STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965330	07/18/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Arcadia Oaks Assisted Living	1013 East Gibson Street Arcadia, FL 34266	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)

St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= G
St - A - 0057 - 58a-5.0185(8) Fac - Medication - Over The Counter (otc) Products S-S= D
St - A - 0082 - 58a-5.0191(3) Fac - Training - S-S= D
St - A - 0084 - 58a-5.0191(5) Fac - Training - Assis Self-Admin Meds & Med Mgmt S-S= D
St - A - 0086 - 58a-5.0191(9) Fac - Training - Adrd S-S= D
St - A - 0090 - 58a-5.0191(11) Fac - Training - S-S= D
St - A - 0091 - 58a-5.0191(12) Fac - Training - Documentation & Monitoring S-S= B
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= G
St - A - 0161 - 58a-5.024(2) Fac - Records - Staff S-S= D
St - A - Z815 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses S-S= C

These are the results of the Biennial survey conducted on at Arcadia Oaks an Assisted Living Facility (ALF).

The following is a description of non-compliance:

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observation, interview and record review, the facility failed to provide supervision and assistance to prevent an unplanned weight loss for 1 (Resident #22) of 3 residents sampled for weight loss.

The findings include:

1. An observation of Resident #22 during the noon meal in the main dining l the resident sitting at a table with 3 male residents. Resident #22 was complaining that she did not like the meal being served. Resident #12 asked Resident #22 if she was going to eat her meal, if not, he would eat it. Resident #22 gave her meal to Resident #12. No staff intervened or asked her if she wanted a substitute meal.
After 25 minutes the surveyor approached Staff D and relayed the information that Resident #22 did not like the meal and had given her food to Resident #12. Staff D stated, "Yes she doesn't like the food here. She gives it to him all the time." After surveyor intervention, Resident #22 then received a ham and cheese sandwich on wheat bread. Resident #22 ate half of her sandwich and gave the other half to Resident #12. She then left the dining

During an interview with Resident #22 on at approximately 2:00p.m., Resident #22 stated that she just doesn't like the food at the facility.

2. A review of Resident #22's medical record revealed no documentation the physician was notified of the weight loss and no efforts made to identify the food preferences of the resident. Resident #22 was admitted to the facility on with diagnoses including , , , , and .
Resident #22's initial weight on was 145 pounds. Resident #22's weight on was 140 pounds. This was a 5 pound weight loss from initial weight. Resident #22's weight on was 136 pounds. A review of Resident #22's weights between and revealed a 9 pound weight loss.

3. An interview with Staff A on at approx. 2:05p.m., revealed Staff A was aware the resident did not like the food and was giving it to Resident #12. She stated attempts were made to move the resident to another table, but she refused. Staff A agreed she did not notify the physician of Resident #22's weight loss and has not

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tried other approaches to ensure the resident did not have an unplanned weight loss.

Class II

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation, record review and interview, the facility failed to ensure each residents right to a safe environment free of hazards; failed to obtain a written order from the Physician, for 2 (Residents #3 and #5) residents observed with half side rails; and failed to maintain good control practices during dining and with residents on isolation precautions.

The findings include:

1. On at approximately 10:00 a.m., the water temperature in the women's on the 100 hallway was tested at 136 degrees. A test of the men's on the 100 hallway was 136 degrees. The water temperatures were checked in the resident closest to the hot water source on the 100 wing, and other random resident

Resident #1, 2's water temperature was 132 degrees from the
Resident #2, 8's water temperature was 132 degrees from the
Resident #12, 6's water temperature was 132 degrees from the
Resident's #14 and #15 in 2's water temperature was 132 degrees from the
Resident #29, 2's water temperature was 124 degrees from the
Resident #30, 1's water temperature was 137 degrees from the
All residents in the affected have some level of with a potential for injury.

A call was made to the Florida Department of Health on at 3:30 p.m., relating to high water temps and the surveyor spoke with Environmental Spec III (ESIII).

The ESIII came to the facility on at 8:30 a.m. A retest of the water on the 100 wing revealed the water temperature in the men and women's be 140 degrees. A retest of the water temp in resident 1's, was 140 degrees. 8's was 133 degrees; resident , the from the water heater, was 124 degrees.

A Contractor from the facilities plumbing company arrived at the facility approx. 10:00 a.m., on tested the water and agreed the water temp was above regulatory standards. He stated, "At these temperatures it would only take seconds for someone to be scalded badly. This is why showers have closure valves in case someone , but the sink and kitchens) don't have them."

