STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964825	10/04/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sunset Lake Village	1121 Jacaranda Blvd Venice, FL 34292	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0028 - 58a-5.0182(4) Fac - Resident Care - Activities Of Daily Living S-S= D
St - A - 0029 - 58a-5.0182(5) Fac - Resident Care - Nursing Services S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= G
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0079 - 58a-5.019(4) Fac - Staffing Standards - Levels S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0167 - 58a-5.025(1) Fac - Resident Contracts S-S= B
St - A - N277 - 58a-5.031(2) Fac - Lns - Resident Care Standards S-S= D
St - A - N278 - 58a-5.031(3) Fac - Lns - Records S-S= D

Specific Tag Findings:
This is to report the findings of a Change of Ownership (CHOW) and Limited Nursing Service (LNS) survey conducted at Sunset Lakes Village on through . The census at the time of the survey was 107 residents with 15 residents on LNS services.

The following is a description of non-compliance:

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on interview and record review, the facility failed to maintain a written record of significant changes in resident condition for 1 (Resident #17) of 3 residents reviewed.

The findings include:

During record review for Resident #17, no documentation was found in the resident record of changes in her skin condition which required additional services.

During an interview on at 3:30 p.m. staff D stated, "the staff from the memory care unit called me down to the memory unit on the weekend to let me know Resident #17 was complaining of a painful between her legs." Staff D stated, "I went and looked at her peri area, it looked tan to me, not red." When asked if she had documented the staff alerting her of a problem or of her observation of Resident #17's skin she stated that she did not write anything down.

During an interview on at 1:00 p.m. staff E stated, "I had observed the on Resident #17 earlier in the week, stated it was red and painful, the resident had an appointment with the doctor on When asked if she had documented her observations of the change in the residents skin condition which required her to go to the doctor and get treatment ordered for the skin she stated that she had not documented her observations or that the resident had an MD appointment to evaluate the .

Class III

0028-Resident Care - Activities of Daily Living 58A-5.0182(4) FAC
Based on observation, interview and record review, the facility failed to provide assistance with (shaving) for 1 (Resident #11) of 10 residents interviewed for staff assistance with Activities of Daily Living (ADL).

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964825	10/04/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sunset Lake Village	1121 Jacaranda Blvd Venice, FL 34292	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

The findings include:

Observation of Resident #11 in his [redacted] at 4:30 p.m., revealed the resident has a full beard. Pictures in the resident [redacted] him younger without facial hair.

Interview with the Resident on [redacted] at 4:30 p.m., revealed the resident would prefer to be clean shaven. The resident stated that he is not capable of shaving himself now that his facial hair is so long. He stated when he arrived in the facility in [redacted] 2013, he did not have a long beard. He stated staff did not assist him to shave and now he would have to pay to get the beard off.

Record review of Resident #11's health assessment completed on [redacted] confirms the resident needs assistance with [redacted]. The resident is alert and oriented.

Interview with the Administrator on [redacted] at 3:00 p.m., verified that there was no documentation that the resident has refused being shaved. However, there is no documentation that the Resident prefers to keep his very long beard.

Class III

0029-Resident Care - Nursing Services 58A-5.0182(5) FAC
Based on interview and record review, the facility failed to maintain nursing progress notes for 1 (Resident #17) of 3 residents reviewed.

The findings include:

No documentation of nursing progress notes were found for Resident #17 in her resident record during record review.

During an interview on [redacted] staff E stated, "The nurses don't routinely chart in the resident record."

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation, interview and record review, the facility failed to insure residents in the memory care unit are safe from neglect. The facility failed to insure residents had access to and wore their own clothing and failed to provide health care consistent with orders for 1 (Resident #17) of 1 resident reviewed. The facility failed to resolve grievances for 2 (Resident #12 and #13) of 2 residents reviewed.

The findings include:

1. In an interview on [redacted] at 3:00 p.m. with the sister of Resident #17, she stated she took the resident to the doctor today and asked to talk to surveyor to discuss the resident's doctor visit. She stated, "My sister is very [redacted] to the point of crying, with redden raw skin between her legs in her [redacted] and bottom area." She stated, "I have seen residents including my sister with 2 adult briefs on at the same time who are left to walk around wet. Wet circles are left on the chairs where these residents sit." She stated, "I noticed a change since the change of

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964825	10/04/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sunset Lake Village	1121 Jacaranda Blvd Venice, FL 34292	

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

ownership, the Administrator used to be here daily and was more involved, now she is away a lot." When asked if she visits her sister often, she stated, "not as often as I should, but the resident's daughter who lives out of town is very involved in her sister's care and has told me she has concerns for her mother." She added, "Resident #17's daughter pays for a private companion to stop in several times a week to check on Resident #17."

