STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969002	**01/04/2018**
NAME OF PROVIDER OR SUPPLIER **THE ROSE GARDEN OF FT MYERS**	STREET ADDRESS, CITY, STATE, ZIP CODE **2117 EARL RD** **FORT MYERS, FL 33901**	

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

0000 - Initial Comments

An unannounced complaint survey for CCR# 2017012442 was conducted through at The Rose Garden of Ft Myers, an assisted living facility (license number #12814) in Fort Myers, Florida.

The complaint contained 1 allegation which was substantiated with deficiencies.

The followiing deficiencies were cited.

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

Based on record review and interview, the facility failed to provide the care and supervision for 2 (Resident #10 and #12) of 12 residents sampled. The facility failed to observe residents' general health daily. They failed to contact residents' physicians concerning a change in the residents' health and well-being. The facility failed to document the provision of care and services and the interventions to identified concerns. This has the potential for residents who have changes in conditions to suffer harmful decline.

The findings included:

1. Record review for Resident #12 showed he was admitted to the facility on . The resident has a , , (inserted through a small hole in the abdomen to drain from the). If functioning properly, it allows for , voiding.

Resident #12's record showed physician's order for pushing fluids dated . Each home health visit note following that order instructs the facility staff to increase fluid intake. The resident's record had no documentation that the facility implemented interventions to increase fluid intake.

During an interview on at 3:30 p.m., the Administrator said the facility did not implement additional interventions to encourage Resident #12's fluid intake, which would reduce the possibility of , .

The Resident Condition Log dated noted Resident #12 received an order for . It did not say the reason the resident was prescribed .

On the resident was sent to the hospital emergency "acute , and acute , retention."

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The Resident Condition Log also documented that on Resident #12 was prescribed the , for 5 days. It did not document the reason for the medication. It did not include any documentation of sending the resident to the emergency .
During a record review, documents from showed the resident's daughter called related to the emergency . The record said the resident was sent to the hospital due to severe abdomen pain.

The resident was started on the , ordered for 7 days by the hospital on . The resident would be on this through .

The Medication Observation Record (MOR) for , , 2017 documented that , was given in the evening on and in the morning on . The resident's record did not have a discontinuation order for the , . There was a physician order on to give , every 6 hours for 5 days. However, there was a physician order on the following day ( ) to discontinue the , . The MOR noted the , was to be given for 5 days. It was given at 8:00 p.m. on and ended on , which was 4 days. Neither the instructions on the MOR nor the order to discontinue was not followed. There was no resident observation record documenting the changes in medications.

A home care note dated said the , for Resident #12 was changed for .
There was no resident observation log note addressing any concerns about the resident having 5 days after returning from the emergency . There was no documentation of the physician being contacted.

A home care note dated said Resident #12 had dark amber (possible indication of , or). Under "Intervention" it noted " analysis collection? pending order." There was no resident observation log note documenting the physician was contacted related to the dark amber .

During an interview on at 12:45 p.m., Nurse Staff D said that the facility did not contact Resident #12's physician related to the home health care note dated . Staff D said that the facility did not document the resident's health care issue related to the dark amber .

The resident's record included an order dated for a analysis (UA) to be completed. The order did not call for home health care to take the specimen. The resident observation record dated noted the order received and noted "awaiting collection of sample at this time."

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On , a Medicine Progress Note was completed by the Advance Registered Nurse Practitioner (ARNP). The note reported the home health care nurse stated is cloudy with a foul smell and relates a with no injury. The ARNP ordered a 1 day treatment.
The resident observation log dated noted the UA was received and faxed to the ARNP. It was noted as waiting for response 3 hours later, the note stated UA result was inaccurate due to collection from bag (the specimen must be taken from the tube, not the bag). A new order was written for home health to collect the UA.

A home health visit note dated signed by a registered nurse said she attempted to obtain specimen but was unsuccessful and will change leg bag tomorrow and obtain specimen. There was no documentation that the physician was contacted regarding the nurse's inability to obtain a specimen.

During an interview on at 12:45 p.m., Nurse Staff D said that when the home health RN came in on , she was unable to draw a specimen from the flow of the from the .
There was no documentation in the resident's record that the physician was notified that a specimen was unable to be obtained. She said this could be from a blocked .

Nurse Staff D said she contacted the resident's physician on for a UA lab. She said there is no documentation of why the UA was being requested. She said the order was not for a home health agency to take the specimen. There was no documentation that a home health nurse took the specimen. There was no documentation that the specimen was inappropriately taken from the resident's bag. She said the specimen inappropriately taken was submitted to the lab. The result was received on , this was 9 days after the first documentation showing an indication of the , . The results of the labs were faxed to the ARNP at 2:30 p.m. on . Nurse Staff D documented that she was waiting the ARNP's response. At 6:00 p.m., Staff D documented that the lab results were inappropriate due to being taken from the , bag. A new order was received for home health to take a specimen and a new lab to be obtained as soon as possible.

