STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942925	11/05/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Hidden Oaks Of Fort Myers	3625 Hidden Tree Lane Fort Myers, FL 33901	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D

Specific Tag Findings:
These are the results of an unannounced Complaint Survey, CCR# 2013011567 which was conducted at Hidden Oaks of Fort Myers an Assisted Living Facility (ALF) on . Census was 104 residents.

The following is a description of non-compliance:

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on record review and interview, facility failed to provide care and services according to resident needs (refill medications) for 6 (Residents #1, #2, #3, #4, #6, and #8) of 10 sampled residents and to have daily observations of residents awareness of general health and physical well-being for 1 (Resident #1) of 10 sampled residents.

The findings include:

1. Medication observation record for Resident #1 found that the following medications were not given as prescribed:
Medication was not given from to (on order).
Medication was not given on and
On there were no skin prep pads to be applied in Left heel.
500 mg 3 times a day was not on premises and was not given on
10 mgs was to be applied every 7 days. It was to be given on . But was not on premises and was given on
Medication cream to be applied at 9 a.m. and p.m. was not given from to
On medication 10 mg was not on premises and was not given.
On 9/7 and no a.m. medications were not available to be given to resident.

Interview with Resident #1 on at 12:12 p.m., revealed that on two occasions he did not receive his pain medication patches that was to be applied once a week. He said that he immediately complained to both the Nurse on premises and the facility's director and both told him that there is nothing to be done. It was the pharmacy's fault. He stated that it took about 3-5 days to receive his pain medication.

Record review for Resident #1 found no documentation indicating that facility re assess the resident for pain management nor notified the residents pain of not providing pain medications on timely manner. Furthermore facility failed to provide evidence of daily observations of residents awareness of general health and physical well-being.

2. Medication record review for Resident #2 found that the following medications were not refill on a timely manner:
Medication Mentoring 500 mg 3 times a day was not given on , , and from to
Medication was not given on , because it was not there. There was no notification of resident's health provider or next of kin on file indicating resident did not receive medications on dates mentioned above.

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3. Medication record review for Resident #3 found that the following medications were not refill on a timely manner:
Medication Cyprohep tab 4 mg (3 times a day) was not given on and . Medication on order Medication Merges 40 mg 9 is was not given on , and from to and finally discontinue that day. There was no notification of resident's health provider or next of kin on file indicating resident did not receive medications on dates mentioned above.

4. Medication record review for Resident #4 found that the following medications were not refill on a timely manner:
Medication 2 mg (every other day) was not given on 2/2 and .
There was no notification of resident's health provider or next of kin on file indicating resident did not receive medications on dates mentioned above.

5. Medication record review for Resident #6 found that the following medications were not refill on a timely manner. Medication Senexen 50 mg at 9:00 p.m., was not given from to . Medication 20 mg was not given on 6/8 and and from to .

6. Medication record review for Resident #8 found that the following medications were not refill on a timely intermediation was not given from to . Documentation indicated that all medications were "On order."

7. The Director of Nursing (DON) stated on at 2:50 p.m., that this issue took place prior to her becoming the DON in the facility. She acknowledged that medications for all residents were not refilled on a timely manner. She also acknowledged that there was no proper pain re-assessment for Resident #1.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observation and interview, 1 (Staff C) of 8 sampled staff did not follow appropriate procedure when assisted 4 out 10 sampled residents with their self-administration of their medications

The findings Include:

1. On at 8:27 a.m., Staff C was observed opening the med cart where all medications for resident were kept. She did not wash her hands or used a hand sanitazer. She placed medications from to a plastic cup and gave them to the resident. Staff did not verbally prompt resident to take medications as prescribed. Staff turned her head to another direction and did not observe resident taking her medication. Staff marked Medication Observation Record (MOR) without observing resident taking her medications.

2. On at 8:35 a.m., Staff C was observed opening the med cart where all medications for resident were kept. She did not wash her hands or used a hand sanitazer. She placed medications from to a plastic cup and gave them to the resident. Staff did not verbally prompt resident to take medications as prescribed. Staff turned her head to another direction and did not observe resident taking her medication. Staff marked MOR without observing resident taking her medications.

