STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942925	05/11/2017
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 monitoring visit was conducted on through at Hidden Oaks of Fort Myers, an assisted living facility (license #5531) in Fort Myers, Florida.

The following is description of deficiency.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observations and staff and resident interviews, the facility failed to ensure residents a safe and decent environment and failed to treat them with dignity and respect by neglecting to minimally clean human waste from resident areas for 13 (#21, #25, #26, #27, #28, #29, #32, #33, #34, #35, #36, #37, and #38) of 90 residents. In addition, the facility was not free of accident hazards by having bed rails with gaps wide enough for an elderly debilitated resident to become potentially entrapped and injured for 9 (#9, #14, #21, #23, #24, #30, #31, #32, and #33) of 90 residents; and by storing unsecured tanks in 1 of 57 resident . tanks contain compressed gas which is a combustible material and are to be secured in metal carts/sleeves to avoid being bumped or damaged. The facility also failed to respond to resident requests for assistance resulting in 1 (#21) resident lying on the floor for over 2 hours trapped between his wheelchair and bed, then being sent out to the emergency evaluation.

The findings included:

1. On during a tour of the facility, the following were identified as having poor sanitation and contaminated with dried feces;
On the Memory Care unit:
Resident #25 and #26's dried feces on the wall;
Resident #27 and #28's had dried feces on the wall and floor outside of the ;
Resident #29's dried feces on the toilet seat of a portable commode being stored in the resident's closet with clothes hanging above it;
Resident #32 and #33's dried feces on the bureau;
On the Phase 1 and II unit:
Resident #34 and #35's dried feces on floor in the , extending out out into the ;
Resident # 36 and #37's dried feces on the floor and inside of the commode insert on the toilet;
Resident #21 and #38's feces all over the , including the shower floor, commode, across the floor into the trash can in the , and on the bed linens. On at 9:40 a.m. Laundry Worker Staff F said Resident #21 told her at 7:00 a.m. his a mess. Staff F said she

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does not usually work in housekeeping but is going to clean his .

2. On during a tour of the facility, the following resident beds were observed to have unsecured rails with spaces exceeding 4 and 3/4 inches which can potentially cause entrapment of resident heads and/or limbs;
On the Memory Care Unit;
Resident #30, #31, #32, and #33's beds had an unsecured side rails with a large gap;
On the Phase I and II Units;
Resident #9, #14, #24, #23, and #21's beds had an unsecured side rails with a large gap.

On at 11:19 a.m., Resident #9 said she had been at the facility for about 10 months and staff had given her the side rail to help her get into bed. The resident said she needed quite a bit of assistance from staff.

On at 2:34 p.m., Maintenance Director Staff B, said the side rails with the gaps have been in the building, are available in storage, and staff have access. Staff B said he had not been inspecting any equipment coming into the building but does now. Staff B said he is not aware of anyone getting injured from side rails that he is aware of and has been here for 3 years. The facility's Director of Nursing Staff A, who was present during the interview said she has been here for several months and has not identified any issues with bed rails as being potential entrapment zones. Staff A said she tries to get an order for them when present and can see now where they would be considered a hazard.

3. On at 9:48 a.m., 6 small tanks of were observed stored behind the door of resident . Five of the tanks were in a cardboard box and 1 tank was setting on the floor next to the box. The tanks were not secured in metal carts/sleeves to avoid being bumped or damaged.

4. On at 9:24 a.m., Resident #1 said she wears a call bell pendant around her neck. The resident said staff are busy at night and seems like a long time before they come. She said there are only 2 staff on the floor and will say they are sorry but were busy.

On at 9:30 a.m., Resident #2 said she does not ring her call bell very often but is aware of others who have had to wait for over an hour to get assisted off the toilet. She said one of them is her and the other is Resident #21.

On at 11:19 a.m., Resident #9 said she required staff assistance to go to the . The resident said she wears a call bell pendant and the other night pushed her call button for staff to come help her. Resident #9 said no one ever came to assist her to the .

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On at 9:15 a.m., Resident #21 said the night before last he was trying to get in bed around 7:00 p.m. and lost his balance. The resident said he got his ankles stuck under the bed. I called on my medallion several times; I kept paging and no one came. My bottom was on the floor and my back was rammed against the chair. I my knee and couldn't move. Resident #21 said he stayed like that for about 90 minutes. When the next shift came, said they knew I had been paging for help. Staff M and Staff N came in and they couldn't lift me so they called 911.

Class II

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

Based on observation and interviews, the facility was not maintained in a clean and sanitary manner to prevent potential oral/fecal borne illness by allowing 13 (Residents #21, #25, #26, #27, #28, #29, #32, #33, #34, #35, #36, #37, and #38) of 90 resident's and , to be soiled with dried feces. Feces on floors and walls create unsanitary living conditions and potential for fecal borne illness if ingested by improper hand washing. If exposed to feces in the environment from improper sanitation; common are , and E ; and (a serious bowel). In addition, the facility was not free of accident hazards by having bed rails with gaps wide enough for an elderly debilitated resident to become potentially entrapped and injured for 9 (Residents #9, #14, #21, #23, #24, #30, #31, #32, and #33) of 90 residents; and by storing unsecured tanks in 1 of 57 resident tanks contain compressed gas which is a combustible material and are to be secured in metal carts/sleeves to avoid being bumped or damaged.

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