STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965334	**11/16/2017**
NAME OF PROVIDER OR SUPPLIER **ARDEN COURTS OF WINTER SPRINGS**	STREET ADDRESS, CITY, STATE, ZIP CODE **1057 WILLA SPRINGS DRIVE** **WINTER SPRINGS, FL 32708**	

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

0000 - Initial Comments

A re-Licensure survey was conducted on . Arden Court of Winter Springs Assisted Living with Limited Nursing Services (LNS) License #9733 had deficiencies at the time of the visit.

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

Based on record reviews and interview, the facility admitted 1 of 6 sampled residents (#10) who exceeded the admission criteria.

Findings:

Record review for resident #10 revealed she was admitted to the facility on . Her admission health assessment form 1823 that was dated on indicated that she required total assistance with her Activities of Daily Living (ADLs,) which exceeded the minimum admission criteria.

On at 3:25 pm, the nursing director confirmed the findings and said the documentation on the form was wrong. However, the record for resident #10 contained no documented evidence to indicate the facility obtained corrected information from a health care provider.

Class III

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record reviews and interview, the facility failed to ensure the health assessment form 1823 was complete for 1 of 6 sampled residents (#10).

Findings:

Record review for resident #10 revealed a health assessment form 1823 that was undated and that did not contain the address and phone number of the examiner, as required.

On at 3:25 pm, the nursing director confirmed the finding and said the form was completed when resident #10 was in the hospital during 2016.

Class III

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on resident record review and interview, the facility failed to ensure that 1 of 6 sampled residents

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(#14) had an updated AHCA Form 1823 Health Assessment completed by the healthcare provider after a significant change occurred as required; and retained a resident (#11) that exceeded the continued residency in an Assisted Living Facility.

Findings:

Resident #14's record review revealed admission unto Hospice care on (significant change) and had no documented 1823 Health Assessment completed by a healthcare provider of the significant change.

On at 5:30 PM, an interview with the Administrator and the Resident Service Coordinator/Registered Nurse confirmed the findings.

Record review for resident #11 revealed he was admitted to the facility on .

On , the resident was sent to the hospital and he returned to the facility on .

A health assessment form 1823 dated on indicated that he required total assistance with bathing and dressing, both of which exceeded the criteria for continued residency in the facility.

On at 3:30 pm, the nursing director confirmed the findings. She said the hospital completed the form and the information was wrong. However, the record for resident #11 did not contain documented evidence to indicate the correct information was obtained from a health care provider.

Class III

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

Based on observations, record reviews, and interviews, the facility failed to provide care and services appropriate to the needs of a resident (#11) whose was not draining, failed to perform quality controls for a resident (#15) who received glucose testing, and failed to follow an order from a healthcare provider for 1 of 6 sampled residents (#10).

Findings:

1. On at 9:15 am, the nursing director identified resident #11 and said he received a Limited Nursing Service (LNS) for an indwelling . In addition, she said the facility staffed licensed

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nurses 24 hours a day and 7 days a week.

Record review for resident #11 revealed he was admitted to the facility on . He had diagnoses of , and history of , and Chronic with an indwelling .

An order from a health care provider dated on indicated he was to be admitted to LNS for a .

A nurse's note dated on at 7am-4pm indicated that right before lunch an aide reported that his drain bag had no in it and the aide had not emptied the bag. The resident stated it started at 4am and he felt as if he had to go but he could not. The nurse tried to manually move his around but was unsuccessful. His abdomen was distended. A call was made two times to a home health agency and a call was placed to his Urologist.

The record did not contain documentation to indicate whether the nurse spoke with his Urologist for guidance.

On at 2:30 pm, the aide noticed that his bed and clothes were wet with . He said he felt better and there remained no in his drain bag.

On at 5 pm, a home health skilled nurse's note indicated that when the new was inserted, a large amount of was drained.

A review of the resident agreement for resident #11 that was dated on indicated that he would receive care and maintenance under the facility's LNS nursing services.

On at 5:45 pm, the nursing director was questioned further as to why a facility nurse did not change his instead of waiting for a home health nurse to arrive. She said because the facility had no supplies for the resident and because the facility's corporate nurse told her that the nurses were not allowed to change .

2. Observations made during testing of the glucose for resident #15 on at 11:50 am revealed the nurse washed her hands. She unlocked the medication cart, removed the supplies from the cart, and then locked the cart. She assisted the resident to a common bath/shower closed the door. She told the resident she was going to check his sugar. She donned gloves, inserted a test strip into the glucose testing machine, prepped his right 4th finger with , wiped the finger

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with a cotton ball, used a lancet to stick his finger, applied a sample to the test strip, then she placed a cotton ball on his finger. The result of the test was 156. The nurse placed the lancet into a sharps container then removed her gloves. She documented the result on the Medication Administration Record (MAR.)

Review of the label on the vial of testing strips revealed it contained the following information:

1- 23-53 milligrams per deciliter (mg/dl)

2- 98-132 mg/dl

3- 267-361 mg/dl

Which was indicative that quality control testing was to be performed.

When questioned further, the nurse said control testing was not performed and the original box that would have contained the manufacturer instructions was thrown away.

On at 12:15 pm, the nursing director said quality control testing was performed but the results were not documented.

Review of the operating manual for the brand of testing machine and strips used by the resident revealed the manufacturer recommended that quality control testing with three levels of solution be performed occasionally as the vial of strips was used and when a new vial of strips was opened, to ensure accurate and reliable results were obtained. (trividiahealth.com.)

3. Record review for resident #10 revealed she had a diagnosis of and she required assistance with self-administration of her medications.

A health care provider order dated on indicated she was to be given (HCTZ) 12.5 mg daily.

A health care provider order dated on indicated that her HCTZ dose was to be increased to 25 mg daily.

Review of the 2016 MAR for resident #10 revealed that from through she was given HCTZ 12.5 mg and HCTZ 25 mg daily.

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The record for resident #10 did not contain an order from a health care provider to indicate she was to be given both doses at the same time on those dates.

On at 4 pm, the nursing director confirmed the findings and was unable to provide an explanation.

Class III

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

Based on resident record review and interview, the facility failed to make every reasonable effort ensuring that medication prescription was refilled in a timely manner for 1 of 6 sampled residents (#14).

Findings:

Resident #14's record review revealed that on that medication , 160-4.5 mg (inhaler) was not given to the resident because the facility did not have any more of the medication in stock.

On at 4:30 PM, an interview with resident #14's spouse stated that she requested to give resident #14 his , inhaler on from the Resident Service Coordinator/Registered Nurse because her husband (#14) was having a hard time breathing. Furthermore, the spouse stated that the Resident Service Coordinator/Registered Nurse checked the medication cart and told her that there was no more , inhaler in stock on the medication cart and that the facility would need to call pharmacy to refill the medication.

The , inhaler medication was not refilled until on (one month later).

On at 5 PM, an interview with the Administrator who confirmed the finding. She stated resident #14's spouse spoke to her briefly about the medication incident verbally.

On at 5:30 PM, an interview with the Resident Service Coordinator/Registered Nurse confirmed the finding that the , inhaler was not refilled on time and that resident #14 went one month without his medication.

Class III