A check of the water heater revealed a defective part for circulating the water needed to be replaced and would have to be shipped over night to arrive on . The plumbing contractor would return on and replace the part. The ESIII stated he would return on to ensure the repairs were completed and the water temps were 120 degrees or below.

An interview with the Administrator on at 12:50 p.m., revealed she was unaware of the increased temperature of the water in the public and the resident on the 100 hallway.

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Interview at 10:25 a.m. with Staff H, revealed she knew the water temp was too hot, and she would keep regulating the temp until she felt it was safe for residents, when providing care.

During an interview with Staff A, on at 10:30 a.m., she stated, "I didn't know it was too hot, no staff or residents complained" (about the water temps).

During an interview with the family member of Residents #14 and #15 on at 10:30 a.m., she stated she often comes to the facility to have lunch with her grandparents and noticed the water was extremely hot when washing the dishes. She stated she was concerned the water temps might one of her grandparents because of their levels.

An interview on at 1:25 p.m. with Staff I, revealed she had informed Staff A, 3 or 4 days ago, the water seemed to be to be too hot. Staff I stated she was testing the water temp on herself and making adjustments before washing or bathing any residents to prevent injury.

An interview with Resident #1 on at 1:30 p.m., she stated, "When I take a shower the water is extremely hot, but I never told anyone." "It gets scalding and I have to keep turning it down."

During an interview with Resident #12 on at 1:45 p.m., Resident #12 stated, "Yes, the water is a little too warm and you have to be careful, I never thought to tell management, didn't think it was my duty."

2. Observation on at 10:00 a.m., revealed had yellow paper around the door knob. An interview with Staff H on , at approximately 10:00 a.m., revealed the yellow paper would identify Resident #4 was on isolation precautions.
At approximately 1:30 a.m., the physical was ambulating Resident #1 in the hallway. Staff F was pushing Resident #4 in the hallway towards the front of the facility. Resident #1 sat down on a bench in the hallway and the physical walked over to Resident #4 and put her hand on the residents shoulder. When Staff F did not intervene, the surveyor informed the physical about Resident #4's insolation precautions. The physical went immediately to wash her hands and Resident #4 was returned to his

3. During the noon meal on , Residents #4, #21, #23, #24, #25, and #26, were observed sitting in small dining area off of the 100 hallway, 4 female residents were sitting at one table and 2 male residents were sitting at another table. The meal included meat loaf, mashed potatoes, a cooked green leafy vegetable, and a roll. Staff H was in the dining meals to all residents. Staff H was observed moving between residents, touching residents, their eating utensils, and allowing residents to touch her and kiss her gloved hands. Staff H was not observed sanitizing her hands or changing her gloves between resident interactions. Resident #23 is and unable know the position of her meal items without cueing. Resident #23 had a piece of meatloaf approximately 6 in. in length. She was not assisted in cutting up the meatloaf to make it easier for her to eat. The Staff H sat between two female residents touching both residents' meals without sanitizing her hands. One resident dropped a piece of her meatloaf on the floor and Staff H picked up the meatloaf and put it in the trash. At that time she did change her gloves but did not wash or sanitize her hands. Staff H began to feed Resident #23, helping her put the spoon to her mouth. Resident #23 was then able to eat her food. Resident #26 asked for something to drink, the aide picked up the glass by touching the drinking surface and handed it to her without first sanitizing her hands.
Staff H, continued to assist both residents with their meal, wiping their mouths with napkins, picking up food items from each resident.

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By 12:20 p.m., Staff H was observed moving between tables to assist male Resident #24 and removing his completed lunch plate from the table. She was then observed moving back to the ladies table, again without sanitizing her hands, touching the rim of Resident #23's glass with her gloved un-sanitized hands.

At 12:30 p.m., Staff H, still wearing the same dirty gloves, placed a piece of meatloaf in Resident #23's hand for her to eat. Throughout the meal, Staff H moved from one table to another and one resident to another without sanitizing her hands or changing her gloves.
At 12:35 p.m., Rice Krispy treats arrived for desert. Staff H began passing out the Rice Krispy treats while removing the dirty dishes from the table.
During the meal, Staff H [redacted] with the residents, encouraging them to eat their meal while addressing the residents as "Honey, Hon and Sweetie."

