and reported the incident to (Supervising LPN). (Staff) was able to get him in the car and bring him home. We tested his sugar which was 31 and we gave him food and drinks." The bottom of the incident report reads, "Facility comments/Recommendations and /or Steps to avoid reoccurrence of incident." Under this heading a writes, "All parties notified. Resident's sugar was taken care of when he came back." The Supervising LPN signs the form on without documenting anything. There was no documentation of a plan for staff to identify Resident #8 as an elopement risk. There was no documented plan to prevent Resident #8 from eloping again. A "Communication Form" written by a Home Health RN and dated reads, "..... seen by psych nurse. Remains and disoriented. Does not remember walking down 41 to Publix last week....Unable to make commitment to not leave the building. MSW (Master in Social work) ordered to assist wife in more secure placement.	A 165			

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A 165	Continued From page 140 Will meet with wife soon." A "Communication Form" written by the same RN and dated _____ reads, "Patient seen by psych nurse. Remains disoriented and _____ Spoke with wife and advised that Facility would like him to be placed in a locked facility. Advised that MSW will consult with her." A "Communication Form" written by the same RN and dated _____ reads, "Patient was seen by psych nurse. Patient remains demented Patient does not remember being at the Publix near the bridge. Says he likes to go to the bridge and watch the boats and fisherman. Repeated to him over and over again that he must not ever walk away from the building. Patient agreed not to walk away from Royal Palm. Needs to be constantly reminded and monitored for his presence in the building." There was no documentation in the medical record there was any plan initiated to constantly monitor the resident by the facility staff. A "Communication form" dated _____ reads, "Patient walked to the VFW 2 times today. He is alert but has memory issues and _____ with need to stay on premises." A note in the RCL dated _____ reads (Resident #8) moved to Patient Care Unit (PCU) today." The PCU is located on the 5th floor and is considered a locked unit. Another note in the RCL on _____ reads, "Made his way downstairs, (Staff) brought him back up." No incident report was filled out on _____ No investigation was documented to determine how the resident left the secured unit. No plan to prevent further elopement was documented. An interview was conducted with the	A 165			

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A 165	Continued From page 141 Administrator on _____ at 2:30 p.m. He stated there had been no adverse incidents filed for Resident #8 after any of his elopements. He stated he had not felt the resident had been injured or was in any danger. He stated the resident had slowly declined and had to be moved to the locked unit. Review of the incident reports and home health documentation shows staff were concerned for the resident's safety. The documentation on _____ shows staff going to the police station. The documentation on _____ shows staff is concerned the resident is on Highway 41. Highway 41 is an extremely busy highway. On _____ the resident was transferred to a locked unit, but there is no documentation that family was advised or notified or that the resident's medical doctor had been informed. The facility "Elopement and Elopement Drills Policy And Procedures" reads, "Upon finding the resident an assessment must be completed and determination made as to whether or not medical assistance is required." An interview was conducted with the Administrator on _____ at 10:00 a.m. He was asked who would have been responsible for assessing a resident's injuries once he was found? He stated the acting Supervising LPN would be responsible. He was then asked where the LPN would document this assessment? He stated, "On the incident Report." Review of the two incident reports in the resident's medical record shows no documentation from the acting Supervising LPN. On _____ it was documented the resident eloped twice and no incident report was completed.	A 165			

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A 165	Continued From page 142 Further review of the "Elopement Policies and Procedures" show no policies regarding: 1. An immediate coordinated staff search of the facility and premises; 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities; 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and 4. The continued care of all residents within the facility in the event of an elopement. An interview was conducted with the Administrator on _____ at 10:30 a.m. He was asked how he would determine residents at risk for elopement? He stated he would do so verbally with staff. He stated there are no written lists to keep track of residents at risk. He stated the only resident in the building at risk would be Resident #8. No assessment tools were observed. An interview was conducted with the LPN Supervisor at 10:40 a.m. on _____. She was asked who was at risk for elopement. She first stated there were no resident's at risk. She then stated Resident #8 is in a locked unit. She was asked if staff should be aware he had a history of elopement? She then stated Resident #8 was at risk. She confirmed there are 17 other residents in the secured unit. In an interview with Staff D, _____, at 10:45 a.m. on _____, she was asked if any residents were at risk for elopement. She stated, "Everybody in the building is ok right now. No one is at risk."	A 165		

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A 165	Continued From page 143 An interview was conducted with Staff B, at 10:50 a.m. on . She was asked if any residents were at risk for elopement? She stated, "What is Elopement?" After explaining what elopement was to the staff she stated, "Besides Resident #8 I don't think any of them would do it." She then stated the supervisors had never discussed who in the building was at risk for elopement since she had started working in the facility about 3 months ago. 3. Resident #9 is a white male who was admitted to the Facility on . He has a history of . and Review of the residents form 1823, dated shows the resident has poor eyesight. The resident receives N 60 units, every morning. Review of the MOR show unlicensed staff providing care for the resident. The MOR shows there are no high and low parameters ordered for this resident's sugar. Review of an "Incident report" dated . timed 12:30 p.m. reads, "Son has (Resident #9) at the dentist office. Brought back. Resident became unstable. Unable to walk, speak, or respond to verbal commands. Resident was checked out by nurse and Home Health nurse. 911 called." On the bottom of the form which had a heading of "(Recommendations and/or steps to avoid reoccurrence of incident)", the RA "Came back same day with low sugar. Son is taking to MD." The form was signed and dated by the LPN supervisor on . was no documentation as to why the resident had a low blood . There was no documentation the medical doctor was notified the resident was	A 165			