During an interview at 3:00 p.m. on staff B stated there is not enough staff to take care of the residents on the memory care unit on any shift. He stated, "I have seen residents with two adult briefs on at one time when I have taken them to the be toileted."

Observation of Resident #17 on at 3:30 p.m., revealed she is sitting in a chair in the common area of the memory care unit, her face grimacing as though she were in pain. Staff in the memory care unit stated Resident #17 had been changed and the Balmex cream ordered had been applied to the reddened areas between her legs and a dry adult brief had been put on her.

Observation by surveyor on at 9:40 a.m., revealed staff K and staff P applying cream to Resident #17 and then took her to common memory care unit.

Observation of Resident #17 on at 11:14 a.m., revealed resident sitting in lounge chair in her with tears rolling down her face, crying out, "help me, it hurts." Several staff walked past Resident #17's stopping to assist her. Staff K and Staff L assisted resident into bed so surveyor could visualize the area between her legs and area. The resident continued to cry out, "I'm afraid I am going to and refused to turn over in her bed, even with assistance of staff. Resident agreed to stand at side of bed. Skin observation of Resident #17 revealed raw, dark reddish purple skin between the folds of the resident's thighs, extending throughout her entire pubic area and to the back of her lower

In an interview on at 11:35 a.m., with the memory care supervisor, surveyor asked if he was aware that Resident #17 was in her out in pain. He stated the treatment the doctor had ordered yesterday had been applied. When asked if the resident had an order for pain medication he stated, "No, I could have the nurse call and get an order for pain medication for her."

After surveyor intervention an order for pain medication was received for diagnosis of diaper 650 mg by mouth every 6 hours and PRN (as needed). The first dose was given at 1:00 p.m. on

In an interview at 4:00 p.m. with staff E, surveyor asked what the resident would be getting for pain during the night. Staff E stated, "Medication techs cannot give PRN (as needed) medications so I better get an order for pain medication around the clock so Resident #17 can get pain medication at night."

E-mail to surveyors from resident's daughter on stating she was aware surveyor checked her mother's bottom on and wanted to make sure the pubic area was also looked at. She stated in the e-mail, "The front shows the its worst between her legs." She wrote MD examined Resident #17 and told her the are 4 inches down, from the pubic area into the fold/crease from her inner thighs and down the upper

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964825	10/04/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sunset Lake Village	1121 Jacaranda Blvd Venice, FL 34292	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

thighs on each leg. It is red/purple in color in the crease and outward.

During an interview on at 3:00 p.m., the sister of Resident #17 stated her sister went to the doctor today wearing someone else's clothes. She stated "My sister has lots of nice clothes and wears a size small, she was wearing extra-large clothes today that did not belong to her, the clothes my sister was wearing today had another residents name on them."

2. Review of the grievance log since the change of ownership on revealed there had been no written complaints/concerns recorded.

During an interviews on at 9:30 a.m. and 2:00 p.m. family members of Resident #12 and #13 reported that they have reported concerns to the Administrator and Program Director for the unit on numerous occasions in the last 2 months and nothing has been done.

The family member of Resident #12 stated there is a "lack of staff since the new company" took over and he has complained of "lack of care for bathing, especially hair washing."

The family member of Resident #13 stated the resident "has a lot of 'l's is not changed often enough. She has had a from the depends that have been too wet. Nothing is done. I let them know and nothing is done. I don't want to wait until she bleeds. She has been sent away from beautician because she smelled so bad."

During an interview on at 4:00 p.m. Resident #12's son stated that after his mother's 2 this week he feels he cannot leave her with the current level of staffing.

Interview with the Administrator on at 11:00 a.m., revealed that Resident #13's daughter had filed a grievance last night that would be investigated.

Class II

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observation, the staff assisting with the self-administration of medication did not assist with self-administration of medications in accordance with Rule 58-A5.0191, F.A.C.

The findings include:

1. at 4:40 p.m., observation of medication pass, Staff C washed hands, donned gloves, took medication out of medicaton cart, dropped 1 drop of medication into residents left eye w/o touching surface of skin, resident wiped eye with tissue, at no time during the process were the eye drop medication identified to the resident.

