STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967498	11/01/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Swan At Lake Conway Alf	3714 St Moritz Street Orlando, FL 32812	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0007 - 58a-5.0181(1) Fac - Admissions - Criteria S-S= D
St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
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 - 0053 - 58a-5.0185(4) Fac - Medication - Administration 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 - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0167 - 58a-5.025(1) Fac - Resident Contracts S-S= B

Specific Tag Findings:

0000-Initial Comments
complaint inspection #2013011426 was conducted.

The facility had deficiencies found during the visit.

0007-Admissions - Criteria 58A-5.0181(1) FAC
Based on observations, record review and interview the facility failed to follow admission criteria for 1 of 7 sampled residents (#5) who was unable to transfer or perform any of her activities of daily living and exceeded requirements for admission to the Assisted Living Facility.

Findings:

Observations on at approximately 9:20 AM noted resident #5 sat in the living 3 other residents.

Observations at approximately 12:30 PM of resident #5 noted she was propelled by a wheelchair to the dining the staff and she was fed lunch by the staff. At approximately 1 PM after lunch, resident #5 was pushed in her wheelchair back to where she sat in the morning.

Record review of resident #5 revealed she was admitted on with a diagnosis of chronic pain and The resident was noted as being non-ambulatory, with decreased visual acuity in left eye and in the right eye. It was noted that the resident was and at times, The

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health assessment form 1823 noted that she was a [redacted] precaution. For activities of daily living the resident needed supervision for ambulation, bathing, dressing, and eating. The resident was noted to need assistance with [redacted] toileting, and transferring. The following required information was not noted on the 1823; if the resident's individual needs could be met in an ALF which was not a nursing or medical facility. It also wasn't noted which type medication administration was needed. The date of the medical examination was not documented on the form. There were no non known [redacted] listed.

She proceeded to take the resident #5 to her [redacted] put her in the bed. Observations at approximately 3:30 PM noted the resident was unable to transfer from the wheelchair to the bed. The staff stated the resident was unable to ambulate, transfer or pivot. She needed total care with her activities of daily living and she changed her briefs on the bed in bed because she was unable to stand. The resident was [redacted] and yelled out incoherent words. Her brief was wet and yellow with [redacted]. Her [redacted] was reddened.

Staff D stated on [redacted] at approximately 3:40 PM that she did not understand why the resident exceeded residency criteria when she met all her needs.

On 11/1//13 at approximately 11:30 AM a hospice nurse came to conduct an assessment and enroll the resident under their services.

Class III

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on interview and record review the facility failed to ensure the health assessment contained all the required information and was accurate for 2 of 7 sampled residents (#5 and #7).

Findings:

Record review of resident #5 revealed she was admitted on [redacted]. The health assessment form 1823 was not dated and did not indicate if the resident's individual needs could be met in a facility which was not a nursing or medical facility. The assessment did not note which type of medication administration was needed. The it was not documented if the resident had any known [redacted]

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Record review of resident #7 revealed she was admitted on . The assessment was not dated and indicated she needed 24 hour supervision. It was not specified what type of medication administration the resident needed.

Class III

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on interview and record review the facility failed to ensure a written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, or other changes which resulted in the provision of additional services were maintained for 1 of 7 sampled residents (#7).

Findings:

During the facility entrance interview on at approximately 9:15 AM the owner/assistant administrator stated resident #7 was in the hospital because of low

Resident record review for resident #7 indicated she was admitted . The health assessment report dated listed status post hip , and . Her status was indicated as memory loss, alert and oriented x 1 and a wheelchair with self-release belt was needed. She needed supervision with eating, assistance with all other activities of daily living (ADLs). Was OK for Assisted Living Facility and needed medication administration. A CVS pharmacy patient information sheet dated indicated extended release 10 millequivalents twice a day for 4 days then every day. The Medication Observation Record (MOR) indicated from 6/1 to "H", meaning in hospital.

The assistant administrator stated on at approximately 1 PM that the doctor ordered lab work, the home health nurse came and did the lab draw. The home health nurse called

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the doctor and when the doctor saw the results told the nurse to send the resident to the hospital was low). There were no notes regarding her hospitalization on and

Class III

0028-Resident Care - Activities of Daily Living 58A-5.0182(4) FAC
Based on observations and interview the facility failed to provide assistance with activities of daily living as needed for 2 of 7 residents (#2 and #4), who were and unable to ask for help.

Findings:

Observations during the facility tour on at approximately 9:20 AM noted 4 residents sat in the living ommon area. The four residents included residents #4 and #5. Resident #5 was and yelled out incoherent words. She sat in the recliner.

Resident #4 stated during an interview on at approximately 10 AM that she could not walk to her She needed her wheelchair, her legs were weak. She dressed herself but needed to be taken to the , if she would go to the "I wear diapers you know, I don't feel it". Observations noted a wheelchair placed by the medication cart, in the hallway entrance.

Observations at approximately 11:15 AM noted that residents #4 and #5 sat in the living the same chairs as observed at 9:20 AM.

