STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942925	07/27/2016
NAME OF PROVIDER OR SUPPLIER **HIDDEN OAKS OF FORT MYERS**	STREET ADDRESS, CITY, STATE, ZIP CODE **3625 HIDDEN TREE LANE** **FORT MYERS, FL 33901**	

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

0000 Initial Comments

An unannounced complaint survey for complaints CCR #2016006363, CCR #2016006919, and CCR #2016008058 was conducted on through at Hidden Oaks of Fort Myers, an assisted living facility (license #5531) in Fort Myers, Florida.

Complaint CCR #2016006363 contained 2 allegations of which 1 was substantiated with citation.
Complaint CCR #2016006919 contained 3 allegations which were substantiated, 1 with citation.
Complaint CCR #2016008058 contained 1 allegations which was substantiated with citation.

A Class II deficiency was identified at A056.

Physical Plant was also cited as part of this complaint investigation; refer to A152 in survey report 0FP716.

The following is a description of the deficiencies.

0007 Admissions - Criteria

Based on record review and interview, the facility failed to ensure 1 (Resident #5) of 2 residents met criteria for admission to an Assisted Living Facility.

The findings included:

Resident #5 moved into the facility on . AHCA Health Assessment form 1823 for Resident #5 dated / indicated Resident #5 needed medication administration. There was no documentation in the file that indicated the facility contacted the provider to clarify this.

On at 11:10 a.m., the Executive Director said they do not do medication administration. They have med techs; they don't administer medications. She said the 1823 should not have said that.

Class III

0025 Resident Care - Supervision

Based on a review of residents for care related to , the facility failed to ensure there were precautions and interventions in place for Residents #15, #29, and #39. The facility failed to provide documentation about changes in the resident's condition for Residents #3, #5,

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#15, #29, and #39.

The findings included:

1. Resident #29 was observed in the hallway at 11:00 a.m. on . . / . . The resident had an obvious scrape on the knees. When questioned, the resident indicated he had . . . . . A review of the resident record revealed there was no evidence in the progress notes of any . . for this resident.

On . . . / . , an interview was conducted with Staff A. She said none of the residents were at risk for . . . . . She further said she was unaware Resident #29 had . . . . . On . . . . at 11:25 a.m., Staff C said she was aware of Resident #29's . . . . and had gotten the nurse for him. On . . . . at 11:30 a.m. the Director of Nurse (DON) said she has been in the facility only a month. She said the facility does not have a . . . prevention program. She said she was unaware of resident 29's . . . . She said she has noted the facility have a lot of residents who . .

A review of Resident #29's record revealed the most current AHCA Health assessment dated . / . identified the resident has a . . . risk. This resident . . . on . . . . / . . On . . . . . , at 12:40 p.m., the Administrator said the . . . . prevention program was to check on the resident every 2 hours. If the resident was less "acute" they would check the resident at meal times 2 times a day.

2. Resident #15, had accident incident reports dated . . . . , . . / . . , and . . . . . all related to the resident falling. The resident was sent to the hospital on . . . . . and . . . . / . . . . None of the incidents or interventions were documented in the resident record.

On . . . . . at 4:30 p.m., Staff D and E were interviewed related to this resident. They indicated the facility has no . . . prevention program and they did not do anything special to prevent . . . for this resident. They further said the resident had a 1/2 side rail to prevent . . . . . They agreed they did do every 2 hour checks on the resident.

3. A review of Resident #39's record, revealed there was no documentation of any . . . . A review of the AHCA Health Assessment dated . . . . . (most current) documented the resident as a " . . . . risk." Review of incident reports documented the resident as falling on . . . . . and on . . / . . . . . There were no interventions noted for this resident.

4. Resident #5 was sent to the hospital on . . . . . There was no documentation in the record showing when the resident went to the hospital or when the resident returned from the hospital.

5. Resident #3 went to the hospital on . . . . . The resident returned the same day from the hospital,

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however, there was no documentation about the return from the hospital in the record.

Class III

0027 Resident Care - Arrangement for Health Care

Based on record review and staff interview, the facility failed to provide care and services to meet the needs for 1 (Resident #3) of 40 sampled residents. The facility failed to give 3 (Resident #1, #3, and #40) out of 40 sampled residents a choice of home health agencies.