2. at 4:45 p.m., observation of medication pass revealed Staff C washed hands, popped pills into medication cups at cart, carried medications to resident in dining handed cup with medications to resident, resident poured cup with meds into her mouth, staff handed resident water and resident drank water and swallowed pills. At no time during the medication pass did Staff C identify to resident what medications the resident was taking.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964825	10/04/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sunset Lake Village	**1121 Jacaranda Blvd Venice, FL 34292**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

3. On at 10:18 a.m., observation of Staff Q popped medications into med cup at cart, brought medication cup to resident, handed medication cup to resident without identifing what medications were being given cup to resident. Resident took 2
of the medications and then refused the rest saying all these pills make me sick. Staff documented did not take, refused on back of MOR. After 5 minutes, the med tech offered the medications to the resident who took 1 more pill. The staff did not identify any of the medications in the cup to the resident.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observation, the facility failed to insure 2 (Residents #10 and #8) of 7 residents who are able to take their own medications have those medications secured in their .

The findings include:

1. Observation of Resident #10's revealed the door was unlocked with the resident out of the . Medications were sitting on the table next to her chair in the living . The medications included: .004% solution, Dorzolimide 2.23% solution, and a tube of D ointment.

2. Observation of Resident #8's revealed a prefilled pill organizer sitting on the table next to the resident. The resident was in the .

Interview with Resident #8 on at 10:37 a.m., she stated "I always leave my door unlocked when I am out of my , I leave my pills right where they are, there is nothing dangerous in there." She stated, "My daughter prefills my medications for me." When asked if she had been told to lock her door when she left her to keep her medications out of sight of anyone who might enter her said, "No one told me I had to keep my pills out of sight."

Class III

0079-Staffing Standards - Levels 58A-5.019(4) FAC
Based on interview with 5 (Residents #12, #13, #14, #15, and #17) of 36 residents family members in the memory care unit, staff interviews and observations, the facility failed to ensure sufficient qualified staff to provide resident supervision, and to provide or arrange for bathing, toileting and dietary services.

The findings include:

1. Interview with the son of Resident #12 on at 10:00 a.m., revealed his mother had 2 recent . The on 10/1 resulted in a when another resident into her. The family member stated he felt there is a lack of qualified sufficient staff to meet the needs of all the residents in the memory care unit. He feels since the change in ownership, staff is not able to maintain the twice weekly shower schedule and that there is a lack of 2 hour scheduled toileting. The family member stated he has been coming to assist with activities. He stated the printed calendar "Is a joke." He reported the exercise program is not followed. He stated he and other families take residents to the Friday afternoon happy hour that is on the second floor.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964825	10/04/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sunset Lake Village	1121 Jacaranda Blvd Venice, FL 34292	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

2. Interview with Resident #13's family member on at 12:00 p.m., confirmed that staff does not shower residents twice a week. She stated her mother was sent away from the facility beautician because "She smelled and had very bad dandruff." She reported it took several days for her mother's hair to be washed after she purchased dandruff shampoo. She reported her mother had a and a from not being changed often enough.

3. During an interview the husband of Resident #14 stated he provides 8 hours of care daily for his wife to be sure she gets the care she needs. Observations revealed Resident #14 was fed by her husband at lunch on and He reported that he puts his wife in her pajamas before he leaves around 7:00 p.m. He stated there was a time when he returned the next day that she was in the same depends and her pajamas from the night before. He confirmed there is two unlicensed staff on the 11-7 shift each night. He stated, "There is not enough staff on that shift, if something happens."

4. An interview with Resident #15's daughter on at 11:30 a.m., revealed her mother has been in the facility just a few months. She stated she has no concerns. She did comment that this was the first time "I've seen here in an activity like water color painting."

5. An interview was conducted on at 3:00 p.m., with the sister of Resident #17. She stated she took the resident to the doctor today and asked to talk to surveyor to discuss the resident ' s doctor visit. She stated her sister is very with redded skin in her peri area. She stated, "I have seen residents including my sister with 2 adult briefs on at the same time who are left to walk around wet. Wet circles are left on the chairs where these residents sit." She stated her sister went to the doctor today wearing someone else's clothes. She stated, "My sister has lots of nice clothes and wears a size small, she was wearing extra-large clothes today that did not belong to her, the clothes my sister was wearing today had another residents name on them." She stated, "I noticed a change since the change of ownership, Administrator used to be here daily and was more involved, now she is away a lot." When asked if she visits her sister often, she stated, "not as often as I should, but the residents daughter who lives out of town is very involved in her sister's care and has told me she has concerns for her mother." She added, "Resident # 17's daughter pays for a private companion to stop in several times a week to check on Resident #17."

