RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

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

Dear Administrator:

This letter reports the findings of a complaint (CCR# 2014007582 & 2014007814) inspection survey conducted on , 2014, by a representative of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **five business days** of receipt of this hand delivered report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
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= G
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= G
St - A - 0164 - 58a-5.024(4) Fac - Records - Inspection Availability S-S= D

Directed Corrective Actions:

1. The Assisted Living Facility is required to employ a Licensed Consultant Pharmacist other than the pharmacist currently consulting for the facility. The initial onsite Consultant Pharmacist visit must take place within 14 days of this notification of the Class II Medication deficiency (A0056) identified on .

The facility must have available for review by the Agency a copy of the Consultant Pharmacist's license.

The facility must submit the Consultant Pharmacist's corrective action plan to the Agency no later than 10 working days subsequent to the initial onsite consultant visit.

Mail a copy of the Consultant Pharmacist's corrective action plan to:

Fort Myers Field Office
2295 Victoria Avenue,
Fort Myers, FL 33901
Phone:(239) 335-1315; Fax:(239) 338-2372
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

Hidden Oaks Of Fort Myers
, 2014

Harold D. Williams, Field Office Manager

Agency for Health Care Administration

Health Quality Assurance

2295 Victoria Avenue,

Fort Myers, Florida 33901

The Consultant Pharmacist must be retained and provide quarterly updates until such time as the Agency has verified the correction of all medication systems.

2. The Assisted Living Facility is required to retrained all staff on control procedures. This training will be provided by a Registered Nurse and will be completed no later than 10, 2014. Documentation of this training will be maintained in each staff file. The documentation must include the following:

a. The title of the training program;
b. The subject matter of the training program;
c. The training program agenda;
d. The number of hours of the training program;
e. The trainee's name, dates of participation, and location of the training program;
f. The training provider's name, dated signature and professional license number.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call Mr. Harold D. Williams, Field Office Manager at (239) 335 1314.

Sincerely,

Harold D. Williams
Field Office Manager

Field Office Manager

D7JR

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942925	09/08/2014
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 - 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= G
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= G
St - A - 0164 - 58a-5.024(4) Fac - Records - Inspection Availability S-S= D

Specific Tag Findings:
An unannounced Complaint Survey, CCR# 2014007582 and CCR# 2014007814 was conducted on ..... at Hidden Oaks, an Assisted Living Facility (ALF) in Ft. Myers, Florida.

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 ensure the contact of the resident's physician and update of the resident's record relating to an injury for 1 (Resident #7).

The findings include:

Upon interview on ..... at 4:30 p.m. the Director of Nursing (DON) acknowledged, with the Administrator present, that she did not contact the resident's physician to notify him that Resident #7 sustained a ..... approximately 7:00 a.m. on ..... She also acknowledged that she did not obtain an order for application of the steri-strips, which were applied by her; and, she did not obtain an order to remove the steri-strips that were observed being removed by her at 11:00 a.m. on ..... The ..... was 1 and 1/2 inch by 1 and 1/2 inch, in the shape of a half moon, on the top of the resident's right hand.

Review of the medical record at this time revealed that there were no nursing progress notes documenting the incident and treatment (more than eight hours after the incident). The Administrator stated, "But the resident received timely and appropriate care." The surveyor advised that the removal of the steri-strips was observed to cause a large amount of ..... from the ..... and cause the resident to experience unnecessary pain and discomfort. The DON acknowledged that the resident was complaining of pain during the procedure.

Class III

0029-Resident Care - Nursing Services 58A-5.0182(5) FAC
Based on record review, observation and interview, the facility failed to ensure nursing progress notes were maintained to reflect resident injury and resident transfer/discharge/re-admission.

The findings include:

Based on record review, observation and interview, nursing progress notes were not maintained/updated as follows:

1. Review of the medical record for Resident #7, on ..... at 4:30 p.m., revealed no nursing progress note relating to the resident sustaining a ..... measuring 1 and 1/2 inch by 1 and 1/2 inch, in the shape of a half moon, on the top of right hand. The ..... was sustained at approximately 7:00 a.m. on ..... and steri-strips were applied. These steri-strips were also removed, at approximately 11:00 a.m. with a large amount of and resident complaint of pain/discomfort.