The findings included:

On / at 9:45 a.m. record review revealed Resident #3 was sent to the emergency / because of increased difficulty getting out of bed. While at the emergency , a spinal computed tomography (CT) noted (an uncommon lung , most often secondary to an process. If not treated, airways may become filled with mucus and make it difficult to breath.) The resident returned from the emergency with discharge instructions suggesting a follow up of the chest be completed. There was no documented evidence found in the record to indicate any follow up occurred or was scheduled to occur.

On at 10:13 a.m., during an interview with the Director of Nursing (DON), she confirmed the discharge (DC) instructions had not been followed up on and said, "I know I put the DC instructions in the doctor's binder and he did not order her one." She added, "There is no signature that he even looked at it. I will call the Nurse Practitioner and get an order for a of the chest." Call placed to the Nurse Practitioner at 10:48 a.m.by the DON.

On at 4:15 p.m., the DON said she had received an order from the nurse practitioner to obtain a of the chest and for the nurse practitioner to "See resident and review results."

2. Residents #1, #3 and #40 were interviewed about choosing a home health agency. Resident #1 indicated she choose the agency that has staff present in the facility. Resident #3 was unaware she was receiving home health care. Resident #40 indicated she did not choose the agency that is current providing care to her.

On at 11:30 a.m., the DON said when home health services are offered she does not offer a choice of agencies to the residents. She just uses the agency which has a space in the facility.

Class III

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0054 Medication - Records

Based on record review and staff interview, the facility failed to update the Medication Observation Record (MOR) each time the medication was offered or administered for 9 (Residents #5, #16, #24, #26, #30, #31, #32, #33, and #35) of 9 resident MORs reviewed.

The findings included:

On , a review of 9 resident MORs revealed the following:

1. On / , there were no initials or explanation on the back of Resident #16's MOR for the 8:00 p.m. doses of , , and Guafenesin ER.

2. On , there were no initials or explanation on the back of Resident #24's MOR for the 8:00 a.m. dose of , .

3. On / , there were no initials or explanation on the back of Resident #24's MOR for the 8:00 a.m. doses of , , , Oyster Shell , and D3.

On , there were no initials or explanation on the back of Resident #24's MOR for the 8:00 a.m. dose of , , , Oyster Shell , D3, , , , and . On , there were no initials or explanation on the back of Resident #24's MOR for the 8:00 p.m. dose of Oyster Shell .

On / , there were no initials or explanation on the back of Resident #24's MOR for the 8:00 a.m. dose of , , , Oyster Shell , D3, , , and .

On , there were no initials or explanation on the back of Resident #24's MOR for the 8:00 a.m. dose of , , , Oyster Shell , and D3.

On , there were no initials or explanation on the back of Resident #24's MOR for the 8:00 p.m. dose of Oyster Shell .

4. On / , there were no initials or explanation on the back of Resident #26's MOR for the 8:00 a.m. dose of , , , Ensure, and .

5. On / , / , / , / , , and / , there were no initials or explanation on

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the back of Resident #30's MOR for the 8:00 a.m. dose of Paste.

On / , there were no initials or explanation on the back of Resident #30's MOR for the 8:00 a.m. dose of .

6. On , there were no initials or explanation on the back of Resident #31's MOR for the 8:00 a.m. dose of and .

On , there were no initials or explanation on the back of Resident #31's MOR for the 8:00 a.m. dose of Ensure and .

On , there were no initials or explanation on the back of Resident #31's MOR for the 8:00 a.m. dose of .

On / , there were no initials or explanation on the back of Resident #31's MOR for the 8:00 p.m. dose of .

On , there were no initials or explanation on the back of Resident #31's MOR for the 8:00 a.m. dose of Ensure, , Pantroprazole, and .

7. On , there were no initials or explanation on the back of Resident #32's MOR for the 8:00 a.m. dose of Floranex, , , , , and .

On , there were no initials or explanation on the back of Resident #32's MOR for the 8:00 a.m. dose of , , , , and .

On / / , there were no initials or explanation on the back of Resident #32's MOR for the 8:00 p.m. dose of Floranex, , , , , and .