6. On at 5:30 p.m., during an interview with memory care supervisor he stated, "There is not enough staff to take care of the residents on the memory care unit on any shift, I have seen residents with two adult briefs on at one time when I have taken them to the be toileted."

7. Observations on and during lunch revealed that after the 4 staff serves the residents, they congregate in the kitchen area washing dishes and setting up for the next course of dessert. There was no staff in either dining or cuing residents to eat.

7. Interview with Staff M on at 12:30 p.m., revealed that staff has the responsibility to scrap and wash the dishes before they send them back to the kitchen.

8. Interview with Staff O on at 2:30 p.m., confirmed that on shower days the staff is required to do the resident's personal laundry as well. Observation at 2:00 p.m. on revealed staff O folding laundry in the laundry

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964825	10/04/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sunset Lake Village	1121 Jacaranda Blvd Venice, FL 34292	

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

9. Interview with the program manager for the secure units on at 5:00 p.m., confirmed the staffing schedule of 2 care givers and 2 med techs on the first and second shift, and sometimes only 1 care giver on the 11-7 shift. He confirmed there was only 1 care giver when Resident #12 this morning. The program manager confirmed that there are 2 residents who urinate and defecate in public area. He stated he was told that Resident #19 pulled down her pants and in the living today. He stated both staff and family told him of this event. He stated that staff is supposed to toilet residents every 2 hours, but "Don't always manage to do it." He confirmed that other residents have been observed soaked from and not toileted timely. The program manager stated he was promised more staff to just do showers and laundry, so staff has time to provide care and to interact with residents doing activities.

Class III

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on observation, record review and interview with facility staff, the facility failed to provide a puree diet for 1 (Resident #16) of 1 resident on a puree diet in a facility of 108 residents.

The findings include:

Observation on during breakfast, Resident #16 was observed eating scrambled eggs and a biscuit.

Review of the hospice notes and care plan for Resident #16 revealed she is on a puree diet with a protein supplement of boost three times a day.

Observation on at 12:20 p.m., revealed the resident sitting in her wheelchair apart from other residents at a desk. The resident was observed eating with her fingers, since no utensils were available. The plate had a frittata of ham, zucchini and potatoes and a medley of corn kernels, green pepper strips and chunks of tomato.

Interview with a nursing assistant on at 12:22 p.m., revealed staff thought the entree was soft enough to be puree and proceeded to smash the eggs. The surveyor asked where her puree food and her utensils were. Another staff brought the resident a built up fork with a blue cover.

Interview with the chef on at 12:30 p.m., confirmed there is only one resident in the facility on a puree diet. He stated a puree hot dog was sent to the unit in a soup bowl. He stated he did not know about the puree soup, puree vegetables and puree dessert that should have been offered. He replied Resident #16 is usually not a good eater.

Class III

0167-Resident Contracts 58A-5.025(1) FAC
Based on review of the new contract with the change of ownership and interview with the Administrator, the facility failed to have an addendum for Limited Nursing Services (LNS).

The findings include:

A review of the current contract that was being signed after the change of ownership of revealed there was no addendum for LNS.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964825	**10/04/2013**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sunset Lake Village	**1121 Jacaranda Blvd Venice, FL 34292**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Interview with the Administrator on at 6:00 p.m., confirmed that the present contract that residents were asked to sign did not include a list for the ancillary services/limited nursing services.

On at 3:00 p.m., the Administrator e-mailed a copy of the revised contract that listed 12 addendums including the list for limited nursing services. The Administrator stated that of the 107 residents, approximately 20 resident/family members have not signed a new contract. She stated that all of the residents would be given the addendum packet to sign as well.

Class

N277-LNS - Resident Care Standards 58A-5.031(2) FAC
Based on record review the facility failed to ensure residents receiving Limited Nursing Service (LNS) services had orders for LNS services.

The findings include:

Record review of residents receiving LNS services, no documentation of orders for LNS services was found in the resident record or LNS book.

Interview on at 5:00 p.m. with staff E, revealed she was not aware that residents receiving LNS services needed an order for those services. She stated I did not know that because I have not gone to LNS certification training. All of our LNS services are provided by outside agencies. When asked if she knew what LNS services were she could name them, but was not able to explain her role in the provision of LNS services.

