STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964874	05/01/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sterling House Of Cape Coral	1416 Country Club Road Cape Coral, FL 33990	
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 - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0092 - 58a-5.020(1) Fac - Food Service - General Responsibilities S-S= D

Specific Tag Findings:
These are the results of an unannounced Biennial and Limited Nursing Services (LNS) survey completed on [redacted] at Sterling House of Cape Coral an Assisted Living Facility (ALF).

The following is a description of non-compliance:

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on interviews, the facility failed provide care and services according to resident needs for 4 (Residents #8, #9, #10, and #12) out of 18 sampled residents.

The findings include:

1. Resident #8 stated on [redacted] at 11:13 a.m., "It's very nice place the girls are nice too, just I don't think they have that many people working here. Sometimes it takes a very long time for girls to answer the call but they are overwhelmed with work. It can take up to 20 minutes some times. It's not their fault. Sometimes they have only 2 girls working here, it used to be 3."

2. Resident #9 stated on [redacted] at 11:31 a.m., "I feel they need more help with the work here, they have to help in the dining [redacted] I clean up the dining [redacted] have too much to do. They supposed to have 3 per each shift sometimes they have only two. The girls are very nice to me. Last night I had to stay up after 10:30 p.m., because I had to wait for someone to remove my quilt in order to go to bed. I first called at 9:30 p.m. it was after 10:30 when they came to help me. I don't blame the girls they are wonderful, they just have so much to do that they don't have time to take care of everything they asked to do. It's understandable."

3. Resident #10 stated on [redacted] at 11:58 a.m. "They need more help here; I feel that it takes longer for the girls to respond to calls. I don't blame them they have to do so much it's incredible the amount of work that girls do, I wish they hire more people here."

4. Resident #12's relative stated on [redacted] around 3:00 p.m., "They come and do housekeeping once a week and they clean the [redacted] The girls are nice, however sometimes it takes a long time to get someone to come and help her to go to the [redacted] the morning. She told me one day it took close to 45 minutes before they came in to help her. I think it's because they don't have that many people working here in the morning like it used to be."

5. Staff A stated on [redacted] at 2:06 p.m., "Right now we have a little situation. There are usually 3 staff in the morning and afternoon shift and two at night. But we had only two sometimes. Two weeks ago they brought another girl from the Fort Myers facility to cover so we can have 3 in the morning and afternoon shift. It's been a whole month that we have to strangle I know they have been trying to hire people but there background is not

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good. I get residents up shower like 2-3 a day then bring residents to dining they night girls assist for breakfast. Next we bring residents back and we toilet them, we clean the dining, set up for lunch, run to the , we have 14 residents each, we have a to clean and then bring the laundry so the night girls have to do that. Take lunch break then take residents for lunch, in the middle of all that residents call for help, sometimes it takes a long time to answer their calls since we multitask. After lunch we clean the dining, bring residents back, pick up trash and prepare for night shift. Night shift to check every two hours and does laundry and med passes, i wish we had more staff."

6. Staff B stated on at 2:26 p.m., "It's close to a month that we are going though that; it's because one of the day people left for another job and one other one is on maternity leave. A girl covers from the other facility in Fort Myers. Residents come first we take care of them first. Let's say an example yesterday 3 residents called at the same time and were two of us. One resident had to wait. We used to work 5 days a week know is 7 days a week; it began a week and a half ago. My last day of was Saturday

7. Staff C said on at 4:00 p.m., "We are understaffed here; they try to look for people. It can be hard sometimes because we don't have enough staff and the residents need to be taking care of all at the same time. Sometimes let's say 3 residents will call in and there are only two of us. It's hard."

8. Staff D stated on at 7:00 a.m., "There are two staff at night time. Sometimes I work in the afternoons too. That shift, the afternoon is the one that has the main issue because each girl has to help set up the dinning, clean 1 day but if they are only 2 girls that happens often they have to clean all 3 between them and they take care of 14 residents each when it's a full house and pull laundry and wash if someone has an accident and bring back to the I get up the residents to be ready. Sometimes 3 residents will call but are only two of us so they have to wait for up to 10 minutes. We try as hard as we can, don't get me wrong we love our residents but there are not enough of us to do what it has to be done. It's overwhelming sometimes." Also there is a resident in who came back from the hospital a week ago with Mersa. They don't have cloth protectors to give us; they just told us use gloves. I think two more residents got it. The one in and #123 goes to visit her all the time."