Observations on between 12 PM to 1 PM noted 5 residents came to eat in dining Residents #4 and #5 were propelled by wheelchair by staff #D. They ate lunch in their wheelchairs. At approximately 1 PM after lunch, resident #5 was pushed in her wheelchair back to where she sat in the morning, a few minutes later resident #4 was wheeled to the living Neither one was toileted before or after lunch. The other residents ambulated with walkers and went to the bath free will.

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Record review of resident #5 revealed she was admitted on with a diagnosis of , chronic pain and . The resident was noted as being non-ambulatory, decreased visual acuity in left eye and in the right eye. It was noted that the resident was and at times, . The health assessment form 1823 noted that she was a precaution. For activities of daily living the resident needed supervision for ambulation, bathing, dressing, and eating. The resident was noted to need assistance with toileting, and transferring. The following required information was not noted on the 1823; if the resident's individual needs could be met in an assisted living facility which was not a nursing or medical facility. There also no date of the medical examination provided.

Record review for resident #4 revealed a health assessment dated that listed diagnoses of , high and . Her cognition was listed as and forgetful . Assistance was needed with bathing, dressing, eating, , ambulation, toileting, and transferring. It was indicated she was suitable for assisted living facility. She needed medications administered. Health assessment dated listed D deficiency, type II, high and accident. Her status was listed as forgetful . She needed medications administered. Supervision was needed with ambulation; she assistance with all other activities of daily living.

At approximately 3:15 PM on staff #D was asked to toilet residents #4 and #5. She took resident #4 to the . The resident was able to stand up. Observations noted she had 2 adult briefs on. I asked to see the brief she had just taken off. Observations noted the brief was soaked and yellow with .

On at approximately 3:35 PM Staff #D proceeded to take resident #5 to her I put her in the bed. Observations at approximately 3:30 PM noted the resident was unable to transfer from the wheelchair to the bed. The staff stated the resident was unable to ambulate, transfer, or pivot. She needed total care with her activities of daily living. Her brief was soaked and yellow with . Her was reddened.

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During interview with Staff #D on at approximately 3:40 PM was asked why the residents had not been toileted since the surveyor's arrival at 9:15 AM on She answered that residents #4 and #5 wore diapers and she changed them twice a day. She was asked how she decided that two times daily was sufficient for changing and she answered that she checked for smells and put two briefs on them at a time.

Class III

0053-Medication - Administration 58A-5.0185(4) FAC
Based on record review and interview the facility failed to ensure to have a staff member who was licensed to administer medications available to administer medications in accordance with a health care provider's order for 2 of 7 sampled residents (#4 & #7).

Findings:

Resident record review for resident #4 revealed a health assessment dated that listed diagnoses of , high and Her cognition was listed as , forgetful and Assistance was needed bathing, dressing, eating, ambulation, toileting and transferring. It was indicated she was OK for Assisted Living Facility (ALF). She needed medications administered. Health assessment dated listed D deficiency, and high Her status was listed as forgetful, She needed medications administered. Supervision was needed with ambulation; assistance with all other activities of daily living.

Resident record review on for resident #7 revealed a health assessment report dated listed status post hip , and Her status was indicated as memory loss, alert and oriented x 1 and a wheelchair with self-release belt was needed. She needed supervision with eating, assistance with all other activities of daily living (ADLs). Was OK for Assisted Living Facility and needed medication administration.

Staff D stated she assisted residents #4 and 37 with self-administration of medications. She was a Certified Nursing Assistant.

The administrator who was not a nurse stated on at approximately 2:30 that the 2 residents needed assistance with medications not medication administered and there was not

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a nurse available to administer medications to any of the facility residents.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observations and interview the facility failed to ensure medications were kept in a locked cabinet, locked cart, or other locked storage receptacle, or area at all times, out of sight of other residents, for 1 of 7 sampled residents (#5).

Findings:

Observations on at approximately 3:40 PM of the resident #5 noted 2 baggies on a dresser top that had a sign that read "AM & PM." Inside there was solution 0.2 one drop in left eye for The other baggie on the dresser had a label that indicated "right eye am" inside there a bottle of 0.5 mg one drop to right eye daily.

Observations on at approximately 1 PM noted 2 bottles and a bottle of peri-wash by the sink by the dining area. The assistant administrator staff #D stated on at approximately 1 PM the peri-wash bottle had water only.

Observations on at approximately 11:30 AM noted a plastic baggie with eye drops with a prescription label dated that indicated one drop to each eye at bedtime. The kitchen was not locked, it was an open area connected to the dining accessible to residents and visitors alike. The refrigerator was not locked nor where the medications inside the refrigerator in a locked container.

The administrator stated on at approximately 11:30 AM that he would ensure that medications were secure from now on.

Class III

0079-Staffing Standards - Levels 58A-5.019(4) FAC
Based on interviews facility record review and interview the facility failed to maintain a written work schedule which reflected its 24-hour staffing pattern for a given time period and failed to maintain the required staff hours per week.