Class III

N278-LNS - Records 58A-5.031(3) FAC
Based on interview and record review, the facility failed to insure progress notes and complete updated monthly assessments were completed for residents on Limited Nursing Service (LNS) services.

The findings include:

Interview with Staff E on at 1:08 p.m. She stated that she is in charge of the LNS residents. Her title is Wellness Director and she works part time during the week and on weekends. She stated all LNS services are provided by 3rd party providers so she really does not evaluate or monitor them, she relies on the home health staff to do that. States she has a weekly conference with home health agency nurses on Tuesdays to monitor resident progress. She stated she does not document what is discussed in these meetings. If a is not healing I go see the patient with the home health nurse to see the She verified the visits with the home health staff are not documented. Those residents are usually sent to the care center in Sarasota for evaluation. When questioned, she stated none of the meetings with the home care agencies is documented in the resident record. States she completes the monthly assessments.

Interview with Staff E, at this time, about the fact that 3 (Residents #17, #11, and #16) out of 3 residents reviewed did not have an updated assessment, she agreed that the assessments completed monthly on residents with

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964825	**10/04/2013**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sunset Lake Village	**1121 Jacaranda Blvd Venice, FL 34292**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

LNS services are incomplete or not up to date. She stated that the residents who are on LNS services for teaching only, she does not complete an LNS monthly assessment or monitor the residents progress, such as Resident #11 who does his own accu-chek and gives his own [redacted]. She verified she does not monitor Resident #11 for his [redacted] sugars or monitor how much [redacted] he is taking. She verified she is not aware of his [redacted] levels or how much [redacted] he is taking.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Sunset Lake Village
1121 Jacaranda Blvd
Venice, FL 34292

Dear Administrator:

This letter reports the findings of a Change of Ownership (CHOW) and Limited Nursing Service (LNS) inspection survey completed on . 2013, by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. 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. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC).

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0025 - 58a-5.0182(1) FAC - Resident Care - Supervision, S/S=D
St - A - 0028 - 58a-5.0182(4) FAC - Resident Care - Activities Of Daily Living, S/S=D
St - A - 0029 - 58a-5.0182(5) FAC - Resident Care - Nursing Services, S/S=D
St - A- 0030 - 58a-5.0182(6) FAC; 429.28 FS - Resident Care-Rights & Facility Procedures, S/S=G
St - A - 0052 - 58a-5.0185(3) FAC - Medication - Assistance With Self-Admin, S/S=D
St - A - 0055 - 58a-5.0185(6) FAC - Medication - Storage And Disposal, S/S=D
St - A - 0079 - 58a-5.019(4) FAC - Staffing Standards - Levels, S/S=D
St - A - 0093 - 58a-5.020(2) FAC - Food Service - Dietary Standards, S/S=D
St - A - 0167 - 58a-5.025(1) FAC - Resident Contracts, S/S=B
St - A - N277 - 58a-5.031(2) FAC - LNS - Resident Care Standards, S/S=D
St - A - N278 - 58a-5.031(3) FAC - LNS - Records, S/S=D

Directed Corrective Actions:

The facility will evaluate all residents on the memory care unit to determine their activities of daily living and medication needs. Evaluations will be completed on all residents no later than 2013. Based on the evaluations residents who require care will be checked and changed as required, no less than every 2 hours.

The facility will train all staff that provides services on the memory care unit on the prevention of neglect and the provision of care with activities of daily living. This training will be provided by a

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Fort Myers Field Office
2295 Victoria Avenue,
Fort Myers, FL 33901
Phone (239) 335-1315; Fax (239) 338-2372

Registered Nurse. Competency checks will be done to ensure all staff is competent in the provision of activities of daily living. These competency checks will be performed by a Registered Nurse. The training will be completed no later than . 2013.

Facility administrative staff will monitor the care provided to residents by all three shifts on the memory care unit to ensure resident needs are being met and residents are not being neglected. This monitoring will occur at least three times per week for all three shifts and will include weekends. This monitoring will continue for at least 90 days.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call ... Catherine Anne Avery, Survey and Certification Support Branch, at (850) 412-4505.

Sincerely,

Harold D. Williams
Field Office Manager

sh

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Fort Myers Field Office
2295 Victoria Avenue,
Fort Myers, FL 33901
Phone (239) 335-1315; Fax (239) 338-2372