4. Observation of Resident #3 during the tour revealed the resident in his [redacted] his wheelchair. His bed was in the left side of the [redacted] two half-rails in the upright position extending to the middle of the bed. The rails were secured to the frame.
Record review revealed the resident had an order for side-rails on admission, , 2012, the order expired after 6 months and was not renewed the physician.

An interview with Resident #3 on , at approximately 1:30 p.m., revealed the resident was not aware of the reason for the side rails and stated they were more of a hindrance than an aid when in bed or transferring to and from the bed. "When I turn from side to side in the bed, I often bang my hand on the rail and I get a [redacted] That really hurts! I would rather not have the rails."

5. Resident #5 was observed in his sitting in his wheelchair. An observation of the Resident's [redacted] two half rails were on the resident's bed. A review of the resident's chart revealed he did not have an order for side rails. Staff A acknowledged Resident #5 did not have an order for side rails. She stated when Resident #5 was admitted, the bed was uncomfortable and the bed was replaced with a bed with side rails already attached and were never removed.

Observation of Resident #5 on [redacted] at approx. 2:30 p.m., revealed the resident in bed with the side rails down.

Class II

0057-Medication - Over The Counter (OTC) Products 58A-5.0185(8) FAC
Based on observation and interview, the facility failed to properly label prescribed over the counter medications for 5 (Residents #1, #14, #20, #26, and #28) of 54 residents.

The findings include:

1. On at approximately 11:30 a.m., observation of the medication carts for the facility revealed Residents #1, #14, #20, #26, and #28 had over the counter medications in the medication drawers which had been prescribed by a physician in a dosage other than what was recommended by the manufacturer. None of the medications included a pharmacy or physicians label with instructions for the correct dosage as prescribed. Some bottles had the residents name written in black permanent marker, while others had markings to identify which resident was to receive the medication.

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Resident #1: 600mg. the manufacturer's label reads take 2 capsules per day; however, the Medication Observation Record (MOR) reads take 1 capsule per day;

Resident #14: 1 bottle of centrum silver with no identification or dosage on bottle; the MOR reads 1 tablet daily;

Resident #20: D-Mannose 500 mg 120 capsules, manufacturer's label reads take 1 twice a day; however, the MOR reads take 1 capsule daily; 1 bottle of PB 8, manufacturers label reads take 2 tablets daily; however, the MOR reads take 1 tablet daily;
1 bottle of the manufacturer's label reads, take 5 capsules daily; however, the MOR reads take 1 tablet daily;

Resident #26: 1 bottle of coconut oil, manufacturers label reads take 2 tablets twice daily; however, the MOR reads take 1 tablet daily; 1 bottle of 600 mg with D, manufacturers label reads take 2 tablets daily; however, the MOR reads, take one tablet daily;

Resident # 28: 1 bottle of manufactures label reads take 2 tablets q 6 hours; however, the MOR reads take 1 tablet q 8 hours as needed; 1 bottle of manufacturers label reads take 1 tablet with a glass of water, do not exceed 3 tablets; however, the MOR reads, take 1 tablet daily.

2. During an interview with Staff A on at approximately 11:45 a.m., she agreed the medications were not labeled with the correct prescribed dosage and 1 medication had no identifying information on bottle. She stated the resident or their families buy the OTC medications ordered by the physician directly from a store because it is less expensive. She stated she is aware all medications must be labeled by the pharmacy if the physicians' orders are different than the labeled recommendations.

Class III

0082-Training - 58A-5.0191(3) FAC
Based on record review and interview, the facility failed to ensure all staff received 1 hour of training in within 30 days of hire for 5 (Staff A, C, D, E, and F) of 5 staff reviewed who were employed over 30 days.

The findings include:

1. A review of staff files on for Staff A hired on revealed training titled borne on

2. A review of staff files on for Staff C hired on revealed training titled borne on

3. A review of staff files on for Staff D hired on revealed training titled borne on and

4. A review of staff files on for Staff E revealed training titled borne on given by the administrator, although Staff E was not employed yet.

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5. A review of staff files on ... for Staff F hired on ... revealed training titled ... borne ... on ... Documentation in Staff F's file revealed the ... borne ... training was 20 minutes long.

6. An interview with the Administrator on ... at 11:45 a.m., revealed she had tapes she used for training, but she had no documentation to show the content included modes of transmission, ... control procedures, clinical management, prevention of ... and ... with an emphasis on appropriate behavior and attitude change. Such instruction shall include information on current Florida law and its impact on testing, confidentiality of test results and treatment of patients and any protocols and procedures applicable to ... counseling and testing, reporting and offering of ... testing. The administrator revealed she was unsure of the content of the tape, but it was what she used for this training.