On , there were no initials or explanation on the back of Resident #32's MOR for the 8:00 a.m. dose of .

8. On , there were no initials or explanation on the back of Resident #33's MOR for the 8:00 a.m. dose of and . On , there were no initials or explanation on the back of Resident #33's MOR for the 8:00 a.m. dose of , , , , and .

On , there were no initials or explanation on the back of Resident #33's MOR for the 8:00 p.m.

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dose of Invega.

On , there were no initials or explanation on the back of Resident #33's MOR for the 8:00 a.m. dose of , , , , , , and .

9. On / , there were no initials or explanation on the back of Resident #35's MOR for the 8:00 a.m. dose of , , and .

10. In an interview on at 3:25 p.m., the Executive Director stated that the staff needed more training.

11. Review of closed file for Resident #5 revealed progress notes dated , , stating Resident 5 refused medications. Telephone status reports to doctor, dated , , and / / all reported Resident #5 was refusing to take medications.

Review of the MOR for the months of and revealed all medications signed for as given every day with no documentation of any refusals.

Resident #5's file also revealed a MOR that had been documented on as medications given for dates of 4-17. The MOR had Resident #5's name and 6 medications handwritten on it but there was no notation of what month/year this MOR represented, it did not list or the name and phone number of resident's health care provider.

On at 10:56 a.m., the Executive director said med techs had not been documenting refusals on the MOR. She also said she was unaware of the MOR that had no month indicated.

Class III

0055 Medication - Storage and Disposal

Based on observation and interview, the facility failed to ensure all medications residents were currently taking were not expired.

The findings included:

Medication Cart 1 was observed on at 1:30 p.m. Inside the cart was a bottle of milk of magnesia which had expired of 2016.

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On the Hope Care Cart, there was a bottle of (a medication for chest pain caused by) which had expired on /

Both bottles were active in the carts and identified as being residents' supplies.

On at 1:35 p.m., the medication tech staff A said she was unaware that the medications were expired.

Class III

0056 Medication - Labeling and Orders

Based on record review and interview, the facility failed to ensure physician ordered medication for 3 (Resident #3, #6, and #12) of 3 sampled residents were refilled in a timely manner. Resident #6 received no pain medication for 4 days despite reportedly having a pain level of 10 (on 0-10 scale) and complaining to facility staff daily. Resident #3 did not receive her prescribed medication used to prevent / for 3 days and was sent to a local hospital emergency to worsening tremors. Resident #12 received no pain medication for 6 days because the prescription for the medication was not filled.

The findings included:

1. On at 10:15 a.m., during an interview with Resident #6 when asked if the facility had ever run out of medications for him, he said, "Yes they lost the script for my pain meds 3 weeks ago. Out of pain meds for 5 days. I complained every day to the nurse. "Pain was about a 10 out of 10 every day in my hip." On / at 12:04 p.m. he said "It was the . They ran out and did not have a script."

On at 12:08 p.m., record review of Resident #6 revealed he has a diagnosis of right hip pain and was being seen by pain management . He had been receiving (extended-release) 20 mg by mouth twice a day for pain relief until being hospitalized recently. Upon return from the hospital on , the had been discontinued. There was an order for 5 mg every four hours as needed for pain with an accompanying prescription. The prescription was filled and the facility administered the as needed until the prescription ran out early on . There was no evidence that any attempt was made to reorder the prior to the prescription running out or to obtain a new prescription for the . From 2:00 a.m. on / until 8:20 p.m. on / , the resident received no pain medication despite reportedly having a pain level of 10 out of 10 and complaining to facility staff daily.

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Further review revealed an order for 5 mg by mouth every 4 hours as needed for pain dated , signed by the resident's facility physician.

On at 12:16 p.m. in an interview with the Director of Nursing (DON) she said, "I think I first found out he had no pain meds when the patient told me." She then said, "I called Dr. [pain , '] office twice to tell me what he should be taking and that he was out of pain meds. On a nurse from his office called and told us they had a prescription for , but we needed to come and pick it up. In the mean time I called Dr. [primary care] and he arranged for a prescription for 5 mg, to cover him long enough until he saw the pain ."

On at 2:45 p.m., the DON confirmed Resident #6 did not receive pain medication from to / .

