STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966892	**04/23/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
HANNAH'S ... ASSISTED LIVING FACILITY	**1909 NW 12TH AVE CAPE CORAL, FL 33993**	

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

0000 - Initial Comments

An unannounced Biennial survey was completed on ... at Hannah's ... Assisted Living Facility, an Assisted Living Facility (ALF) in Cape Coral, Florida.

The facility received citations as a result of this survey.

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on observation, resident record reviewed, and staff interview, the facility inappropriately admitted 1 (Resident #2) of 3 residents to the facility This resident requires total care with her Activities of Daily Living (ADLs).

The findings included:

A review of Resident #2's health assessment dated ... showed she requires total assistance with all of her ADLs, including: bathing, dressing, ... eating, toileting, ambulating, and transfers.

An interview was conducted with Staff A on ... at 11:22 a.m. She stated Resident #2 requires total care with all of her ADLs. She has not tried to see how much Resident #2 can do for herself. She does total care for all ADLs for Resident #2.

Observation on ... at 11:22 a.m. showed Resident #2 was not able to perform ambulation and transfer. Both of her hands are contracted. Staff A stated that she is not able to grasp anything.

Observation on ... at 12:50 p.m. showed Staff A feeding Resident #2. Resident #2 was not participating in this activity. Further review of Resident #2's record shows she is now receiving hospice care. However, when Resident #2 was admitted to the facility she was not able to perform any of her ADLs with assistance or supervision, which would make her an appropriate admission. Instead, she required total assistance with all ADLs on admission which makes this admission inappropriate.
Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on resident record reviewed, observation, and staff interview, the facility failed to ensure 1 (Resident #2) of 3 residents received care and services according to her health assessment.

The findings included:

A review of Resident #2's health assessment dated ... showed the physician requested she receive "restorative ... program." Further review of Resident #2's record showed there was no documentation showing she received this program.

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0025 Continued From page 1

An interview was conducted with Staff A on ... at 11:30 a.m. She reviewed the health assessment and stated she does not know anything about this program. She has not done any type of restorative ... program for Resident #2.
Observation of Resident #2's hands on ... at 11:22 a.m. showed they are both contracted closed.
Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28 FS

Based on observations, staff interview, and resident record reviewed, the facility failed to ensure the residents were able to utlize one of the exits to evacuate the building in an emergency by locking the screen door and 1 (Resident #1) of 2 residents did not have a physician's order for half side rails.

The findings included:

1. An initial tour was conducted at the facility on ... at 9:20 a.m. Observation on ... at 9:30 a.m., showed a lock on the back door screen going to the outside back yard. The lock was locked. An interview was conducted with Staff A at the time of the observation. She said there was an incident that caused the facility to lock this door. A resident cut the screen on the door and got out. She eloped from the facility and is no longer living here. The staff unlocked the lock when she was told the residents will not be able to evacuate the building in an emergency.

During an interview on ... at 3:20 p.m. the local fire inspector indicated that as a result of the message left by the surveyor on ... he visited the facility on ... spoke with Staff A, and found the same situation. He indicated that he instructed Staff A to remove the lock and all hardware from the door and that he will revisit in one week to make sure it is removed.

2. Observation on ... at 9:20 a.m. showed Resident #1 had two half side rails on her bed. One side rail on each side of her bed. A review of Resident #1's record showed an order for a hospital bed dated ... There was no order for half side rails.

An interview was conducted with Staff A on ... at 3:00 p.m. She reviewed Resident #1's record and confirmed the order showed hospital bed and no order for half side rails.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, resident record reviewed of one of three personnel records reviewed and staff interview, the facility failed to ensure 2 (Residents #2 and #5) of 2 residents were administered medications by a licensed nurse.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966892	04/23/2015
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HANNAH'S [redacted] ASSISTED LIVING FACILITY	1909 NW 12TH AVE CAPE CORAL, FL 33993	

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

0053 Continued From page 2

The findings included:

1. Observations at 1:00 p.m. on [redacted] showed Staff A giving Residents #2 and #5 their medications. She would crush their medications, put the crushed medications in a spoon full of apple sauce and spoon feed the crushed medications to Residents #2 and #5. An interview was conducted with Staff A on [redacted] at 1:35 p.m. She said she crushes these residents' pills and spoon feed the medications to the residents.

2. Observation on [redacted] at 2:15 p.m. revealed Staff A crushing a medication for Resident #5, putting the crushed medication on a spoon of apple sauce and spoon feeding it to Resident #5.

3. An interview was conducted with Staff A on [redacted] at 2:15 p.m. She indicated that gives medications to Resident #2 and #5 this way all the time. The residents can't put medications in their mouth without Staff A spoon feeding it to them. She also stated she is not a licensed nurse, she is a certified nursing assistant (CNA). A review of Staff A's personnel file shows she is a CNA and there is no nursing license.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and staff interview, the facility failed to ensure Resident #2's medication was securely stored.

The findings included:

Observation on [redacted] during the initial tour of the facility showed at 9:40 a.m. a box of medication from hospice was stored in the refrigerator.

An interview with Staff B was conducted at this time. She stated [redacted] is stored in this box for Resident #2. She also said this is the only refrigerator in the home and confirmed the [redacted] is not locked and secured.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on observation, three of three resident records reviewed, and staff interview, the facility was crushing medications with no orders from their physicians for which specific pills are to be crushed for 3 (Residents #1, #2 and #5) of 3 residents reviewed.