Class III

0084-Training - Assis Self-Admin Meds & Med Mgmt 58A-5.0191(5) FAC
Based on record review and interview, the facility failed to ensure all unlicensed staff who assist with self-administration of medications had the required 4 hour class prior to passing any medications for 1 (Staff C) of 3 medication staff reviewed.

The findings include:

1. Record review revealed Staff C is noted to be a medication assistant on the staff schedule. A review of her personnel record on ... revealed she was employed on ... No 4 hour medication training course was found in the file. A two hour up-date from ... was found in the file.

2. An interview with the administrator stated she did not know why the class documentation was missing from the file, but was sure it had been provided.

Class III

0086-Training - ADRD 58A-5.0191(9) FAC
Based on observation, record review and interview, the facility failed to ensure all staff were trained in the Department of Elder Affairs approved Level 1 and 2 ... training by an approved trainer within 3 months and 9 months respectively for 5 (Staff A, C, D, E and F) of 5 staff reviewed and employed over 3 months. The facility is a secured facility.

The findings include:

1. Upon arrival at the facility at 9:00 a.m. on ..., the surveyors had to push the outside buzzer and wait for staff to release the front door. All visitors, staff and residents entering and exiting throughout ... and ... had to be allowed to enter and exit by staff due to the secured doors.

2. A review of the personnel record for Staff A revealed she was hired as a direct care staff on ... Although she had Level training on ... it was not within 3 months of hire, and she also lacked any Level II training.

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3. A review of the personnel record for Staff C revealed she was hired as a direct care staff on . She lacked any Levels I and II training.

4. A review of the personnel record for Staff D revealed she was hired as a direct care staff on . She lacked any Level I training.

5. A review of the personnel record for Staff E revealed she was hired as a direct care staff on . She lacked any Levels I and II training.

6. A review of the personnel record for Staff F revealed she was hired as a direct care staff on . She lacked any Levels I and II training.

7. An interview with the Administrator on at 11:45 a.m., revealed she was not aware she needed the training due to the fact she was a secured facility. She stated they did not advertise care and would need to review the regulation. The regulation was shared with the administrator at that time.

Class III

0090-Training - 58A-5.0191(11) FAC
Based on record review and interview, the facility failed to ensure direct care staff received an in-service within 30 days of hire relating to and the facilities policy for 4 (Staff A, C, E and F) of 4 direct care staff reviewed and employed over 30 days.

The findings include:

1. A review of the personnel record for Staff A revealed she was hired as a direct care staff on . No policy or training was found in this personnel record.

2. A review of the personnel record for Staff C revealed she was hired as a direct care staff on . No policy or training was found in this personnel record.

3. A review of the personnel record for Staff E revealed she was hired as a direct care staff on . No policy or training was found in this personnel record.

4. A review of the personnel record for Staff F revealed she was hired as a direct care staff on . No policy or training was found in this personnel record.

5. An interview was conducted with the Administrator on at 11:45 a.m. She stated she was not aware it was required and would review the regulation.

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Class III

0091-Training - Documentation & Monitoring 58A-5.0191(12) FAC
Based on record review and interview, the facility failed to ensure all documentation of training met requirements including: 2. The subject matter of the training program; 3. The training program agenda; 4. The number of hours of the training program; and 5. The trainee's name, dates of participation, and location of the training program for 6 (Staff A, B, C, D, E, and F) of 6 staff records reviewed.

The findings include:

1. Review of personnel records for Staff A, B, C, D, E, and F revealed all training documents included the date and title of training, some included time length of training and were signed by the administrator or a trainer. The training lacked the subject matter of the training program; the training program agenda; the number of hours of the training program; and the trainee's name, dates of participation, and location of the training program.

2. An interview with the administrator on at 11:45 p.m. revealed she as unaware of the requirements for documentation. The regulation was shared and the example of Vanguards training (located in some of the facility's personnel files) was reviewed and the required documentation on the reverse side of the training certificate was discussed.

Class

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on observation, record review and interview, the facility failed to provide a therapeutic diet for 1 (Resident #14) of 7 resident records reviewed for diet orders.