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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)		

2. The Director of Nursing (DON) was interviewed on at 1:00 p.m. regarding Resident #5 relating to the time period through The DON stated that the resident was discharged to the hospital during that time. Review of the medical record revealed no nursing progress notes documenting the discharge to the hospital or readmission to the facility.

In addition, further review of the record revealed no physician order to send the resident to the hospital and no transfer record from the hospital on readmission to the facility. The DON stated she had the records, but could not find them.

3. At 11:30 p.m. on the DON was asked for the medical record for Resident #8. At 12:30 p.m. the Administrator and DON was asked for the medical record for Resident #8. At 2:00 p.ml the Administrator was asked for the medical record for Resident #8.

At 4:30 p.m. the surveyor was advised, by the DON and Administrator, that the record could not be located. The surveyor exited the facility at this time.

A faxed copy of the medical record, over 400 pages, was received by the AHCA area office on ; two days after the on-site survey. Review of this fax transmission revealed records from 2011, 2012, and 2013.

There were only 12 pages (out of 400) dated with the year 2012. They included:
1 Controlled Inventory Record, 2 Medication Observation Record's (MOR) dated 2014, 2 MOR's dated 2014, 2 MOR's dated 2014, and 5 Physician orders dated through 2014.

The last nurse's progress note, documented on "Resident's Condition Log", was dated

The Administrator advised on that Resident #8 was discharged from the facility on

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on record review, observation, and interview the facility failed to ensure a safe environment by not maintaining acceptable control practices and by failing to obtain a physician order for the treatment of a resident injury.

The findings include:

1. During medication pass observation on at 10:30 a.m. Staff C, who was providing medication assistance to residents, had an wrap bandage on her lower left arm and palm/fingers of her left hand. The bandage prevented Staff C from washing or her hands after interacting with residents.

In addition, Staff C was observed to open a packet of by putting her bare right index finger inside the packet.

2. During medication pass observation on at 10:10 a.m. Staff B, who was providing medication assistance to residents, was observed pouring a glass of water for a resident and carrying the glass (to the resident) by placing two bare fingers inside the glass.

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

3. At 11:30 a.m. on the Director of Nursing (DON) was observed bringing Resident #7 into the nursing office. The DON was then observed removing a steri-strip bandage from a on the top of the resident's right hand. The was in the shape of a half moon and appeared to have a measurement of approximately one and 1/2 inches by one and 1/2 inches. The DON stated she had placed the steri-strips on the site, early this morning, after the resident sustained the

The was and the DON had the resident place her right hand over the office garbage can (containing trash) to catch the The DON started to remove the steri-strip dressing. The resident grimaced and stated "It hurts."

The DON took a bottle of normal 1/3 full, from a cabinet in the office, and poured the normal on the Observation of the bottle, at this time, revealed it was not labeled with the date and time when it was initially opened. The container's label was stained and was loose and frayed on the edges. Standard of practice requires that normal solution be dated/timed, upon opening; and subsequently used within 24 hours or discarded.

During the removal of the steri-strip dressing, the was observed to profusely and the top layer of skin lifted and moved. The resident right arm was extended and held over the garbage can, by the DON, for 20 minutes. The resident stated, "This hurts, I think my arm is broke." The resident was observed to grimace and was heard to make a soft cry. The removal of the steri-strips and application of a clean dressing took 45 minutes. During the procedure, the door to the opened by staff that entered the obtain supplies and ask the DON questions.

The DON was observed to apply and remove her gloves 5 times during treating Resident #7's hand; but failed to wash her hands, between changing her gloves on 3 occasions. Washing hands upon removing and prior to applying gloves is a standard of practice to maintain proper control.

After the treatment was completed, the DON was observed placing the garbage, used to collect Resident #7's next to the desk in the office. Standard of practice dictates that spills should be addressed immediately with clean up and containment as a part of standard precautions in all health care settings.

