STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911223	03/06/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Vick Street Manor	22332 Vick Street Port Charlotte, FL 33980	
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 - 0053 - 58a-5.0185(4) Fac - Medication - Administration S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Specific Tag Findings:
These are the results of an unannounced Complaint Survey, CCR# 2014002233 conducted on [redacted] at Vick Street Manor an Assisted Living Facility (ALF) located in [redacted] Charlotte, FL.

The complaint contained 12 allegations. Four of the allegations were confirmed at the time of the investigation. One of the allegations was confirmed without deficiency.

The following is a description of non-compliance:

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on record review and interview, the facility failed to provide care and services to meet resident needs (prevent injuries) for 2 (Residents #2 and #12) of 20 sampled residents and to provide appropriate supervision to the same residents.

The findings include:

1. Record review for Resident #12 revealed on [redacted] at 12:20 a.m., Resident Aid J observed that the resident was unsteady and had slid down a couple of times. He reported the findings to Shift Supervisor, Staff D. Staff D told Staff J to make sure to observe the resident every half an hour. Staff returned on 12:50 a.m. and to check on Resident #12 and found him on the floor. 911 was called resident was send to the hospital. Notified next of kin on [redacted] at 1:25 p.m.

The resident's spouse notified the facility on [redacted] that Resident #12 was diagnosed with a hip [redacted] and was awaiting surgery. On [redacted] the facility was notified by a rehabilitation center that the resident was not doing well and advance directives were faxed as per next of kin request to the rehabilitation center. On [redacted] the resident's spouse arrived in the facility and picked up the resident's personal inventory. She told the facility that Resident #12 was actively dying and was under Hospice care at the rehab. center.

2. Resident #2 [redacted] on [redacted] on water in the Bayberry dining [redacted]. The resident hit his left shoulder on the wall and complained of pain. The resident refused to go to the emergency [redacted] an evaluation. The physician was notified and ordered an X-Ray of the shoulder to be done. There was no documentation of the record of when the X-Ray was completed. As of [redacted] there was no results of the X-Ray located in the chart and staff was unsure of the results. After surveyor intervention, the X-Ray results were obtained. The X-Ray was completed on [redacted] and the results indicated there is "Osteopenia. There is down sloping [redacted] acromion. No [redacted] seen. There is no [redacted]. There is [redacted] marginal spurring. Impression: Moderate [redacted]. No [redacted] seen."

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Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on interview and observation, the facility failed to ensure staff who receive assistance with self-administration of medication in an Assisted Living Facility training was appropriately assisting Resident #2 with self-administration of medication.

The findings include:

The facility has staff who received assistance with self-administration of medication in an Assisted Living Facility training providing the medications to all residents.

Observation of Resident #2 on ... at 8:40 a.m., revealed the resident to be alert. He stated that he used to give his own ... but does not remember taking it this morning. The resident was able to test his own ... sugar without any direction.

During an interview on ... at 8:50 a.m. the medication technician, who was doing medications for this unit, stated the resident can do the needle part of the injection, but she must tell him the appropriate dosage and ensure he is giving the correct amount as he cannot do this. She stated his ... sugar was 137 this morning.

Review of the resident's record revealed he is receiving a dosage of ... (an ... like product) 2 times a day and it to have sliding scale coverage based on the ... sugar 4 times a day. The resident is not capable to determining the correct dosage for coverage. Review of the record revealed documentation on ... stating the resident's ... sugar was 505. The physician was notified and 10 units (unknown type as not documented) was given by the medication technician. The resident could not accurately self-administer the ...

During an interview on ... at 10:30 a.m., the nurse supervisor indicated the resident was doing hand over hand to self-administer the medication, but he is no longer able to do this. She agreed the medication technician should not be handling the resident's ... and determining dosing as they do not have training to do this. As a result of this the resident has been given 45 day notice to be discharged. She agreed she would administer the resident's ... until such time as he is discharged from the facility.