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NAME OF PROVIDER OR SUPPLIER ROYAL PALM RET CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 AARON STREET PORT CHARLOTTE, FL 33952		
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A 165	Continued From page 144 critically enough to go to the hospital. Review of the "Sugar Checks" shows on the resident's fasting sugar was 70. Review of the MOR on shows the resident received 60 units of N at 7:00 a.m. There was no documentation the ensured the resident ate something before the he was sent to the dentist office. On the resident's fasting sugar was 60. The MOR show the resident was given 60 units of with no interventions. On the residents fasting sugar was documented as 49. He was given 60 units of with no interventions. On the resident's sugar was documented as 54. The resident was given 60 units of with no interventions. On the resident's sugar was 55. The resident was given 60 units of with no interventions. On the resident's sugar was 48. The resident was given 60 units of with no intervention. In each of these instances the medication should have been held and the medical doctor notified before giving Class III	A 165			
AN277	58A-5.031(2) FAC LNS - Resident Care Standards (2) RESIDENT CARE STANDARDS. (a) A resident receiving limited nursing services in a facility holding only a standard and limited nursing license must meet the admission and continued residency criteria specified in Rule 58A-5.0181, F.A.C. (b) In accordance with Rule 58A-5.019, F.A.C.,	AN277			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911942	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER ROYAL PALM RET CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 AARON STREET PORT CHARLOTTE, FL 33952		
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AN277	Continued From page 145 the facility must employ sufficient and qualified staff to meet the needs of residents requiring limited nursing services based on the number of such residents and the type of nursing service to be provided. (c) Limited nursing services may only be provided as authorized by a health care provider's order, a copy of which shall be maintained in the resident's file. (d) Facilities licensed to provide limited nursing services must employ or contract with a nurse(s) who shall be available to provide such services as needed by residents. The facility shall maintain documentation of the qualifications of nurses providing limited nursing services in the facility's personnel files. (e) The facility must ensure that nursing services are conducted and supervised in accordance with Chapter 464, F.S., and the prevailing standard of practice in the nursing community. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to assess the need for Limited Nursing Services (LNS) for 1 (Resident #1) of 8 residents receiving Supplemental The findings include: On at 10:00 a.m., the Resident Care Supervisor told this surveyor there were 3 residents on supplemental. The residents identified were Resident #3, #5 and #11. Upon observation during the initial tour it was revealed: Resident #3 has not been using supplemental	AN277			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911942	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED: _____
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AN277	Continued From page 146 ... since her last hospitalization per resident interview ... Resident #11 has supplemental tanks in the ... she states during interview she has not used ... since she was admitted. Resident #5 states in interview ... at 5:19 p.m., that she uses ... at night, she was able to demonstrate that she was independent with her supplemental ... administration stating I have been using this for years. During the initial tour and dining observation additional residents were identified who were using supplemental ... including Resident #7 and Resident #1. In an interview with Resident Care Supervisor ... at 3:00 p.m., she stated she did not have a list of residents on supplemental Surveyor requested a current list of residents receiving supplemental ... In an interview with Resident #5 at 5:19 p.m. she stated, "They finally put a sign on my door today letting people know I am on ... I was worried about possible smokers." On ... at 9:00 a.m., the complete list of residents receiving supplemental ... was received from the Resident Care Supervisor. It included 8 residents. Residents #1, #5, #7, #11, #12, #13, #14 and #15. Not all of the residents on the list are receiving supplemental ... All residents who were receiving supplemental ... were able to demonstrate the ability to manage their supplemental ... use except Resident #1.	AN277			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911942	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER ROYAL PALM RET CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 AARON STREET PORT CHARLOTTE, FL 33952		
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AN277	Continued From page 147 In an interview at 3:00 p.m., Resident #1 stated, "I have an O2 concentrator and portable tanks, now I just have to use it at night, its ordered to be at 2 liter, I would have to ask the nurse to help me if I have a problem, I can't put the water in the CPAP machine, I need help, the night aide comes to my put water in my CPAP machine. One large and 6 small tanks crated in closet. I don't need those tanks and I don't want to pay for them. I leave my O2 concentrator on at all times because I can't see to turn it on and off, the aides help me with the O2 if I need help, I can't see the gauge to know what the dial is set for." In an interview with Executive Administrator at 11:52 a.m., he stated Resident #1 spoke to him yesterday afternoon and stated she did not need help with her she stated she was about the surveyor questions. Surveyor asked if ED thought a resident who has limited vision can regulate the concentrator, he stated "She said she can." During an interview on at 12:05 p.m., the Resident Care Supervisor (RCS), stated that Resident #1 told her she can take care of her own Surveyor went to Resident #'s RCS to task resident on use. Resident was out of building at lunch activity. Resident due back in building at 1:30 p.m. RCS stated she will let surveyor know when resident returns to facility. The plan was RCS and surveyor will task resident on O2 use when she returns to building. During an interview on at 12:14 p.m., Staff C stated, "I don't think she would be able to control her concentrator." She stated, "I have never had to help her with it but the aides at night probably help her. When she takes her pills	AN277			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911942	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED: _____
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AN277	Continued From page 148 she puts the pills on a paper towel and feels around for them and we need to be sure she takes them all because she can't see them." During an interview on _____ at 1:50 p.m., the Executive Director (ED) and Resident Care Supervisor, at the elevator, stated they had just brought a magnifying glass to the resident's _____ tried to see if Resident #1 could control her O2 concentrator with an assistive device. They verified she was unable to see the ball on the gauge to regulate the liters of supplemental _____ she was receiving. The Administrator and Resident Care Supervisor agreed Resident #1 needs assistance with her supplemental _____ and will put her on LNS services for assistance from a nurse with her _____ Class III	AN277			



