STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910486	R
NAME OF PROVIDER OR SUPPLIER **BARKLEY PLACE**	STREET ADDRESS, CITY, STATE, ZIP CODE **36 BARKLEY CIRCLE** **FORT MYERS, FL 33907**	

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

0000 Initial Comments

An unannounced revisit survey was conducted on at Barkley Place, an Assisted Living Facility in Fort Myers, Florida. This was a follow-up to the Relicensure survey completed on /

The following is description of the deficiency:

0056 Medication - Labeling and Orders

Based on record review, interview, and observation, the facility failed to ensure medications were refilled in a timely manner for 2 (Residents #14 and #15) of 3 residents surveyed.

The findings included:

1. Review of the physicians orders for Resident #14 showed the facility faxed to the residents physician on and / / that the resident was almost out of is a medication used for . On the physician responded to the faxes writing, "Will send . (Prescription) via mail."

Review of Resident #14's Medication Observation Record (MOR) showed starting on Resident #14 stopped receiving due to the medication being unavailable. The record showed this continued until . The record showed the facility failed to have his prescription for filled for a total of 10 days. There was no documentation of any action by Facility staff to obtain the resident's medication during those 10 days.

During an observation at 1:00 p.m. on / of Resident #14's medication card showed 30 pills of remaining on the card. One pill was removed from the card. The prescription card shows the medication was delivered on and he received one dose from the card on .

During an interview with Resident #14 at 1:20 p.m. on he was asked about the he was taking. He said it does not work for me. The dosage needs to be increased. I'm up all night, every two hours. The resident was not aware that he had not received the medication from / to . He said I slept better last night.

Review of the corrective action plan by the facility for previous deficient practice showed auditing reports will be done daily by the Health Service Director and the Administrator and any issues with delay in medications will be communicated to the doctor and documented in the progress notes within 8 hours. The binder was to be reviewed and signed off daily by both Health Service Director and the

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Administrator.

Review of the binder showed one date audited on / . There was no documentation in the book that the Health Service Director or the Administrator signed that they had audited the medications daily.

During an interview with the Health Service Director at 1:30 p.m. on she verified the medication should have been audited and the physician should have been contacted to obtain the medication. She was not able to explain why the corrective action had not been followed.

During an interview with the Administrator at 1:40 p.m. on / she said she had been on leave. She was not able to explain why the corrective action plan had not been followed. She verified the medication should have been obtained in a timelier manner.

2. Review of Resident #15's medical record showed she had been re-admitted to the Facility on . Review of the resident's medication orders showed she was ordered , Thera-M tablet and D3 on admission.

Review of resident #14's MOR showed she did not received theses supplements until .

During an interview with Staff O, LPN at 12:40 p.m. on she verified the resident had not received these medications when she was admitted to the Facility. Staff O said she had faxed the pharmacy on and let them know she did not have the resident's supplements. On / she had not received the supplements. She did not come back to work until . She verified she had not re-faxed the Pharmacy on .

During an interview with the Health Service Director at 1:30 p.m. she verified Resident #15's supplements should have been obtained in a timelier manner or contacts with the physician and pharmacy should have been documented.

Class III

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11910486	A. Building B. Wing	12/30/2015

Name of Facility	Street Address, City, State, Zip Code
BARKLEY PLACE	36 BARKLEY CIRCLE FORT MYERS, FL 33907

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix A0053 Reg. # 58A-5.0185(4) FAC LSC	Correction Completed	ID Prefix A0054 Reg. # 58A-5.0185(5) FAC LSC	Correction Completed	ID Prefix A0081 Reg. # 58A-5.0191(2) FAC LSC	Correction Completed
ID Prefix A0092 Reg. # 58A-5.020(1) FAC LSC	Correction Completed	ID Prefix A0093 Reg. # 58A-5.020(2) FAC LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By**	**Date:** 12-31-15	**Signature of Surveyor:**	LARRY TAYLOR, RNS	**Date:** 12-31-15
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**		**Date:**

Followup to Survey Completed on: / /

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[illegible], 2015

Administrator
Barkley Place
36 Barkley Circle
Fort Myers, FL 33907

Dear Administrator:

This letter reports the findings of a State Licensure Revisit Survey conducted on 30, 2015 by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

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 and Revisit Report

YOSF

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