The findings included:

1. A review of Resident #1's record showed there is a physician order dated [redacted] It shows staff are to administer

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0056 Continued From page 3

medications crushed in yogurt or pudding.

An interview was conducted with Staff A on [redacted] at 1:00 p.m. She stated she crushes all of Resident #1's medications.

2. Observation at 1:00 p.m. on [redacted] revealed Staff A crushing Residents #2 and #5's medications, putting them in applesauce and administering them to both Residents #2 and #5.

An interview was conducted with Staff A at 1:00 p.m. on [redacted] She confirmed she crushes all of the medications for Residents #2 and #5 each time she give them their medications.

3. A review of Resident #2's physician orders showed the staff are to crush all medications and Resident #5's doctor order dated [redacted] showed "may crush appropriate medications and place in food."

4. An interview was conducted with Staff A at 1:45 p.m. on [redacted] She was asked if she knew what medications can be appropriately crushed and she stated if a pill can't be crushed the nurse will tell her and they will get the liquid form.

Class III

0092 - Food Service - General Responsibilities - 58A-5.020(1) FAC

Based on resident record reviewed, observations, and staff interview, the facility failed to ensure 2 (Resident #2 and #4) of 4 residents received their therapeutic diets as ordered by their physicians.

The findings included:

1. A review of Resident #2's health assessment dated [redacted] showed a diet order for pureed. Observation on [redacted] at 12:30 p.m. showed Resident #2 was given two slices of whole bread that was not pureed.

An interview was conducted with Staff A at 12:45 p.m. on [redacted] She confirmed Resident #2 gets pureed food and she did not puree the two slices of bread. Observation also showed Resident #2 did not eat the bread.

2. Observation at 12:40 p.m. on [redacted] showed Staff A put one scoop of thickener in Resident #4's glass of water, and Resident #2 got three scoops of thickener in her water. Staff A was interviewed at this time. She said she puts this amount in their glasses for every meal.

A review of Resident #4's Health assessment dated [redacted] showed an order for nectar thick liquids. A review of this glass of water showed the one scoop of thickener did not make the water nectar thick.

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

0092 Continued From page 4

A review of Resident #2's doctor order on ... showed pudding thick liquids. A review of her glass of water showed it was not pudding thick.

Once this was brought to Staff A's attention she put the appropriate amount of thickener in Residents #2 and #4's glasses of water to thicken them to comply with the physicians' orders.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and staff interview, the facility failed to ensure Residents #1, #2, and #5 live in a facility free from hazards by using an unsanitary pill crusher.

The findings included:

Observation at 1:00 p.m. on ... showed Staff A crushing Resident #2's ... in a pill crusher. When she was finished administering Resident #2's pills she wiped the pill crusher with a napkin and put Resident #5's ... in the pill crusher and crushed it. Further observation of the pill crusher showed there was brown substance, white powdery substance in and throughout the pill crusher and in the grooves of the twist top. There was a sticky substance on the outside of the pill crusher. At 2:15 p.m. Staff A crushed Resident #5's ... in the pill crusher without cleaning it.

An interview was conducted with Staff A at 3:00 p.m. on ... She stated she wipes the pill crusher for each use and puts the pill crusher in the dishwasher every day.
Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on one of three personnel records reviewed and staff interview, the facility failed to ensure maintain staff records which contained documentation of background screening for Staff B.

The findings included:

A review of Staff B's personnel record showed she was hired on ... The background screening on ... showed she was "eligible." Another background screening was done on ... however, the results show "Awaiting Privacy Policy." It does not show "eligible."

An interview was conducted with Staff A at 3:00 p.m. on ... She stated Staff B had an updated background screening done. When she reviewed this screening she confirmed it did not show "eligible" and showed "Awaiting Privacy Policy." She did not know what this statement means.

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0161 Continued From page 5

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on observation, three of three resident records reviewed, and resident and staff interviews, the facility failed to ensure Residents #1 and #5 had completed health assessments and Resident #2 had Power of Attorney papers since Resident #5 did not sign her contract.

The findings included:

1. A review of Resident #1's health assessment dated ... showed she needs help with taking her medications. However, there was no other box checked to let the staff know what type of assistance Resident #1 needs. There was no diet order on this health assessment for Resident #1. Observation during lunch on ... at 12:30 p.m. showed Resident #1 received a regular diet.

2. A review of Resident #2's record showed her contract was signed on ... by someone other than Resident #2. Further review of Resident #2's record showed there was no power of attorney papers indicating this person is to sign Resident #2's contract. An interview was conducted with Resident #2 at 10:10 a.m. on , however, she was not able to answer any questions appropriately.

An interview was conducted with Staff A on ... at 10:12 a.m. She stated the person who signed Resident #2's contract is her daughter. She also looked through Resident #2's record and confirmed there was no power of attorney papers indicating Resident #2's daughter is the person who should be signing her contract.

3. A review of Resident #5's health assessment dated ... showed there was no medication mode. Observation on ... at 1:30 p.m. showed Staff A administering medications to Resident #5. An interview was conducted at this time during which Staff A stated that she crushes and gives Resident #5 her medications this way every day. Resident #5 can't put medications in her mouth without Staff A spoon feeding them to her.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2015

Administrator
Hannah's Assisted Living Facility
1909 Nw 12th Ave
Cape Coral, FL 33993

Dear Administrator:

This letter reports the findings of a state licensure survey that was completed on 2015 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 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,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form

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