STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964663	10/10/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sterling House Of Ft Myers	14521 Lakewood Boulevard Fort Myers, FL 33919	

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

List of Tags Cited:
St - A - 0029 - 58a-5.0182(5) Fac - Resident Care - Nursing Services S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0082 - 58a-5.0191(3) Fac - Training - [redacted] S-S= D
St - A - 0092 - 58a-5.020(1) Fac - Food Service - General Responsibilities S-S= D
St - A - 0167 - 58a-5.025(1) Fac - Resident Contracts S-S= D

Specific Tag Findings:
These are the results of an unannounced Biennial and Limited Nursing Service (LNS) survey conducted on [redacted] through [redacted] at Sterling House of Ft. Myers an Assisted Living Facility (ALF).

The following is a description of non-compliance:

0029-Resident Care - Nursing Services 58A-5.0182(5) FAC
Based on family interview and record review, the facility failed to allow an unpaid family member of 1 (Resident #8) of 8 residents to administer their father's medication.

The findings include:

Resident #8 was in the process of being interviewed on [redacted] at 3:00 p.m. At the time of the interview the daughter of the resident was present. While interviewing the resident, he became, somewhat agitated in regards to the questions, and proceeded into tangents in regards to the facility, and staff member. The daughter interrupted and explained that her father was very upset about an ongoing incident that had been occurring between, her father, the facility and the family. The daughter went on to explain:

"The family hired a private Licensed Practical Nurse (LPN) who was caring for my father, and giving my father his medication. The LPN left for no reason in the mean time I the daughter gave him his medication. I was picking up and paying for the medication, and giving my father his medications. The Clinical Manager (CM) came into tell me I was not allowed to give my father medications, that it was against the law and against state regulations (daughter could not recall date or time). When asked if that was a policy or a regulation, and was the daughter shown the policy regulation she replied never thought to asked for it. The daughter went on to say CM was very persistent urging to agree to take over the medication for a reasonable amount of money which was $46.00 a month. But I received a bill for over $4300.00. That was for half of [redacted] all of [redacted] and [redacted] it was $563.00. Then when I complained the CM She said that the prior Administer told you that cost for giving medications $461.00. I never saw the prior Administrator, and his signature is not on the agreement that I signed. From the time this all started. I explained to my father about the agreement of the facility giving him medications, and he was in agreement, and proceeded to take the medication from the staff. But when I showed my father the bill the facility sent me, my father became very angry, and started to refuse taking medication from the staff. The daughter continued to say had 3 meeting with facility staff, 2 meetings with CM and Acting Executive Director, and 1 meeting with just CM in regards to the bill. Every meeting ended the same way, will check out things and get back to you. Not heard back from the facility. Mean while my father is very angry, and

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my father not taking any medicine."

Review of the resident's medical record for Resident #8 revealed the resident is and has been a resident in the facility since . Further review of the nurses notes failed to demonstrate where staff has discussed with the daughter issues on giving her father medications.

The Clinical Manager and the Acting Executive Director were interviewed on at 9:00 a.m., in regards to the daughter administering medications to her father. The staff member were also questioned on the amount of money that was charge the resident. The CM denied that she had told the daughter it would be only $46.00 for medication administration. She also implied that the former Executive Director had spoken to the daughter in regards to a $461.00 charge monthly for the medication administration. When asked to see the documentation as to the conversations with the daughter, the facility staff said they had not documented the conversations.

On at 11:00 a.m. the daughter produces the documentation provided by the facility. The only documentation that had been provided, was the invoice sent from facility with charges included for based contrated rate of 3,178.00, another personal service rate $196.43 dated Personal service rate $461.00 date , and Personal rate $553.00 dated totaling New activity of $4,388.43. Also the daughter had a signed copy of the service plan dated No where on the service plan was any cost provided, to include a cost for the medication administration.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation and interview, the facility failed to insure a homelike environment was maintained for residents in 23 : 101, 102, 105,107, 108, 109, 110, 112, 113, 116, 119, 122,124, 125, 127, 130, 131, 132, 134, 137, 138, 139 and 141) of 42 resident observed.

The findings include:

A tour of the facility on with the Administrator and newly hired Administrator in training revealed heavily stained carpets in 101, 102, 105,107, 108, 109, 110, 112, 113, 116, 119, 122,124, 125, 127, 130, 131, 132, 134, 137, 138, 139 and 141.

A family interview was conducted with Resident #7's Daughter on at 11:30 a.m., when asked if she felt the facility was home like the daughter replied, "Yes it is home like, but feel it could be a little cleaner. They do not have the staff to clean, so I clean my mothers , but I should not have to do this."

A family interview was conducted with Resident #8's Daughter on at 3:00 p.m. When asked if she felt the facility was home like the daughter replied, "My dad's not being cleaned anymore. Garbage not being picked up, and the sewer drain smells pretty bad, and the maintenance man said that he was not allowed to use drain cleaner."

In an interview at 3:00 p.m., the Administrator stated that : 101, 137 and 138 had already been identified as needing the carpets cleaned by the facility and were scheduled to be cleaned. The Administrator

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agreed the carpets in all the . . . identified by surveyor did have stains and needed to be cleaned.

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC
Based on record review and interview, the facility failed to demonstrate that 3 (Employees H, I, and G) of 3 staff reviewed for educational training received the training.