9. Staff E stated on at 7:30 a.m., "There is a resident that is 2 person assist she is unable to stand. Two staff here had hurt their backs here. One is she has to be out for a week one more got hurt 2 days ago. It's so hard for us because since the resident cannot assist its weight so we ourselves, then of course when one girl is out there are only 2 girls working, and that is hard in the morning and afternoon shifts. I forgot to tell you; the nurse notified me that the resident in has mersa. I think two more residents got it, goes in her I sits in the same table. She hasn't come out of her I use disposable clothing protectors and masks. No large quantity of gowns and masks to go around i wish they had more, we have families we don't want our children to get sick."

Class III

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 respond to resident grievance for 1 (Resident #9) out of 18 sampled residents, failed to ensure a homelike environment was maintained for residents in 6 #101, #103, #105, #107, #110, and #112) of 42 resident observed, and to respond to residents light calls on timely manner for 4 (Residents #8, #9, #10, and #12) out of 18 residents. The facility failed to apply appropriate control standards consistent with established and recognized standards within the community for 1 (Resident #5) out of 18 sampled residents by not taking adequate steps to prevent the spread of

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The findings include:

1. Interview with Resident #9 on at 11:31 a.m. stated, "I have another issue that I want to discuss with you. I had a rooster that was handmade, I made it myself. It's ceramic. I had it up on the shelf. It's gone. Someone took it from there. I don't know why. It has emotional value to me because I made it myself. I also lost my camera not too long ago. The case is still here but not my camera. I paid $100.00 for it."

Interview with the Executive Director (ED) on at 11:30 a.m. revealed that she was aware of both items missing. She said that facility does not have an inventory log upon admission. She said, "They come with big boxes; we supposed to have everything written down?" She said, "I asked the family to give me a picture of the rooster so I can have it posted at the staff It was not found." Surveyor asked, "What about the camera?" She said was not found either most probably was lost or she accidentally threw it at the trash can, it was sitting at the shelf." However, resident still has the case and as per resident the camera was always in the case so if the was accidentally thrown in the garbage the case would not have been still there. The Administrator stated that she talked to the resident's family for both incidents but did not have any grievance report for the complaint nor documentation of responding to the grievance either. She said, "We always follow through and try to find items missing; this is a very trusty community that does not happen often. I encourage residents to close their door and even lock it. They don't do that; it's their choice."

2. A tour of the facility on at 9:40 a.m., revealed heavily stained carpets in #101, #103, #105, #107, #110, and #112.

The Administrator stated on around 5:00 p.m., that she was aware of the stains and she was in process of hiring a company that was to come and clean all

3. Resident 8 stated on at 11:13 a.m., "It's very nice place the girls are nice too, just I don't think they have that many people working here. Sometimes it takes a very long time for girls to answer the call but they are overwhelmed with work. It can take up to 20 minutes some times. It's not their fault. Sometimes they have only 2 girls working here, it used to be 3."

4. Resident #9 stated on at 11:31 a.m., "I feel they need more help with the work here, they have to help in the dining I clean up the dining have too much to do. They supposed to have 3 per each shift sometimes they have only two. The girls are very nice to me. Last night I had to stay up after 10:30 p.m., because I had to wait for someone to remove my quilt in order to go to bed. I first called at 9:30 p.m.; it was after 10:30 when they came to help me. I don't blame the girls they are wonderful, they just have so much to do that they don't have time to take care of everything they asked to do. It's understandable."

5. Resident #10 stated on at 11:58 a.m., "They need more help here; I feel that it takes longer for the girls to respond to calls. I don't blame them they have to do so much it's incredible the amount of work that girls do, I wish they hire more people here."

6. Resident #12's relative stated on around 3:00 p.m., "They come and do housekeeping once a week and they clean the . The girls are nice, however sometimes it takes a long time to get

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someone to come and help her to go to the the morning. She told me one day it took close to 45 minutes before they came in to help her. I think it's because they don't have that many people working here in the morning like it used to be."

Resident council meeting revealed that residents complaint on for lack of response on timely manner of call lights. Even though residents began complaining in facility did not take any action to respond to the residents' complaints.