The findings include:

1. Observation of and revealed all residents were served the exact same thing for their noon meal on these days.

2. On a review of Resident #14's file revealed a physician's order for a "Calorie Controlled, No Added Salt, Low Fat and Low diet."

3. Observation on and revealed all residents were served the same regular diet including a regular dessert.

4. Interview on with Staff A revealed the kitchen served only regular diets. Staff A was unaware of any residents having any therapeutic diets. She stated they only serve regular diets.

5. An interview on with the staff cooking, revealed the cook had no knowledge of any residents' diet orders other than a regular diet. Recipes were requested for the entrees (chicken and dumplings and meatloaf

entrees) served on ... and ... A review of the recipes revealed they were not calorie or fat/cho restricted. This was further verified by the cook who also acknowledged that all desserts were full calories and not restricted.

Class III

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC
Based on observation, interview and record review, the facility failed to maintain a safe environment, free from hazards, maintaining furnishings in good condition.

The findings include:

1. On ... at approximately 10:00 a.m., the water temperature in the women's ... on the 100 hallway was tested at 136 degrees. A test of the men's ... on the 100 hallway was 136 degrees. The water temperatures were checked in the resident ... closest to the hot water source on the 100 wing, and other random resident ...

Resident #1, ... 2's water temperature was 132 degrees from the ...
Resident #2, ... 8's water temperature was 132 degrees from the ...
Resident #12, ... 6's water temperature was 132 degrees from the ...
Resident's #14 and #15 in ... 2's water temperature was 132 degrees from the ...
Resident #29, ... 2's water temperature was 124 degrees from the ...
Resident #30, ... 1's water temperature was 137 degrees from the ...
All residents in the affected ... have some level of ... with a potential for injury.

A call was made to the Florida Department of Health on ... at 3:30 p.m., relating to high water temps and the surveyor spoke with Environmental Spec III (ESIII).

The ESIII came to the facility on ... at 8:30 a.m. A retest of the water on the 100 wing revealed the water temperature in the men and women's ... be 140 degrees. A retest of the water temp in resident ... 1's, ... was 140 degrees. ... 8's ... was 133 degrees; resident ... the ... from the water heater, was 124 degrees.

A Contractor from the facilities plumbing company arrived at the facility approx. 10:00 a.m., on ..., tested the water and agreed the water temp was above regulatory standards. He stated, "At these temperatures it would only take seconds for someone to be scalded badly. This is why showers have closure valves in case someone ..., but the sink ... and kitchens) don't have them."

A check of the water heater revealed a defective part for circulating the water needed to be replaced and would have to be shipped over night to arrive on ... The plumbing contractor would return on ... and replace the part. The ESIII stated he would return on ... to ensure the repairs were completed and the water temps were 120 degrees or below.

An interview with the Administrator on ... at 12:50 p.m., revealed she was unaware of the increased temperature of the water in the public ... and the resident ... on the 100 hallway.

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Interview [redacted] at 10:25 a.m., with Staff H revealed she knew the water temp was too hot, and she would keep regulating the temp until she felt it was safe for residents, when providing care.

During an interview with Staff A, on [redacted] at 10:30 a.m., she stated, "I didn't know it was too hot, no staff or residents complained" (about the water temps).

During an interview with the family member of Residents #14 and #15 on [redacted] at 10:30 a.m., she stated she often comes to the facility to have lunch with her grandparents and noticed the water was extremely hot when washing the dishes. She stated she was concerned the water temps might [redacted] one of her grandparents because of their [redacted] levels.

An interview on [redacted] at 1:25 p.m. with Staff I, revealed she had informed Staff A, 3 or 4 days ago, the water seemed to be to be too hot. Staff I stated she was testing the water temp on herself and making adjustments before washing or bathing any residents to prevent injury.

An interview with Resident #1 on [redacted] at 1:30 p.m., she stated, "When I take a shower the water is extremely hot, but I never told anyone." "It gets scalding and I have to keep turning it down."

During an interview with Resident #12 on [redacted] at 1:45 p.m., Resident #12 stated, "Yes, the water is a little too warm and you have to be careful, I never thought to tell management, didn't think it was my duty."

2. On [redacted] at approximately 9:30a.m., during a tour of the facility several resident [redacted] were identified to have carpet stains in the 100 hallway. Resident [redacted] 101, 102, 111, 116, 119 and 312 had dirty carpets and black scuff marks on the doors and walls. [redacted] had peeling and chipped paint on the wall behind the front door.
The mechanical [redacted] on the 100 unit was filled with wheelchairs, walkers, electric scooter, a mattress, a small refrigerator and other misc. items. The maintenance [redacted] the 300 hallway was filled with carpet remnants, plywood, and shelving that was piled to the ceiling.