2. On / at 10:44 a.m., record review of Resident #3 revealed that, on / / , an employee from a home health agency notified the facility that "Resident stated she had difficulty getting OOB [out of bed] this morning, attributed it being from resident not getting her [a medication used to prevent /]." A call was placed to the facility nurse practitioner, 9-1-1 was called, and the resident was sent out via for evaluation.

On / at 11:00 a.m., record review from the local hospital Emergency Resident#3 was seen on / . The record stated the resident presents "with worsening of tremors. She apparently has [history] of tremors and , but tremors have been worse the past few days. has not had a , but reports being off of her for at least a couple of days." The record further indicated the Resident received and "her tremor has improved."

On at 11:16 a.m., record review of the signatures for medications administered on the Medication Observation Record (MOR) for Resident #3 revealed signatures circled on and for 500 mg. 2 tablets by mouth twice daily. On the back of the MOR, there were notations for , , / , and / indicating (generic name for) was "In order." When a signature is circled on a MOR, it generally means a medication was not administered and an explanation as to why it was not administered is entered on the back of the MOR.

On at approximately 11:20 a.m., in an interview with Staff A, med tech, she confirmed the circled signatures were entered by her and said, "I think the 10th was the last pill and I ordered it but it hadn't come in but I think they had to get a hard copy for it. I think I forgot to circle it on the 11th."

On / at approximately 12:30 p.m., in an interview with the DON, she said she first became aware the had not been administered when the employee from the home health agency informed her

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on . She said one of the med techs had "Inadvertently sent a card of back to the pharmacy" and that she contacted the pharmacy and a new card of was delivered to the facility the same day (/). She confirmed the had not been given to Resident #3 but thought she had only missed the for one day.

3. On at 11:05 a.m. Resident #12 said the facility has run out of her medications in the past.

Resident #12's chart revealed a Nurse Practitioner progress note dated "Patient has chronic pain that has been present since her . She is on 50 [a pain reliever] which she did not have for 6 days due to medication needing refill."

Review of Resident #12's, MOR for 2016 showed patch with circles around dates for 16 and 19 (medication was ordered every 3 days). There was no explanation on the back of the MOR for the circles nor are there any progress notes in the file for these dates.

On at 2:30 p.m., the Executive Director said the prescription must not have been filled by pain management, she hadn't been aware of it and will look into it.

4. On / at 2:45 p.m. when asked about the procedure for reordering of medication the DON said, "The procedure for reordering pain meds is to have the med. techs call the pharmacy to see if there are refills left at least a week before the prescription is due to run out but there was really no procedure in place up until 2 weeks ago."

Class II

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

Dear Administrator:

This letter reports the findings of a survey for complaint CCR# 2016006919, CCR# 2016006363, and CCR# 2016008058 completed on , by representatives 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).

The inspection resulted in findings of non-compliance in the following area

St - A - 0007 - 429.26(11) Fs; 58a-5.0181(1) Fac - Admissions - Criteria, Class III
St - A - 0025 - 429.26(7) Fs; 58a-5.0182(1) Fac - Resident Care - Supervision, Class III
St - A - 0027 - 58a-5.0182(3) Fac - Resident Care - Arrangement For Health Care, Class III
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records, Class III
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal, Class III
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders, Class II

Directed Corrective Actions:

The Assisted Living Facility is required to employ a Licensed Consultant Pharmacist other than the pharmacist currently consulting for the facility to review the facility's medication policies and practices (Florida Statutes 429.42(1)). The initial onsite Consultant Pharmacist visit must take place within 14 days of the facility receiving this directed plan of correction.

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.

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

Hidden Oaks Of Fort Myers
[illegible], 2016

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

Jon Seehawer, Field Office Manager

Agency for Health Care Administration

Health Quality Assurance

2295 Victoria Avenue, [illegible] #[illegible]

Fort Myers, Florida 33901

The facility will follow all recommendations of the Consultant Pharmacist.

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

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 contact . Laura Manville, Survey and Certification Support Branch, at (727) 552-1955 Jon Seehawer, R.N., Field Office 08, (239) 335-1315

Sincerely,

Jon Seehawer, R.N.
Field Office Manager

SH

D7JR