STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969059	**09/26/2018**
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 CCR #2018010719 was conducted on at American House Coconut Point, an assisted living facility (license #12898) in Bonita Springs, Florida.

The complaint contained four allegations, of which two were substantiated.

The following is description of the deficiencies.

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

Based on observation, record review, staff interview, and family interview, the facility failed to offer personal supervision appropriate to the needs for assistance with eating for 5 residents (Residents #3, #5, #7, #8, and #9) out of 5 residents reviewed .

The findings included:

1. Observation on at 11:30 a.m., during lunch in Memory Care dining , revealed 5 residents (Residents #3, #5, #7, #8, and #9) sitting at dining tables waiting with their meals and not receiving assistance from facility staff.

Staff B reported at 12:00 p.m., she was assigned to assist the residents in the dining eating. She was alone because the other staff member assigned to the dining to do an errand in the kitchen and she was away from the dining 20 minutes.

Record review of Residents #3, #5, #7, #8, and #9's Health Assessment (1823) revealed they required assistance with meals per their health care provider order.

On at 2:35 p.m., during an interview with the husband of Resident #10, he reported he noticed at dinner time on the 2:00 p.m., to 10:00 p.m., shift that the shift is understaffed and residents that need assistance to eat are not getting assistance. He reported his wife is independent with eating.

On at 12:00 p.m., during an interview with the family of Resident #7, they reported he needs assistance to eat and the staff do not provide assistance at meals . They reported it has been reported to the Memory Care Director numerous times.

On at 2:45 p.m., during an interview with the Memory Care Director, she reported she was not

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aware the residents were not being assisted by staff during meals.

Class III

0052 - Medication - Assistance with Self-Admin - 429.256(3-4); 58A-5.0185 (3)

Based on observation, record review, and staff interview, the facility failed to ensure 3 (Residents #4, #6, and #7) of 5 sampled residents received appropriate assistance to ensure they received all medications as per physician's orders.

The findings included:

1. Clinical record review for Resident #4 revealed an order to rinse with [redacted] mouth wash) for 30 seconds and spit twice a day starting on [redacted] after [redacted].

On [redacted] the physician issued a second order for [redacted] twice a day until [redacted]. The order specified to discontinue the previous order for [redacted].

Review of the medication observation record (MOR) failed to reveal documentation the resident was assisted with administration of the [redacted] as per the physician's order.

On [redacted] at 11:00 a.m., interview with the unit manager confirmed the lack of documentation that Resident #4 received assistance with the [redacted] as per the physician's orders She said she remembers talking to the physician's nurse who said the [redacted] was no longer needed but did not document the conversation or obtain an order to discontinue the medication.

On [redacted] at 3:00 p.m., the Wellness Director said he remembers a concern about Resident #4 swallowing the [redacted] instead of spitting it out. He said the nurse should have obtained an order to swab the resident's mouth with the [redacted].

2. Clinical record review for Resident #6 revealed a physician's order dated [redacted] to decrease [redacted] ([redacted]) to 10 milligrams daily every morning per family's request.

Review of the MOR for [redacted] 2018 revealed Resident #6 continued to receive assistance to administer [redacted] 20 milligrams (twice the dose ordered) until [redacted]. There was no documentation the resident received [redacted] after [redacted].

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On the pharmacy sent a fax alerting the facility they would dispense a 3 day supply of until the physician approved the refills.

On the Advanced Registered Nurse Practitioner (ARNP) signed the fax authorizing a one month supply of all non-controlled medications with 11 refills, including the .

The clinical record, including the MOR, failed to reveal documentation Resident #6 was assisted with self-administration of the necessary medication in or .

On at 11:30 a.m., the Unit Manager said once the ARNP ordered the refill, the should have been noted on the MOR. She confirmed the facility failed to ensure the medication was obtained from the pharmacy and failed to assist the resident with self-administration of the necessary medication.

3. Review of the clinical record for Resident #7 revealed on the physician issued an order to discontinue ( ) 10 milligrams at 12:00 p.m. and start 20 milligrams by mouth every morning.
Review of the MOR revealed Resident #7 continued to be assisted with administration of 10 milligrams (half the dose ordered) at 12:00 p.m., from through .

Observation of the Resident's medications revealed a bottle of 10 milligrams.

On at 2:10 p.m., interview with Medication Technician Staff A revealed she assists Resident #7 with administration of medication as per the label on the container.

On at 1:30 p.m., interview with the unit manager confirmed she failed to transcribe the change of order causing the resident to receive half the dose of the necessary medication.

Further review of the clinical record for Resident #7 revealed a telephone order dated for ( ) 250 milligrams daily for 5 days.

There was no documentation in the clinical record or the MOR the resident received assistance to administer the prescribed .

The clinical record lacked documentation the physician discontinued the order for the .

On at 1:30 p.m., the Unit Manager confirmed Resident #7 never received the as ordered. She said the physician ordered the for a , however the spouse was concerned

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about the effect the medication on the and refused the . The Unit Manager said she did not contact the physician to inform him the was not administered as ordered.

Review of the physician's order report form revealed Resident #7's medications included Polyethylene 3350 ( ) ½ capful by mouth in 6 ounces of water or juice once daily.

Review of the MOR revealed Resident #7 received the medication daily until . There was no documentation the medication was administered after .

On at 2:00 p.m., interview with Med Tech Staff A revealed Resident #7 used to take the Polyethylene but it was discontinued a long time ago.

The clinical record did not contain a physician's order to discontinue the Polyethylene .

On at 2:15 p.m., interview with the Unit Manager confirmed the absence of an order to discontinue the Polyethylene .

4. Interview on at 3:00 p.m., with the Wellness Director revealed the facility did not have a specific process to ensure all new physicians' orders are properly transcribed onto the MOR. He said all physician orders must be documented in the clinical record. When there is a new order, the nurse faxes it to the pharmacy and adds it to the MOR. He said if a resident or responsible party refuses a medication, the physician needs to be contacted and a note should be entered in the clinical record. The Wellness Director said he was in the process of developing a quality assurance program that will include guidelines for missed medications.

Class III