3. On at 8:40 a.m., Staff C was observed opening med cart where all medications for resident were kept. She did not wash her hands or used a hand sanitazer. She placed medications from to a plastic cup.

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Resident was not present when staff placed medication in the cup. Resident was sitting in the living [redacted] in the next [redacted]. Staff did not verbally prompt resident to take medications as prescribed. Staff marked MOR prior assisting resident with his self administration of his medications.

4. On [redacted] at 8:50 a.m., Staff C was observed opening the med cart where all medications for resident were kept. She placed medication from [redacted] to a plastic cup and gave them to the resident. She told her, "This is your [redacted]" Resident was standing up next to med cart. Resident accidently dropped medication from plastic cup to med cart. Staff told resident to place medication in her hand and to take it. Resident dropped medication on the floor. Staff took another medication from [redacted] and place it to plastic cup and gave it to resident. Resident again dropped medication from cup to med cart and then to the floor. Staff ended up picking up medication from the floor. Staff had already marked the MOR as given before the incident took place even though resident did not receive her medication.

5. DON acknowledged that Staff C did not follow appropriate procedure when assisted all 4 residents with their self-administration of their medications.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on record review and interview, facility failed to refill medications in a timely manner for 6 (Residents #1, #2, #3, #4, #6, and #8) of 10 sampled residents.

The findings include:

1. Medication observation record for Resident #1 found that the following medications were not given as prescribed:
Medication [redacted] was not given from [redacted] to [redacted] (on order).
Medication [redacted] was not given on [redacted] and [redacted].
On [redacted] there were no skin prep pads to be applied in Left heel.
[redacted] 500 mg 3 times a day was not on premises and was not given on [redacted]
[redacted] 10 mgs was to be applied every 7 days. It was to be given on [redacted]. But was not on premises and was given on [redacted].
Medication [redacted] cream to be applied at 9 a.m. and p.m. was not given from [redacted] to [redacted].
On [redacted] medication [redacted] 10 mg was not on premises and was not given.
On 9/7 and [redacted] no a.m. medications were not available to be given to resident.

Interview with Resident #1 on [redacted] at 12:12 p.m., revealed that in two occasions he did not receive his pain medication patches that was to be applied once a week. He said that he immediately complained to both the Nurse on premises and the facility's director and both told him that there is nothing to be done. It was the pharmacy's fault. He stated that it took about 3-5 days to receive his pain medication.

Record review for Resident #1 found no documentation indicating that facility re assess the resident for pain management nor notified the residents pain [redacted] of not providing pain medications on timely manner.

2. Medication record review for Resident #2 found that the following medications were not refill on a timely manner:
Medication Mentoring 500 mg 3 times a day was not given on [redacted] and from [redacted] to [redacted].

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Medication was not given on because it was not there. There was no notification of resident's health provider or next of kin on file indicating resident did not receive medications on dates mentioned above.

3. Medication record review for Resident #3 found that the following medications were not refill on a timely manner:
Medication Cyprohep tab 4 mg (3 times a day) was not given on and Medication on order Medication Merges 40 mg 9 is was not given on and from to and finally discontinue that day. There was no notification of resident's health provider or next of kin on file indicating resident did not receive medications on dates mentioned above.

4. Medication record review for Resident #4 found that the following medications were not refill on a timely manner:
Medication 2 mg (every other day) was not given on 2/2 and There was no notification of resident's health provider or next of kin on file indicating resident did not receive medications on dates mentioned above.

5. Medication record review for Resident #6 found that the following medications were not refill on a timely manner:
Medication Senexen 50 mg at 9:00 p.m., was not given from to Medication 20 mg was not given on 6/8 and and from to

6. Medication record review for Resident #8 found that the following medications were not refill on a timely intermediation was not given from to Documentation indicated that all medications were "On order."

7. The Director of Nursing (DON) stated on at 2:50 p.m., that this issue took place prior to her becoming the DON in the facility. She acknowledged that medications for all residents were not refilled on a timely manner.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Hidden Oaks Of Fort Myers
3625 Hidden Tree Lane
Fort Myers, FL 33901

Re: CCR #2013011567

Dear Administrator:

This letter reports the findings of a Complaint survey that was conducted on , 2013 by a representative 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 surveyor. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

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Enclosure: State Form

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