STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966453	06/12/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Oceanview Retirement Home	**3091 NW 43rd Street Lauderdale Lakes, FL 33309**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0123 - 58a-5.021(4) Fac - Fiscal - Resident Trust Funds & Adv Payments S-S= D
St - A - 0126 - 58a-5.021(7) Fac - Fiscal - Resident Accounting S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D
St - A - L241 - 58a-5.029(2) Fac - Lmh - Records S-S= D

Specific Tag Findings:

0000-Initial Comments
An Assisted Living Facility biennial relicensure survey was conducted on . . . . . Oceanview Retirement Home had licensure deficiencies found at the time of the visit.

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

Based on observation and interview, it was determined the facility failed to follow . . . . . control practices to ensure the safety of residents well-being. As evidenced by the facility failure to follow proper hand washing . . . . . control practices during medication administration for 2 out of 10 sampled residents (Resident #6 and #7).

The findings include:

On . . . . . the facility's cook was observed to assist Resident # 7 with her medication. The cook was observed to not wash her hands but to proceed to the medication cart and prepare the medications for Resident #6. The cook was observed to prepare the medications for Resident #6, then assist her with self administration of medications and then return the medications belong to Resident #6 to the medication cart and then update the MOR without washing and or sanitizing her hands.

During an interview with the Administrator on . . . . . at approximately 3:00 PM, he confirmed surveyor's findings.

Class III

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0078-Staffing Standards - Staff 58A-5.019(2) FAC

Based on record review and interview, it was determined that the facility failed to (a) ensure all staff members had documentation of freedom from communicable signed by a qualified health care professional for 2 out of 3 sampled employees (Employee #1& Employee #2), documentation of completion of annual screening for employee #1.

The findings include:

1. Review of the personal files revealed the files for employee #2 and #3 lacked documentation of freedom from communicable that was signed and dated by a qualified health care professional as required. An interview with the Administrator at 4 PM on , revealed the facility is unable to provide documentation of freedom from communicable these employees.

2. A review of the personal file for employee #1 revealed the file lacked documentation of freedom from that was signed and dated by a qualified health care professional on an annual basis as required. An interview with the Administrator at 4:01 PM on , revealed the facility was unable to provide documentation of freedom from dated within the previous year for employee #1

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC

Based on record review and interview, the facility failed to ensure 1 out of 3 sampled employee files contained documentation of completion of all required in-service training.

The findings include:

1). Interview with the Administrator on at approximately 2:37 PM revealed Employee #2's date of hire was Further interview revealed she provides direct care for the residents. Review of Employee #2's personnel record revealed the file lacked documentation of completion of the following in-services within 30 days of hire, as required:

1. Resident rights in an assisted living facility.
2. Recognizing and reporting resident , neglect, and
3. Resident elopement response policies and procedures.

Class III

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0093-Food Service - Dietary Standards 58A-5.020(2) FAC

Based on observation and interview, it was determined that the facility failed to ensure that that menus were planned and dated in advance and that residents were encouraged in menu planning. Additionally, the facility failed to ensure that food served within the facility was served attractively at safe and palatable temperatures and that eating ware was provided to residents.

The findings include:

1) Tour of the facility on revealed the posted menu on the wall of the dining was dated . . . . An interview was conducted with the cook on at 9:13 AM during which she stated that the observed menu was the current menu and that there were no other menus available. An interview was conducted with the Administrator on at approximately 9:49 AM, he stated that he was unaware the menu needed to be dated for the current week.

2) Confidential interviews conducted with 6 random residents revealed that they did not have input or allowed to participate in menu planning. An interview was conducted with the Administrator on at approximately 10:11 AM, he stated that he does have a type of meeting where the residents can give some input but going forward he will ensure that the menus reflect more of the choices and preferences of the residents and he will encourage the residents to participate more in the planning of each menu.

3) Observation of the lunch food service conducted on at 12:20 PM revealed:

i. the Cook randomly providing food service for some of the residents observed in the facility. She stated the residents eat when they want to and so she serves the residents who come to the dining a walk in basis.

ii. Observation of the food preparation revealed the Cook would routinely slop the beans and hot dogs onto saucers and serve to the residents. The beans were observed to be running over the edge of the saucer.

iii. Residents were observed to have to ask for bread/roll in order as one was not observed provided with the hot-dog.

. . . Residents were also not provided with soup and had to request soup from the cook who stated that she knows the residents and will give them what she knows they like to eat.

v. The cook was observed not to follow the portion sizes specified on the menu but would "eyeball" the items being served as she prepared the plates.

vi. There were no lettuce/tomato as well as fresh fruit provided during the lunch food service as specified on the menu.

vii. One unsampled resident was observed during the lunch food service to request a hot-dog roll from the cook. The resident was observed to be handed the roll and was observed to place the roll on the table as there was not enough the saucer to hold the roll.

4. An interview was conducted with the Cook on at approximately 12:37 PM, she stated that she does not utilize a thermometer during food service as she does not need to. Food items being served were observed left plated for various time periods, until the residents would show up in the dining The Cook was not observed to check the food temperatures of the meals to ensure palatable temperatures.

5. Observation of the food service on , revealed the Cook was unable to show the correct portion

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sizes being served. An interview was conducted with the Cook on [redacted] at approximately 12:41 PM during which she stated that there are no proper measuring equipment available and that there is a scale but she does not use it to measure the food items.

Class III

0123-Fiscal - Resident Trust Funds & Adv Payments 58A-5.021(4) FAC

Based on record review and interviews, it was determined that the facility failed to ensure that resident's funds were not co-mingled with facility's funds.

