Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11953272	A. BUILDING: _____ B. WING _____	R 12/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD RETIREMENT CENTER	1220 JIMMY ANN DRIVE DAYTONA BEACH, FL 32117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments A revisit survey was conducted at Lakewood Retirement Center Assisted Living Facility on . Deficient practice related to the revisit was identified at the time of the survey.	{A 000}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11953272	A. BUILDING: _____ B. WING _____	R 12/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD RETIREMENT CENTER	1220 JIMMY ANN DRIVE DAYTONA BEACH, FL 32117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12(2) Care Provider Background Screening Clearinghouse.- (b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on observation, facility record review and staff interview the facility failed to maintain an updated employee roster on the Agency for Health Care Administration (AHCA) Provider Background Screening Clearinghouse website for 4 out of 6 current employees and 3 former employees.	CZ814		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11953272	A. BUILDING: _____ B. WING _____	R 12/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD RETIREMENT CENTER	1220 JIMMY ANN DRIVE DAYTONA BEACH, FL 32117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ814	Continued From page 1 The findings include: Employee A, Administrative Assistant, was observed and interviewed multiple times during the two-day complaint and revisit survey conducted on . She stated she had worked at the facility since . Her work station was at the front reception desk. She answered the phone, completed clerical work and assisted the residents as needed. Employee D, Certified Nursing Assistant (CNA), was observed throughout the two-day survey to be providing care to the residents. She was interviewed on at 12:39 pm. She stated she just started working at this facility on . During an interview with the Administrator on at 1:10 pm she provided the weekly staff schedules for the time frame of through . She stated that Employees F, I and J are former employees. Employee H is on leave. Employee D started on and Employee G. is an agency staff member. Review of the staff schedules from through revealed: Employee A was scheduled every week day from 9:00 am until 3:00pm (30 hours/week) from through (Photographic evidence obtained). Employee D was scheduled to work 44 hours the week of through . She worked 29 hours the week of through . She worked 4.5 hours the week of through (Photographic evidence obtained).	CZ814		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11953272	A. BUILDING: _____ B. WING _____	R 12/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD RETIREMENT CENTER	1220 JIMMY ANN DRIVE DAYTONA BEACH, FL 32117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ814	Continued From page 2 Employee F, a former employee, worked 15 hours the week of through . Additional times worked were as follows: Worked 14 hours the week of through ; Worked 10 hours the week of through ; Worked 20.5 hours the week of through ; Worked 15 hours the week of through ; Worked 15 hours the week of through ; Worked 15 hours the week of through ; Worked 5 hours the week of through ; Worked 15 hours the week of through ; and worked 15 hours the week of through (Photographic evidence obtained). Employee G is an agency staff member that has works 20 or more hours per week. She is scheduled to work three eight our shifts (24 hours) from through . She worked 24 hours the week of through . Additionally shoe worked the following hours: She worked 24 hours the week of through ; Worked 24 hours the week of through ; Worked 24 hours the week of through ; Worked 16 hours the week of through ; Worked 24 hours the week of through ; Worked 24 hours the week of through ; Worked 16 hours the week of through ; Worked 16 hours the week of through ; Worked 16 hours the week of through ; and worked 24 hours the week of	CZ814		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11953272	A. BUILDING: _____ B. WING _____	R 12/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD RETIREMENT CENTER	1220 JIMMY ANN DRIVE DAYTONA BEACH, FL 32117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ814	Continued From page 3 . . . . . through . . . . . (Photographic evidence obtained). Employee H is a facility employee. She was scheduled 8 hours for the week of . . . . . through . She worked 12 hours the week of . . . . . through . . . . . , worked 12 hours the week of . through . . . . . , worked 12 hours . . . . . through , worked 32 hours the week of . . . . . through . . . . . , worked 18.5 hours the week of through . . . . . , worked 22 hours the week of through , worked 12 hours . . . . . through . . . . . , worked 14 hours through , and worked 16 hours the week of . . . . . through (Photographic evidence obtained). Employee I is a former employee. She worked 49 hours the week of . . . . . through . Employee J is a former employee. She worked 25 hours the week of . . . . . through , worked 20 hours the week of . . . . . through . . . . . , worked 20 hours the week of through , and worked 25 hours the week of . . . . . through . Review of the Agency for Health Care Administration Provider Background Screening Clearinghouse website revealed Employees A, D, F, G, H, I and J were not on the employee roster as of at 20:53 hours (Photographic evidence obtained). During an interview with the Administrator on at 3:30 pm she confirmed that she	CZ814		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11953272	A. BUILDING: _____ B. WING _____	R 12/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD RETIREMENT CENTER	1220 JIMMY ANN DRIVE DAYTONA BEACH, FL 32117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ814	Continued From page 4 had not updated the employee roster on the AHCA Clearinghouse website for a long time. She could not remember the last time she did it. She stated she remembered doing it but could not remember exactly how to do it anymore. She would have to sign in and figure it out. Unclassified	CZ814		