A call was made to the DeSoto County Fire Inspector who arrived on [redacted] and verified the combustible items stored in the mechanical [redacted] a hazard and must be removed.

Class II

0161-Records - Staff 58A-5.024(2) FAC
Based on record review and interview, the facility failed to ensure the personnel records were complete as required for 6 (Staff A, B, C, D, E and F) of 6 staff reviewed.

The findings include:

1. A review of Staff A's file revealed Staff A was employed as a direct care staff on [redacted]. At an unknown later date she began to pass medications also. Staff A had no job description for the medication assistant. Further review found no freedom from Communicable [redacted] statement from a health care provider nor any freedom from [redacted] statement for 2012 or 2013. A background screening was found as eligible on [redacted], but none was obtained prior to starting employment from [redacted] to [redacted].

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The file also lacked Level 2 training by and training by

2. A review of Staff B's file revealed she was employed on as a direct care staff. Staff B's file was missing a direct care aide job description.

3. A review of Staff C's file revealed she was employed on as a direct care aide and at an unknown later date also became a medication assistant. No job description for the med assistant was completed. Further review found no freedom from Communicable statement from a health care provider nor any freedom from statement for 2012. A background screening was found as eligible on but none was obtained prior to starting employment from to
This staff also lacked either current First Aid or in the file. Although Staff C is passing medications no 4 hour medication assistance training was found in the file, only a 2 hour medication up-date from The file also lacked Level 1 training by and Level 2 training by and training by

4. A review of Staff D's file revealed she was employed on as a receptionist, but at some unknown date became a cook. There is no job description for a cook in the personnel file. Further review found no freedom from Communicable statement from a health care provider nor any freedom from statement for 2011 or 2013. The only statement from a health care provider was on and needed to be reassessed by . A background screening was found as eligible on , but nothing from to An expired (over 5 years prior) screening from the Department of Justice revealed the finding of eligible was "Based on information retrieved from the Central Communications Center (CCC) databases. A substantiated reportable incident refers to a complaint reported while the applicant was employed in a DJJ or contract provider program or facility." The file also lacked Level 1 training by

5. A review of Staff E's file revealed she was employed on as a direct care aide and at some unknown date became a medication assistant. There was no job description for medication assistant in the file. File review revealed the Communicable statement was not obtained within 30 days of hire but obtained late on . No further freedom from statement has been obtained since. An eligible background screening was obtained on , but none was obtained prior to starting employment from to No First Aid and was present in the file from to The file also lacked Level 1 training by and Level 2 training by and training by

6. A review of Staff F's file revealed she was employed on as a direct care aide. There was no job description available in her record. There was no Communicable statement nor freedom from statement since hire or annual by An eligible background screening was obtained on , but none was obtained prior to starting employment from to The file also lacked Level 1 training by and Level 2 training by and training by

7. An interview with the Administrator revealed she was not aware the above items were needed or missing from the personnel files. She verified the medication assistant task was not part of the resident care aide job description and could not verify when each staff had added these job duties to their work routine. She had no evidence the medication training was received prior to passing medications. She further stated the facility has a Live Scan for background screening on site at their building and did not know why the background screenings were not done.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965330	07/18/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Arcadia Oaks Assisted Living	**1013 East Gibson Street Arcadia, FL 34266**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)

Z815-Background Screening; Prohibited Offenses 408.809, 435.02(2), 435.06
Based on record review and interview, the facility failed to ensure Background screenings were completed prior to beginning employment for 5 (Staff A, C, D, E, and F) of 6 staff reviewed.

The findings include:

1. A review of Staff A's file revealed Staff A was employed as a direct care staff on . . . . . A background screening was found as eligible on , but none was obtained prior to starting employment from . . . . . to . . . . .

2. A review of Staff C's file revealed she was employed on as a direct care aide and at an unknown later date also became a medication assistant. A background screening was found as eligible on but none was obtained prior to starting employment from . . . . . to . . .