The findings include:

An interview with the Assistant Administrator at 11 AM on [redacted], revealed the facility serves as representative payee for 3 resident's income (Resident #1, #2, #3).

A review of the facility's records revealed bank statements for the current and prior three months which reflected that all resident trust funds were deposited into the facility's business account and not in the resident's trust fund account. The bank statement revealed that deposits as well as all liabilities pertaining to the operation of the facility were deducted from one account.

An interview was conducted with the Assistant Administrator/Business Office Manager on [redacted] at 11:26 AM, she stated that she was informed by the Administrator that the resident's funds should be kept in a separate bank account. She stated that she had not yet gotten around to placing the resident's funds into their own account but that she will promptly ensure that going forward the funds will be separated.

Class III

0126-Fiscal - Resident Accounting 58A-5.021(7) FAC

Based on record review and interviews, it was determined that the facility failed to ensure that quarterly statements were provided to its residents which reflected all income and expenses.

The findings include:

Confidential interviews conducted with several residents revealed that they did not receive quarterly statements from the facility and the residents were unaware of the total amount of income received on their behalf by the facility.

Record review was conducted for Resident #1, Resident #2 and Resident #3 and revealed a log kept by the facility of the total expenses incurred by each resident. A separate log was observed kept for each resident which detailed the allocation of stipend given.

An interview was conducted with the Assistant Administrator on [redacted] at 1:43 PM, she stated she was

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unaware that the resident's were required to have a quarterly statement. She stated the residents do receive a log showing the amount of [redacted] stipend given to each resident monthly but that the log did not indicate the total amount of the income, the source of the income or the funds deducted by the facility prior to disbursing the stipend.

Class III

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

Based on observations and interviews, it was determined that the facility failed to ensure that it provided a decent living environment for its residents to reside in.

The findings include:

Tour of the facility conducted on [redacted] at 10:15 AM revealed the following:

a) [redacted] - Bed A was observed to have torn/ripped sheets. Bed B was observed to have a boxspring that was badly deteriorated. The bed frames were observed to be rusting and covered with newspaper. The windows were observed to be broken and missing the operating lever. The walls were observed to be dirty.

b) [redacted] - The fire sprinkler outlet was observed to be covered in thick layers of muck/dust. The furniture was observed to be broken and badly deteriorated. The baseboard around the [redacted] observed to be falling off the wall and deteriorated with evidence of insect infestation/damage. The ceiling vent was observed to be extremely dirty.

c) [redacted] - Headboards were observed to be taped up with duct tape. Both mattress and box spring were observed to be extremely filthy; the mattress and boxsprings were observed covered in a white covering which was observed to be blackened with dirt and had numerous spots which appeared to be stains from multiple bodily fluids.

d) The hallway [redacted] was observed to have a large mirror that was desilvered. The [redacted] a strong pungent odor of stale [redacted] pervasive throughout the [redacted] The shower curtain was observed to be bleached in multiple areas and blackened with soap residue and in overall bad condition. The walls were observed to have peeling/chipped/ discolored paint.

e)f [redacted] - Bed B mattress and boxspring badly deteriorated. The box spring was observed held together by duct tape.

f) [redacted] - Box spring and mattress for both beds were observed to be extremely blackened from use and in poor condition. Bed A was observed to be positioned in front of the closet which was used by both residents. Large cobwebs were evident across the ceiling over the window, wall behind the dresser was observed to have faded painting and evidence of paint dripping down the entire surface of the wall. The exit door was observed to have a large hole.

g) [redacted] - Both beds were observed to have mattresses covered in white cover. The covers were observed

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blackened with use and heavily stained.

h) # . The exterior screen was observed to be extremely dirty with particle build up evident throughout. Both beds were observed to be extremely dirty and excessively soiled.

i) The hallway was observed to have a mirror that was desilvered, the cabinets were observed to be falling apart, the shower curtain was observed to be in very bad condition and excessively bleached; the walls were observed to have peeling paint.

j) # - ceiling was observed to have multiple areas of water damage. The observed to have cabinets that are deteriorated, the mirror was observed to be desilvered, the wall showed evidence of peeling paint and the shower curtain is badly bleached. The closet was observed to have multiple containers of OTC medications used by resident in Bed A.

k) - Bed B was observed to have a mattress that was sunken in and extremely dirty. The walls were observed to be excessively soiled. The bed linen (both beds) were observed to be in very poor condition and bleached in multiple areas. The mattress /boxspring covers were observed to be blackened with use and excessively soiled. The light switch on the wall was observed to be non-functional..

l) The adjacent observed to have a vanity that was deteriorated. The caulking surrounding the sink and bathtub was observed to be separating from the wall. The mirror was observed to be desilvered. The walls were observed to be excessively stained with chipped/peeling paint.

Class III

L241-LMH - Records 58A-5.029(2) FAC

Based on record review and interviews, it was determined that the facility failed to ensure that a Community Living Support Plan was maintained for each resident for which it is a Limited Mental Health Provider.

The findings include:

Record review completed on revealed an admission / discharge log which lists Resident #4 as a limited mental health resident. A review of the file for Resident #4 revealed no documentation of a Community Living Support Plan as required.

An interview was conducted with the Assistant Administrator on at approximately 3:56 PM during which she stated that Resident #4 was a limited mental health resident and that she could not locate the Community Living Support Plan. Further interview with the Administrator revealed that no further documentation was available.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Oceanview Retirement Home
3091 NW 43rd Street
Lauderdale Lakes, FL 33309

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2013 by representatives of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after **, 2013** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/ls
Enclosure

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