The findings include:

1. Review of the personal file for Employee H revealed she was hired on in the position of Resident Assistant. Further review of the staff members training record did not demonstrate that she had the training for Incident reporting, Resident Rights, and Elopement.

2. Review of the personal file for Staff I revealed they were hired on . . . . . I in the position of License Practical Nurse (LPN). Further review of Staff I training records failed to demonstrate they had training for Incident Reporting, Resident Rights, and Elopement.

3. Review of the personal file for Staff G revealed this staff member was hired on . . . . . in the position of Resident Assistant. The training record failed to demonstrate the education for Incident Reporting and Elopement.

This was confirmed by the Business Manager on . . . . . at 9:30 a.m.

Class III

0082-Training - . . . . . 58A-5.0191(3) FAC
Based on record review and interview, the facility failed to demonstrate that 1 (Employee H) of 3 employees reviewed for training received . . . training.

The findings include:

Employee H's personal file indicated that staff was hired on . . . . . in the position of Resident Assistant. Review of the staff member's education records failed to demonstrate the staff member had training. This was confirmed by the Business Manager on . . . . . at 9:30 a.m.

Class III

0092-Food Service - General Responsibilities 58A-5.020(1) FAC
Based on observation and interview, the facility failed to ensure food was served in a safe and sanitary manor, to prevent the spread of food borne illness to those residents receiving an oral diet.

The findings include:

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Observation of the lunch meal on at 12:00 p.m., revealed the following:

As Employee D was observed continually placing her right thumb in the interior of the bowl as she was serving the salads to the residents. Employee D was also observed placing her thumb on the rim of the resident's plate as she proceeded to serve the residents their main entrée.

The staff member than proceeded to retrieve another plate of food from the tray line again placing her thumb directly on the rim of the plate before serving it to the residents. Employee D was also observed picking a dirty plate located in front of the resident, while she was serving another resident a lunch platter. Employee D was never observed washing or sanitizing her hands.

During the same period of time Employees F and G were serving the resident their lunch meal. Employees F and G were also serving salads to the resident's, but were never observed washing or sanitizing their hands. Employees F and G then proceeded to retrieve the finished salad bowls from the resident, but were never observed washing or sanitizing their hands before continuing to serve the resident the main entrée.

Class III

0167-Resident Contracts 58A-5.025(1) FAC
Based on interview and review of 1 (Resident #8) of 2 resident contracts. The facility failed to give a 30 day notice the resident's family for a change in regards to medication administration.

The findings include:

Resident #8 was in the process of being interviewed on at 3:00 p.m. At the time of the interview the daughter of the resident was present. While interviewing the resident, he became somewhat agitated in regards to the questions and proceeded into tangents in regards to the facility and staff member. The daughter interrupted and explained that her father was very upset about an ongoing incident that had been occurring between her father,the facility and the family. The daughter went on to explain:

"The family hired a private Licensed Practical Nurse (LPN) who was caring for my father and giving my father his medication. The LPN left for no reason. In the mean time I (the daughter) gave him his medication. I was picking up and paying for the medication and giving my father his medications. The Clinical Manager (CM) came in to tell me I was not allowed to give my father medications, that it was against the law and against state regulations (daughter could not recall date or time). When asked if that was a policy or a regulation, and was the daughter shown the policy regulation she replied never thought to asked for it. The daughter went on to say the CM was very persistent urging to agree to take over the medication for a reasonable amount of money which was $46.00 a month. But I received a bill for over $4300.00. That was for half of all of and it was $563.00. Then when I complained the CM. She said that the prior Administer told you that cost for giving medications $461.00. I never saw the prior Administrator, and his signature is not on the agreement that I signed. From the time this all started. I explained to my father about the agreement of the facility giving him medications, and he was in agreement, and proceeded to take the medication from the staff. But when I should my father the bill the facility sent me, my father became very angry, and started to refuse taking medication from

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the staff. The daughter continued to say had 3 meeting with facility staff, 2 meetings with CM and Acting Executive Director, and 1 meeting with just CM in regards to the bill. Every meeting ended the same way, will check out things and get back to you. Not heard back from the facility. Mean while my Father is very angry, and my father not taking any medicine."

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On at 11:00 a.m., the daughter produced the documentation provided by the facility. The only documentation that had been provided, was the invoice sent from facility with charges included for based contrated rate of 3,178.00, another personal service rate $196.43 dated . Personal service rate $461.00 date , and Personal rate $553.00 dated . Totaling new activity of $4,388.43. Also the daughter had a signed copy of the service plan dated . No where on the service plan was any cost provided, to include a cost for the medication administration.

Review of the contract for Resident #8 signed and dated by the daughter on indicates the following:

Under the section in regards to Service and Accommodations item F Rate changes. "We will provide thirty (30) days written notice of any change in the rates for Basic Services, Select Services, Therapeutic Services, the Predictable Maximum related to Care Groups or monthly fees for services within each care group. We may offer or require a change in Personal Services Plan when determine additional services as requested or required. The new Personal Service Rate resulting from change in your Personal Service Plan is effective immediately after after written notice is given."

The facility staff to include the Clinical Manager and the Acting Executive Director were questioned on at 9:00 a.m., on whether they had given the daughter a 30 notice of change in medication administration billing, and replied, we did not think we had to give a notice.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Sterling House Of Ft Myers
14521 Lakewood Boulevard
Fort Myers, FL 33919

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.

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 surveyors. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

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Enclosure: State Form

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

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2295 Victoria Avenue,
Fort Myers, FL 33901
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