3. A review of Staff D's file revealed she was employed on . . . . as a receptionist, but at some unknown date became a cook. A background screening was found as eligible on , but nothing from . . . to . . . An expired (over 5 years prior) screening from the Department of . . Justice revealed the finding of eligible was "Based on information retrieved from the Central Communications Center (CCC) databases. A substantiated reportable incident refers to a complaint reported while the applicant was employed in a DJJ or contract provider program or facility."

4. A review of Staff E's file revealed she was employed on . . . as a direct care aide and at some unknown date became a medication assistant. An eligible background screening was obtained on but none was obtained prior to starting employment from . . . to . . . . . .

5. A review of Staff F's file revealed she was employed on . . . as a direct care aide. An eligible background screening was obtained on , but none was obtained prior to starting employment from . . . . to . . . . . .

6. An interview with the administrator revealed she was not aware the above items were needed or missing from the personnel files. She further stated the facility has a Live Scan for background screening on site at their building and did not know why the background screenings were not done.

Unclassified

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

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

Dear Administrator:

This letter reports the findings of a Biennial survey that was conducted on 2013 by a representative 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) A025 Resident Care – Supervision. Class II

The facility failed to provide supervision and assistance to prevent an unplanned weight loss for 1 of 3 residents sampled for weight loss.

2) A030 Resident Rights. Class II

The facility failed to ensure each residents right to a safe environment free of hazards; failed to obtain a written order from the Physician, for 2 residents observed with half side rails; and failed to maintain good control practices during dining and with residents on isolation precautions.

3) A057 Medication - Over the Counter (otc) Products. Class III

The facility failed to properly label prescribed over the counter medications for 5 residents.

4) A082 Training Class III

The facility failed to ensure all staff received 1 hour of training in within 30 days of hire for 5 of 5 staff reviewed who were employed over 30 days.

5) A084 Training – Assis. Self-Admin. Meds & Med. Mgmt. Class III

The facility failed to ensure all unlicensed staff who assist with self-administration of medications had the required 4 hour class prior to passing any medications for 1 of 3 medication staff reviewed.

6) A086 Training ADRD. Class III

The facility failed to ensure all staff were trained in the Department of Elder Affairs approved Level 1 and 2 training by an approved trainer within 3 months and 9 months respectively for 5 of 5 staff reviewed and employed over 3 months. The facility is a secured facility.

7) A090 Training Class III

The facility failed to ensure direct care staff received an in-service within 30 days of hire relating to and the facilities policy for 4 of 4 direct care staff reviewed and employed over 30 days.

8) A091 Training – Documentation & Monitoring. Class

The facility failed to ensure all documentation of training met requirements including: 2. The subject matter of the training program; 3. The training program agenda; 4. The number of hours of the training program; and 5. The trainee's name, dates of participation, and location of the training program for 6 of 6 staff records reviewed.

9) A093 Food Service – Dietary Standards. Class III

The facility failed to provide a therapeutic diet for 1 of 7 resident records reviewed for diet orders.

10) A152 Physical Plant – Safe Living Environ/Other. Class II

The facility failed to maintain a safe environment, free from hazards, maintaining furnishings in good condition.

11) A161 Records – Staff. Class III

The facility failed to ensure the personnel records were complete as required for 6 of 6 staff reviewed.

12) Z815 Background Screening; Prohibited Offenses. Unclassified

The facility failed to ensure Background screenings were completed prior to beginning employment for 5 of 6 staff reviewed.

Your directed plan of correction must include the following:

1) Involve residents and/or families in the development of menus. Offer substitutions to residents who indicate that they do not like the food being served. Monitor Resident #22's weight weekly until weight has stabilized and report changes to physician. Continue to monitor weight until weight has stabilized for 3 months. Train staff to monitor and assist residents during dining.

2) Check hot water temperature at all faucets including sinks and bathing areas to ensure that the hot water does not exceed 120 degrees. Develop a monitoring system to monitor hot water to ensure that it does not exceed 120 degrees. Continue to monitor hot water for 3 months.

3) Train all staff facility on Contact Isolation Precautions.

4) Train/retrain all staff on ... control and safe food handling.

5) Evaluate all residents for use of side rails. For residents who require side rails get a health care provider's order for the side rails. Monitor facility every 6 months for use of side rails.

A Directed Plan of Correction is not intended as the sole intervention(s) to be instituted by a provider, but is intended to impose directed interventions to address immediate concerns with identified deficient practice.

Please be advised that 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 (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after 2013 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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

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

Sincerely,

for:
Harold D. Williams
Field Office Manager

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Enclosure: State Form

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

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