Upon interview on at 4:30 p.m. the DON acknowledged, with the Administrator present, that she did not contact the resident's physician to notify him regarding Resident #7's did not obtain an order for application of the steri-strips and did not obtain an order to remove the steri-strips. She also acknowledged that there were no nursing progress notes documenting the incident. The Administrator stated, "But the resident received timely and appropriate care." The surveyor advised that the removal of the steri-strips caused a large amount of from the and caused the resident to experience unnecessary pain and discomfort. The DON acknowledged that the resident was complaining of pain during the procedure.

The Administrator was also advised, at this time, regarding the unacceptable control practices observed by the surveyor.

Class II

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on record review, observation, and interview the facility failed to ensure that prescriptions for 5 (Resident #1, #2, #4, #5, and #6) out of 6 sampled residents were filled or refilled in a timely manner.

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

The findings include:

1. During observation of a medication pass on [redacted] at 9:15 a.m., for Resident #1, review of the Medication Observation Record (MOR) revealed documentation that 5 physician ordered medications, to be given once a day, were not provided to the resident because they were "Not available (in the medication cart)" on [redacted]. In addition, the MOR documented that 2 physician ordered medications, to be given twice a day and every 12 hours, were not given on [redacted] citing the foregoing reason.

Upon interview at this time, Staff A (involved with the medication pass) stated, "We always have the medications for the residents, we order when the supply gets low. Sometimes medications are not here because of a problem with payment. We can usually get medications the same day if we call the pharmacy by 9:30 a.m." Staff A could not explain to the surveyor why Resident #1 was not given their medications on [redacted].

2. During observation of a medication pass on [redacted] at 9:30 a.m. for Resident #2, review of the MOR revealed documentation that [redacted] 1.4% eye drops were self-administered by the resident. Upon questioning, Staff B stated this medication is self-administered and kept in the resident's [redacted].

Upon interview at 10:30 a.m. this date, the Director of Nursing (DON) stated that Resident #2 was alert and oriented. The resident's [redacted] observed at this time, with the resident and DON present. When asked, the resident was able to locate the eye drops. The DON picked up the bottle and handed it to the surveyor. The surveyor noted, at this time, that the bottle was empty. When asked if the bottle was empty, the resident stated, "I have not had any drops for the past several days. I wish I had them, my eyes feel better when I use them." The DON acknowledged that the bottle of eye drops was empty and stated, "I will order them."

The resident expressed that she experienced eye discomfort because she was not provided with her prescribed eye drops.

Further review of Resident #2's [redacted] 2014 MOR revealed [redacted] was ordered to be given weekly and scheduled to be taken by the resident on [redacted]. There was no documentation that this medication was provided to the resident. In addition, a [redacted] patch was ordered to be applied [redacted] every 72 hours and scheduled to be applied [redacted] and [redacted]. There was no documentation that this medication was provided to the resident.

3. On [redacted] at 10:15 a.m. Staff B was observed telling the DON that Resident #4 did not have all his medications. The resident's [redacted] 2014 MOR and medications available were reviewed at 12:30 p.m. with the DON present. The DON acknowledged, at this time, that the resident did not have [redacted] (a available, as ordered by the physician; and this medication had not been given on 9/4 and 9/7 at 5:00 p.m.

It was also noted at this time, that [redacted] Carvedidol, and [redacted] medications were not documented as given on 9/4 and 9/7 at 5:00 p.m. No documented explanation was given for these omissions.

4. On [redacted] at 3:00 p.m. the [redacted] 2014 MOR was reviewed for Resident #5. The resident was scheduled to receive [redacted] (a controlled substance/pain reliever) 15mg tab every 8 hours. There was no documentation that the resident received this medication, as ordered by the physician, on [redacted] at 10:00 p.m., [redacted] at 10:00 p.m., and on [redacted] at 6:00 a.m., 2:00 p.m. and 10:00 p.m. A nurses medication note states [redacted], 6:00 a.m. [redacted] on order not given."

Interview of the DON on [redacted] at 1:00 p.m., revealed that the Resident #5 was discharged to the hospital on [redacted]. Review of the medical record revealed no physician order to send the resident to the hospital. In

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addition, there was no documentation that the resident was sent to the hospital or returned from the hospital. The DON stated she had the records, but could not find them.

Review of the 2014 MOR revealed that the resident continued to have the same physician's order, but did not receive the medication 15 times during due to the medication "not here, on order" as documented on nurses medication notes.

