STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969059	**01/24/2018**
NAME OF PROVIDER OR SUPPLIER **AMERICAN HOUSE COCONUT POINT**	STREET ADDRESS, CITY, STATE, ZIP CODE **8460 MURANO DEL LAGO DR** **BONITA SPRINGS, FL 34135**	

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

0000 - Initial Comments

An unannounced complaint survey for CCR# 2017014235 and CCR# 2018000540 was conducted on at American House Coconut Point, an assisted living facility (license #12898) in Bonita Springs, Florida.

The complaint for CCR #2017014235 contained 1 allegation, of which 1 was substantiated.
The complaint for CCR #2018000540 contained 2 allegations, of which 1 was substantiated with citation and 1 was substantiated without citation.

The following is description of the deficiencies.

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

Based on record review and staff interview, the facility failed to obtain a complete Health Assessment 1823 form for 2 (Resident #1 and #9) of 3 residents sampled.

The findings included:

Record review for Resident #1 found he was admitted to the facility on . . . . . . The Health Assessment 1823 form on file was missing the following items:
- The date in which the assessment was completed.
- The address and telephone number of the provider that filled out the assessment.
- Where the facility was to indicate what services will be provided by them on page 5 was left blank.
- The Administrator's signature on page 5.

Record review for Resident #9 found she was admitted to the facility on . The Health Assessment 1823 form on file was missing the following items:
- The date the assessment was completed.
- Name, title, signature, license number, address, and telephone number of the examiner.
- The Administrators name and signature on page 5.

During an interview on at 3:50 p.m., the Administrator and Wellness Director acknowledged the lack of appropriate documentation. They said they will make sure that all Health Assessment forms will be completed as required from now own.

Class III

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

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record reviewed and staff interview, the facility failed to obtained an accurate Medication Observation Records (MOR) for 2 (Resident #1 and #3) of 3 residents MORs sampled.

The findings included:

A review of Resident #1's MOR for 2017 to , 2018 revealed:
1. , 0.5 mg tablet (take 1 tablet by mouth at bedtime) was not given on , without an explanation as to why it was not given.
2. 50 MG tablet (take one tablet by mouth twice daily) was not given on at 6:00 p.m.
3. Powder 238 GM BT (take 17 grams my mouth once daily dissolve in 4-8 oz water /juice) was not given on .
4. 50 MG tablet (take one tablet by mouth twice daily) was not given on at 6:00 p.m.
5. 50 MG tablet (take one tablet by mouth twice daily) was not given on at 6:00 p.m.
There were no explanations noted as to why they were not given.

A review of Resident #3's MOR for 2017 to , 2018 revealed:
1. 10 mg (take one tablet a day at 8 p.m.) was not given on .
2. , 0.005% eye drops (install one drop to both eyes at bed time) was not given on .
3. , (take 1 tablet 0.25 mg by mouth at bedtime) was not given on .
There were no explanation noted as to why they were not given.

During an interview on at 11:56 a.m., the Wellness Director and the Administrator acknowledged the lack of appropriate documentation. They said that the MOR did not indicate as to why the medications were not given to the residents. They said they are both new hires and they realized there is an issue with lack of appropriate documentation.

Class III

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

Based on record review and staff interview, the facility failed to ensure that the medications for residents who receive assistance with self-administration of medication were filled or refilled in a timely manner for 3 (Residents #1, #2, and #3) of 3 residents' Medication Observation Records (MOR) reviewed.

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

The findings included:

A review of Resident #1's MOR from 2017 to , 2018 revealed:
1. Powder 238 GM BT (take 17 grams my mouth once daily dissolve in 4-8 oz water /juice) was not given on , with a note stating "not on cart."
2. , 0.5 mg tablet (take 1 tablet by mouth at bedtime) was not given on , with a note stating "medication was out of stock."
3. Methylprednisonole 4 mg was not given on , with a note stating "reorder has ' nt arrived yet."

During an interview on at 11:56 a.m., the Wellness Director and the Administrator said they were aware of issue related to Ropinilone and that it was not given on . They said the medications were sent out to the pharmacy 7 days prior to refill, but additional clarification for the order was needed. While they were waiting for the clarification, they ran out of the medication. The medication was to be delivered by the pharmacy, but the resident's daughter went to the pharmacy and picked up the medication her self. They had discussed the issue with her, but she was upset since that was not the first time this had happening.

A review of Resident #2's MOR from 2017 and , 2018 revealed:
1. Rosuvastatin Calsium 10 mg tab (take 1 tablet by mouth twice a day) was not given on at 9 a.m., with a note stating "called pharmacy and spoke with staff there. Would be coming in tonight."
2. , , 5 mg (take 1 tablet by mouth once daily) not given on , , and with a note stating "pending delivery."
3. Acidophilus Cap 100 mg (take 2 capsules by mouth once daily) was not given on with a note stating "med not available pharmacy contacted."

A review of Resident #3's MOR from 2017 to , 2018 revealed:
1. , 5 mg was not given on with a note stating "pending delivery."

During an interview on at 1:00 p.m., the facility Wellness Director and the Administrator said they have been working for the facility for a month. They admitted there are some issues with medication refills. They said the facility has made steps to change over to a new pharmacy in , 2017. They admitted there were times that the staff hasn't reordered medications in time, they are aware of the problem, and they are trying to resolve it with the new pharmacy.

Class III

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

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

Based on observation and interview, the facility failed to ensure a safe living environment for the residents.

The findings included:

During the initial tour of the facility with the Maintenance Director on at 8:55 a.m., the call light system was tested to ensure that it was functioning properly.

On at 9:00 a.m., the call light cord in # was from the wall when Maintenance Director pulled the cord. He tried to reattach the cord, but he was unsuccessful.

On at 9:05 a.m., the call light cord in # was from the wall when the Maintenance Director pulled the cord. He tried to reattach the cord, but he was unsuccessful.

On at 9:38 a.m., the receptionist did not respond to the call light in # . When the maintenance Director reached her on the portable radio, she said she did not have a call light from # on her end.

During an interview on at 9:45 a.m., the Maintenance Director said he has been working for the facility for only two weeks. He said part of his monthly assignments are to check the call lights, but he has not completed the assignment as of yet. He said he has no previous audits from the previous Maintenance Director. He said when staff has an issue they place an electronic work order that he gets immediately and he has no pending orders currently for call lights.

During an interview on at 11:30 a.m., the facility's Wellness Director and Administrator said they have been working for the facility for only a month. During the recent resident council meeting that took place last week, they became aware of the call lights issues. They said they will call corporate to ensure the issue can be resolved as soon as possible.

Class III