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Findings:

During the facility entrance conference conducted on at approximately 9:20 AM the owner stated the census was 6 residents; one just moved out and one was in the hospital: 5 residents were home.

Individual resident record review on revealed:

Resident #1 admitted on

Resident # 2 was admitted

Resident #3 admitted

Resident #4 was admitted on

Resident # 5 was admitted

Resident #6 was admitted

Resident #7 was admitted

On 2013 the facility's census increased to 6 residents. For a census of 6-15 residents the facility needed a minimum of 212 weekly staff hours.

Review of the weekly staff schedule for the weeks of

10/7 to (should have been week of 10/6 to

(should have been week of to

to (should have been week of to

to & to 11/7 (should have been week of to 11/2). The schedule listed staff D, staff E and another individual. Staff D stated that staff E and the other individual no longer worked at the facility. She did not know when the staff worked last.

According to the schedule and staff D's statement on at approximately 1:45 PM, if the administrator worked 2 times a week for a total of 24 hours, then staff D worked 188

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hours a week, more hours that there are in a week (7 days x 24 hours = 168) in order to meet the required 212 staff hours.

The dates on the schedule were not consistent with the actual calendar dates for the month of .

Interview with family member of resident #2 at 1:50 p.m. on , when asked if there are other employees who work at the facility he responded yes a woman named (said staff name) staff F will sometimes assist staff D.

During an interview with resident #2 on at 10:55 AM. The resident was asked if there were any other employees other than staff D and she replied yes that there is another lady who came in when staff D was off and that so far the other lady was nice. When asked how long ago she stated that it was recently that the other employee worked.

The daughter of former resident #6 stated on at approximately 11:15 AM that last Monday she came to see her mom and the new girl, name unknown, was on the phone and not caring for the residents.

On at approximately 1 PM attempted to contact former facility staff, to no avail. Staff E, had a non-working number. The operator message stated try this number again. A message was left for Staff E. At the same time the telephone call waiting beeped. A woman asked if I just called her. I told her I was wanted to speak with staff E or staff F. She asked why I wanted to speak with them. I asked her name, she just hung up.

The daughter of resident #3 came to visit on at approximately 5:30 PM. She stated there was other staff besides staff D, but she did not know their names.

The assistant administrator stated on at approximately 5 PM that only she and the administrator worked at the facility, the 2 other staff quit and there was no new staff.

The administrator stated on at approximately 7:15 PM he had given the responsibility of staffing to the assistant/staff D but evidently she was doing a good job.

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0081-Training - Staff In-Service 58A-5.0191(2) FAC
Based on interview and personnel record review the facility failed to provide or arrange for 1 of 8 sampled staff (F) to attend an in-service training in Recognizing and reporting resident , neglect and .

Findings:

Personnel record review on , at approximately 2 PM revealed that staff F hired . attended an in-service training on Residents Rights on . There was no evidence to confirm she attended an in- service training Recognizing , and Neglect and .

The administrator stated on , at approximately 1 PM that staff F evidently did not have the training, as he was unable to locate a certificate. The staff was no longer employed by the facility.

Class III

0167-Resident Contracts 58A-5.025(1) FAC
Based on resident record review and interview the facility failed to ensure that the resident contracts for 5 of 7 sampled residents (#2, #4, #5, #6, and #7) contained all the mandated requirements.

Findings:

Resident record review on , revealed:

Resident # 2 was admitted .

Resident #4 was admitted on .

Resident # 5 was admitted .

Resident #6 was admitted .

Resident #7 was admitted .

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Individual resident record review revealed the contact for residents #2, #4, #5, #6 and #7 did not include the following components:

1. The daily, weekly, or monthly rate.

2. A provision giving at least 30 days written notice prior to any rate increase.

3. Any rights, duties, or of residents, other than those specified in Section 429.28, F.S.

4. A refund policy which shall conform to Section 429.24(3), F.S.

5. A written bed hold policy and provisions for terminating a bed hold agreement if a facility agrees in writing to reserve a bed for a resident who is admitted to a nursing home, health care facility, or facility. The resident or responsible party shall notify the facility in writing of any change in status that would prevent the resident from returning to the facility. Until such written notice is received, the agreed upon daily, weekly, or monthly rate may be charged by the facility unless the resident ' s medical condition, such as the resident ' s being comatose, prevents the resident from giving written notification and the resident does not have a responsible party to act in the resident ' s behalf.

6. A provision stating whether the organization is affiliated with any religious organization, and, if so, which organization and its relationship to the facility.

The administrator stated on at approximately that he did not know where the other pages of the contract where.

Class

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Swan At Lake Conway Alf
3714 St Moritz Street
Orlando, FL 32812

Dear Administrator:

Re: CCR #2013011426

This letter reports the findings of a complaint investigation survey that was conducted on , 2013, to , 2013 by representative(s) 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 , **2014,** 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 surveyor(s). Should you have any questions please call Lorraine Henry at .

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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