4. During an interview on at 11:00 a.m., with Resident #5 the surveyor asked when the Resident Assistant comes in to work with her does she wear a gown over her clothes and she responded, "No, I don't think so, what does it look it?" The surveyor explained it might yellow, or blue, it might plastic or linen, but it would be over her regular clothes, and she would have it on when she comes in and she responded, "Oh, no then she doesn't." The surveyor asked Resident #5 if the wears gloves and washes her hands when she works with her and she responded, "Yes, they do that."

During an observation on at 11:00 a.m., the surveyor observed no singe on the door indicating staff and/or visitors were to see the nurse for instructions; the surveyor did see a box of gloves in the ; however there were no gowns in the

During an interview with Sales Manager on at 11:30 a.m., she stated, "I have a soft spot for this resident. I know her daughter comes about a few times a week and she has visitors from the church a few times a week. I know she has " The surveyor asked her if she was aware if she had anything else going on and she responded, "I only heard that its spread, I heard it spread to her " The Sales Manager had been observed while on the previous tour to have contact with the resident and leave the washing her hands.

A review of Nursing Communication Log Book dated Evening Shift documents "Resident #5 returned with a lot of meds discontinued - see papers at desk. Unable to stand - 2 sassiest, very heavy- cannot follow commands, says "I am" but is not - no open areas. will be in tomorrow from VanGuard - Probably & for "

During an interview on at 12:00 p.m., with Staff A, she stated, "I have only given her breakfast this morning, she got a shower from the Hospice people. So I will go in and giver her lunch and then clean her after I do lunch out here." The surveyor asked if she would let the surveyor know when she would do that so she can observe.

A review of the resident's Progress notes documents the resident being treated for
/ -Resistant

A review of the Visitor Log book revealed that it documents Resident #5 frequently has visitors, including on and by different visitors. These visitors are not advised of the contact precaution and/or to wash their hands upon leaving the visiting any other resident in the facility.

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Class III

0054-Medication - Records 58A-5.0185(5) FAC
Based on record review, observation, and interview, the facility failed to accurately maintain and Medication Observation Record (MOR) for 1 (Resident #10) out of 5 sampled residents.

The findings included:

During an observation of the morning Medication Pass with Employee F on at 8:50 a.m., she failed to administer Resident #10, medication as prescribed the physician.

During an interview on at 8:55 a.m., with Employee F she stated, "I have to call the pharmacy and find out why it's not here."

A review on at 8:57 a.m., of Resident #10's MOR revealed Employee F had initialed all the 9:00 a.m. medication she was observed administering to Resident #10 with the exception of . The box for , for was empty, there was no initials, no circled initials and there was no reason on the back of the MOR to indicate as to why the resident did not receive this medication at 9:00 a.m., as indicated on the MOR. At 4:45 p.m., a second copy of the resident's MOR made to show the box remained empty and there still was no reason indicating a reason for the medication not being given.

An interview with Employee F on at 4:30 p.m., she stated, "I have a verbal order from Employee G that says we can give the when it comes in tonight."

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on record review, observation and interview, the facility failed to properly store prescription and nonprescription medication for 4 (Residents #4, #15, #19, and #20) out of 39 residents. The facility failed to follow physician orders for 1 (Resident #16) out of 39 residents.

The findings included:

1. An observation on at 11:30 a.m., of Resident #16 lying in bed with the concentrator across the her. Upon closer inspection of the flow meter, the surveyor was unable to determine the level of Resident #16 was receiving; the black ball appeared to be above 5 Liters in the flow meter. The surveyor asked for the Licensed Practical Nurse (LPN) to come with the last physician order for to confirm how many Liters Resident #16 should be getting. After two attempts, the LPN and the Health & Wellness Director arrived at the the order indicating Resident #16 should be at 2 Liters via nasal cannula.

During an interview with the Health and Wellness Director she was asked to look at the flow meter and when asked if she was able to tell how much it is on she said, "No, it looks like it is all the way up. You know we can't control it if someone else touches it, like her family."

During an interview with the LPN she was asked to look at the flow meter and asked if she was able to tell how much it is on and stated, "I was in here this morning and checked the concentrator, I am not seeing it.

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She is not on 2 liters."

During an interview with Staff B, assigned to Resident #16, the surveyor asked if she had been in the to take care of her, if she knows how much the resident's is on, and if anybody from her family has been in today. Staff B responded, "I have been in here today, the last time at 10:00. Nobody from her family has been here today. I have not touched the concentrator. She is supposed to be on 2 Liters, no I can't tell because the little ball is not there." The surveyor asked Staff B if she would mind looking at the Visitors Log book the Sales Manager had brought up and confirm that no one from the family has been in. Staff B took the log book and stated, "Nope, they always sign in and their names aren't here. Besides I would have seen them and they haven't come in."