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Royal Palm Ret Center
2500 Aaron Street
Port Charlotte, FL 33952

Dear Administrator:

This letter reports the findings of a Biennial and Limited Nursing Service (LNS) 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) A 008 Admissions – Health Assessment. Class .

Your Assisted Living Facility failed to ensure the Administrator or his designee are signing Section 3 of the 1823 Health Assessment Form.

2) A 025 Resident Care – Supervision. Class I

Your Assisted Living Facility failed to provide adequate nursing supervision in providing care for 4 dependent residents by monitoring as ordered by the medical doctor, holding medications as ordered by the medical doctor, notifying the medical doctor of critically low and high sugars, and failing to monitor food intake after administering This resulted in 1 resident being hospitalized on 5 separate occasions for hyper- and and having emergency medical technicians

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



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2295 Victoria Avenue, ...
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administer _____ glycogen to save his life on 3 separate occasions, having 1 resident being hospitalized for _____ and the immediate potential injury for 4 residents.

3) A 030 Resident Rights. Class I

Your Assisted Living Facility denied 4 _____ residents reviewed of their right to appropriate health care by allowing unlicensed staff to administer _____ for these 4 residents resulting in the hospitalization of 2 residents and the immediate potential injury for 4 residents.

4) A 032 Resident Care – Elopement Standards. Class III

Your Assisted Living Facility failed to identify and assess 1 resident as an elopement risk. The facility failed to develop adequate policies and procedures to identify staff responsibilities and specific duties when a resident elopes resulting in 1 resident eloping from the facility 4 times and the potential for further resident elopements.

5) A 052 Medication – Assistance with self-administration. Class III

Your Assisted Living Facility failed to read medication labels in the presence of 3 residents while assisting the residents in self-administration of medication.

6) A 053 Medication Administration. Class I

Your Assisted Living Facility allowed unlicensed staff to administer _____ to 4 _____ residents resulting in the hospitalization of 2 residents for _____ and _____ and the immediate potential danger for 4 residents related to _____ and _____ with a potential for kidney failure, _____ and _____.

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

Your Assisted Living Facility stored expired medication past 30 days and also stored discarded medication greater than 45 days.

8) A 057 Medication – Over the Counter (otc) Products. Class III

Your Assisted Living Facility failed to label over the counter medications with residents' names and store the OTCs in several areas of the facility.

9) A 077 Staffing Standards – Administrators. Class I

Your Assisted Living Facility Administrator failed to ensure adequate supervision of all staff and provision of safe, adequate care to all residents living in the facility.

10) A 080 Training – CORE and Competency Test. Class III

Your Facility Administrator failed to ensure he maintained the required continuing education requirements



for his position as the facility administrator.

11) A 093 Food Service – Dietary Standards. Class III

Your Assisted Living Facility failed to ensure a sufficient amount of eating ware including plate covers and adaptive equipment as needed are available for all residents.

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

Your Assisted Living Facility failed to file adverse incident reports for 2 residents surveyed for hypoglycemic events and elopements.

13) N 277 LNS – Resident Care Standards. Class III

Your Assisted Living Facility failed to assess the need for Limited Nursing Services (LNS) for 1 resident receiving Supplemental

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. This consultant pharmacist must not be the pharmacist currently employed by your facility.

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 ensure the availability of a nurse to administer medications whenever required to the residents indicated in citation A 053 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 oversight by a person who is currently eligible to be an Assisted Living Facility Administrator until the current Administrator completes this requirement.



Nothing in this DPOC limits the Agencies authority and responsibility to impose administrative sanctions as provided by law.

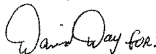
Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit.

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

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

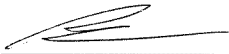
Thank you for the assistance provided to the surveyors. Should you have any questions please call this office at (239) 335-1315.

Sincerely,



Harold D. Williams
Field Office Manager

Enclosures

Accepted by: 

Printed Name: MARK ACKERMAN Title: EXECUTIVE DIRECTOR

Date: 6/19/13