Class III

0053-Medication - Administration 58A-5.0185(4) FAC
Based on observation, interview and record review, the facility failed to ensure 1 (Resident #2) of 6 sample residents received medication admiinistration from licensed staff.

The findings include:

The facility has staff who received assistance with self-administration of medication in an Assisted Living Facility training providing the medications to all residents.

Observation of Resident #2 on ... at 8:40 a.m., revealed the resident to be alert. He stated he used to give his own ..., but does not remember taking it this morning. The resident was able to test his own ... sugar without any direction.

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During an interview on at 8:50 a.m. the medication technician who was doing medications for this unit stated that the resident can do the needle part of the injection, but she must tell him the appropriate dosage and ensure he is giving the correct amount as he cannot do this. She stated his sugar was 137 this morning.

Review of the resident's record revealed he is receiving a dosage of (an like product) 2 times a day and it to have sliding scale coverage based on the sugar 4 times a day. The resident is not capable to determining the correct dosage for coverage. Review of the record revealed documentation on stating the resident's sugar was 505. The physician was notified and 10 units (unknown type as not documented) was given by the medication technician. The resident could not accurately self-administer the

During an interview on at 10:30 a.m. the nurse supervisor indicated the resident was doing hand over hand to self-administer the medication, but he is no longer able to do this. She agreed the medication technician should not be handling the resident's and determining dosing as they do not have training to do this. As a result of this the resident has been given 45 day notice to be discharged. She agreed she would administer the resident's until such time as he is discharged from the facility.

Class III

0054-Medication - Records 58A-5.0185(5) FAC
Based on a review of resident's Medication Observation Records (MOR) and interview with administrative staff, the facility failed to ensure there was documentation indicating the amount of sliding scale administered for 1 (Resident #2) of the residents reviewed.

The findings include:

Resident #2 has a sliding scale for administration 4 times a day. The resident is to test his and then give a ordered amount of based on the sugar results. The orders are as follows: "Humulog 100 units per milliliter less than 100 sugar give 20 units. For sugar 101-150=30 units sugar 151-200=40 units sugar 200-300 = 50 units, and greater than 400=70 units."

Review of the MOR for this resident revealed regular 4 times a day documentation of the glucose results, but there was no documentation on the MOR of the amount of given/taken by the resident.

During an interview on at 4:00 p.m. the Nursing Director indicated agreement this MOR does not show what dosage was being given for the results.

Class III

0165-Risk Mgmt & QA; Adverse Incident Report 429.23 FS; 58A-5.0241 FAC
Based on record review and interview, the facility failed to file an adverse incident report as required for Resident #12.

The findings include:

Record review for Resident #12 found that on at 12:20 a.m. Resident Aid J observed that resident was

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unsteady and had slid down a couple of times. He reported the findings to Shift Supervisor, Staff D. Staff D told Staff J to make sure to observe the resident every half an hour. Staff returned at 12:50 a.m. to check on Resident #12 and found him on the floor. 911 was called resident was send to the hospital. Notified next of kin on [redacted] at 1:25 p.m.

The resident's spouse notified the facility on [redacted] that resident was diagnosed with hip [redacted] and await surgery. On [redacted] the facility was notified by a rehabilitation center that resident was not doing well and advance directives were faxed as per next of kin request to the rehab center. On [redacted] the resident's spouse arrived in the facility and picked up the resident's personal inventory. She told the facility that Resident #12 was actively dying and was under Hospice care at the rehab. center.

Record review found no documentation of adverse incident. The Administrator stated during interview conducted on [redacted] at 1:50 p.m. that the previous Administrator did not file the incident because she felt that the report will trigger an AHCA inspection.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Vick Street Manor
22332 Vick Street
Port Charlotte, FL 33980

Re: CCR #2014002233

Dear Administrator:

This letter reports the findings of a Complaint survey that was conducted on , 2014 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 , 2014 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
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