At 11:38 a.m., Staff F was asked sometime later today could you please leave a copy of the physician order for the for me. Staff F returned to Resident #16 11:41 a.m. with a copy of the physician order for The surveyor and Sales Manager left Resident #16's 11:50 a.m., there were no vital signs taken or saturation rate taken.

During an interview at 1:10 p.m., with Staff F when asked if she contacted Hospice she stated, "No." The Health & Wellness Director stated, "That's what I am doing, I am doing the Incident Report and then I will contact Hospice and the family and tell them what happened." The surveyor asked if anyone had gotten vital signs or O2 sat rate and she responded, "I took her vitals about 25-30 minutes ago. They are - 82 - 18. We aren't allowed to do saturations."

2. An observation on at 10:45 a.m. with the Sales Manager, during a tour of Resident #19's a bottle of lubricant eye drops on bedside table

An observation on at 10:50 a.m. with the Sales Manager, during a tour of Resident #20's a bottle of on table in living area and Bayer chewable in

An observation on at 10:55 a.m. with the Sales Manager, during a tour of Resident #4's a bottle of temporary pain relief; a bottle of night medicine and a bottle of vapor rub on her table in the dining area. When asked how does she get her medication, Resident #4 states the nurse gives her medicine.

An observation on at 11:15 a.m. with the Sales Manager, during a tour of Resident #15's an unsecured tank under the resident's kitchen sink.

An observation on at 11:14 a.m. with the Sales Manager, during a tour of Resident #1's there were two bottles of centrifugal liquid medication in his

A record review on for Resident #1's Self Administration of Medication Review was completed on , and Resident #1 was missing a Self-Administration of Medication Review for and

During an interview Resident #1 had stated he administers his own medication and keeps it locked in his

A record review on for Self Administration of Medication Review revealed Residents #4, #19, and #20 have not been assessed for approval or have a physician order to self-administer their medications.

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A record review on [redacted] for Resident #15's Self Administration of Medication Review was completed on [redacted] and [redacted] Resident #15 was missing a Self-Administration of Medication Review for [redacted] and [redacted].

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC
Based on record review the faciklity failed to ensure that Staff D and Staff E had the required training.

The findings include:

1. Record review for Staff D (Resident Assistant/med tech/housekeeper/server hired [redacted]) found no evidence of the following training: resident rights in ALF, recognizing and reporting resident [redacted] neglect and [redacted] resident behavior and needs and providing assistance with ADL.

2. Record review for Staff E (Resident Assistant/med tech/housekeeper/server hired [redacted]) found no evidence of the following training: reporting major incidents, reporting adverse incidents, facility's emergency procedure including chain of command and staff roles relating to emergency evacuation and resident behavior and needs and providing assistance with ADL.

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 manner, to prevent the spread of food borne illness to those residents receiving an oral diet.

The findings include:

Observation of the lunch meal on [redacted] at 12:02 p.m., revealed the following:

Employee A was observed continually placing her right thumb in the interior of the bowl as she was serving the salads to the residents. Employee B was also observed placing her thumb on the rim of the residents' plates as she proceeded to serve the residents their salads and main entrée.

Staff F was observed throwing an article in the garbage, then went to a resident's table and picked up a glass with her thumbs touching the upper side of the glass. She went to the kitchen and returned with a glass of thicken orange juice and placed it in front of the resident.

Staff B was observed wearing a hair net that was covering a very small part of her ponytail (upper part). Observation took place on [redacted] at 12:34 p.m. She walked in the kitchen and came back with a pitcher of juice. In few minutes at 12:37 p.m., she was observed wearing a hair net that covered only her ponytail and not the full hair. Staff was observed coming in and out of the kitchen multiple times. Staff B was observed pre-opening the packaged butter and placing them at residents' plates prior serving them on [redacted] at 12:46 p.m., 12:48 p.m. and 12:49 p.m.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Sterling House Of Cape Coral
1416 Country Club Road
Cape Coral, FL 33990

Dear Administrator:

This letter reports the findings of a Biennial and Limited Nursing Services (LNS) 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

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