A home health visit note dated said the UA was collected. It did not say if the leg bag had been changed.

Resident #12's observation log dated noted the resident was observed with coming out his mouth. He was complaining about severe pain in the abdomen. The resident was transferred to the emergency . The record did not say if the resident's physician was notified.

The hospital record dated noted the clinical impression as , , , ,

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that was associated with a , and acute insufficiency. The admission diagnosis was for a .

2. Record review of Residents #12's weight on showed the resident weight was 170 pounds. Five months later, on Resident #12's weight was recorded as 156 pounds.

During an interview on at 3:30 p.m., Nurse Staff D said the facility's policy is a weight loss of more than 5 pounds should be reported to the physician. The 14 pound weight loss for Resident #12 was not reported to the physician.

3. Record review revealed Resident #10 had lost 12 pounds in 3 1/2 months from his admission on until . There was no documentation that indicated the doctor was notified of this change in condition.

During an interview on at 2:00 p.m., Nurse Staff D said that any weight loss over 5 pounds is supposed to be reported to the doctor. She then confirmed that no documentation of doctor notification was in the record.

Class II

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

Based on record review and interview, the facility failed to provide 2 (Resident #10 and #12) of 12 residents sampled access to adequate and appropriate healthcare consistent with established and recognized standards within the community and failed to coordinate services by third party providers for Resident #10. This has the potential for residents who have changes in conditions to suffer harmful decline.

The findings included:

1. Record review for Resident #12 showed he was admitted to the facility on . The resident has a (inserted through a small hole in the abdomen to drain from the). When functioning properly, it allows for voiding.

Resident #12's record had a physician's order dated to push fluids. Each home health visit note following that order instructs the facility staff to increase fluid intake. The resident's record had no documentation that the facility implemented interventions to increase fluid intake.

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On at 3:30 p.m., the Administrator said the facility did not implement additional interventions to encourage Resident #12's fluid intake. Additional fluids would reduce the possibility of a .

The Resident Condition Log dated noted Resident #12 received an order for . It did not say the reason the resident was prescribed an .

On Resident #12 was sent to the emergency "acute and acute retention."

The Resident Condition Log also documented that on Resident #12 was prescribed the for 5 days. It did not note the reason for the medication. The log did not document sending the resident to the hospital.
During a record review, documents from showed Resident #12's daughter called about the emergency . The record said the resident was sent to the hospital due to severe abdomen pain.

Resident #12 was started on the ordered for 7 days by the hospital on . The resident would be on this through .

Resident #12's Medication Observation Record (MOR) for , 2017 showed was given in the evening on and in the morning on . The resident's record did not have a discontinuation order for the . There was a physician order on to give every 6 hours for 5 days. However, on the following day ( ), there was a physician order to discontinue the . The MOR noted the was to be given for 5 days. It was given at 8:00 p.m. on and ended on , which was 4 days. Neither the instructions on the MOR nor the order to discontinue was not followed.

A home care note dated said Resident #12's was changed for .
There was no resident observation log note addressing any concerns about 5 days later the resident having after returning from the emergency . There was no documentation the physician was contacted.

A home care note dated said Resident #12 had dark amber (possible indication of or). Under "Intervention" it noted " analysis collection? pending order." There was no resident observation log note noting if the physician was contacted about the dark amber .

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On at 12:45 p.m., Nurse Staff D said that the facility did not contact physician related to Resident #12's home health care note dated . Staff D said that the facility did not document issue related to the dark amber .

Resident #12's record included an order dated for a analysis (UA) to be completed. The order did not call for home health care to take the specimen. The resident observation record dated noted the order received and noted "awaiting collection of sample at this time."

A Medicine Progress Note dated was completed by the Advance Registered Nurse Practitioner (ARNP). The note reported the home health care nurse stated is cloudy with a foul smell and relates a with no injury. The ARNP ordered a 1 day treatment for Resident #12.
The resident observation log dated noted the UA was received and faxed to the ARNP. It was noted as waiting for response 3 hours later, the note stated UA result was inaccurate due to collection from bag (the specimen must be taken from the tube, not the bag). A new order was written for home health to collect the UA.

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On at 2:00 p.m., Nurse Staff D said that any weight loss over 5 pounds is supposed to be reported to the doctor. She then confirmed that no documentation of doctor notification was in the record.

Class II