The DON acknowledged that the medication was not given because it was not received from the pharmacy.

The resident was not provided with prescribed used as a comfort measure.

5. Review of the medical record for Resident #6 revealed she was admitted to the facility on and no longer resides in the facility. The facility Administrator advised the surveyor that the resident was discharged from the facility on The discharge was not documented as part of the medical record.

A physician's order dated states 500 mg po (by mouth) (three times a day) times 7 days." Further review of the medical record revealed no documented reason for the to be given and no MOR documentation that the was given. Upon interview on at 2:00 p.m., the DON stated that the MORs for this resident could not be located for the time period of (date of admission) to (date of discharge).

On (2 days after the onsite survey was completed by AHCA) a fax was received by the AHCA area office containing MORs for and 2014. The 2014 MOR was not included in the fax transmission and the 2014 MOR only included "prn" (as necessary) medications. The MOR is a double sided document, but only the front side of the documents was received.

Review of the 2014 MOR revealed that the medication (an ordered was not started until 9 a.m. on 5 days after the order was written. The order was written for 21 doses, but only 19 doses were recorded as given as of the stop date of at 5:00 p.m.

Resident #6 also had a physician order for 500mg one tab (2 times a day) x 7 days. This order was dated Review of the MOR revealed that the first dose of the medication was given at 9 a.m. on 3 days after the medication was ordered. Only 12, out of the 21 ordered doses, were recorded as given without an explanation as to why the resident did not receive the 21 doses. There was no physician's order, on record, to discontinue this

The resident experienced an unreasonable delay in the initiation of designed to relieve pain and/or discomfort related to an process.

Class II

0164-Records - Inspection Availability 58A-5.024(4) FAC
Based on record review, observation and interview, the facility failed to ensure the availability of resident's records, for AHCA survey review, for 3 (Residents #5, #6, and #8) out of 3 sampled residents.

The findings include:

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

1. Interview of the Director of Nursing (DON), on at 1:00 p.m., revealed that the Resident #5 was discharged to the hospital on Review of the medical record revealed no physician order to send the resident to the hospital. In addition, there was no documentation that the resident was sent to the hospital or returned from the hospital. The DON stated she had the records, but could not find them.

2. Review of the medical record for Resident #6 revealed she was admitted to the facility on and no longer resides in the facility. The facility Administrator advised the surveyor that the resident was discharged from the facility on The discharge was not documented as part of the medical record.

A physician's order dated states 500 mg po (by mouth) (three times a day) times 7 days." Further review of the medical record revealed no documented reason for the to be given and no MOR documentation that the was given. Upon interview on at 2:00 p.m., the Director of Nursing (DON) stated that the MOR's for this resident could not be located for the time period of (date of admission) to (date of discharge).

On (2 days after the onsite survey was completed by AHCA) a fax was received by the AHCA area office containing MORs for and 2014. The 2014 MOR was not included in the fax transmission and the 2014 MOR only included "prn" (as necessary) medications.

The MOR is a double sided document, but only the front side of the documents was received.

3. At 11:30 p.m. on the DON was asked for the medical record for Resident #8. At 12:30 p.m. the Administrator and DON were asked for the medical record for Resident #8. At 2:00 p.m. the Administrator was asked for the medical record for Resident #8.

At 4:30 p.m. the surveyor was advised, by the DON and Administrator, that the record could not be located. The surveyor exited the facility at this time.

A faxed copy of the medical record, over 400 pages, was received by the AHCA area office on two days after the on-site survey was completed. Review of this fax transmission revealed records from 2011, 2012, and 2013.

There were only 12 pages (out of 400) dated with the year 2014. They included:
1 Controlled Inventory Record dated 9 through 2014,
2 Medication Observation Record's (MOR) dated 2014,
2 MOR's dated 2014,
2 MOR's dated 2014 and
5 Physician orders dated through 2014.

The last nurses progress note, documented on the "Resident's Condition Log", was dated

The Administrator advised on that Resident #8 was discharged from the facility on The last medical record documentation, of any type, was a Medication Observation Record dated through with "self" written on it.

Class III