STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911132	12/04/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Ocean View Manor	624 S Atlantic Avenue Daytona Beach, FL 32118	

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

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0126 - 58a-5.021(7) Fac - Fiscal - Resident Accounting S-S= D
St - A - 0167 - 58a-5.025(1) Fac - Resident Contracts S-S= D

Specific Tag Findings:

0000-Initial Comments

A complaint survey (CCR #2013009606) was conducted at Ocean View Manor on 2013. Deficiencies were identified.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on a review of resident and facility records, and interview with the Administrator, the facility failed to ensure a system was in place for receiving, documenting and resolving grievances for 2 of 3 discharged residents sampled (Residents #1 and #3).

The findings include:

1. A complaint was received by the agency for failure to provide a refund to Resident #3 after he was discharged without notice by the facility, then charged for a bed hold for up to one month.

The facility's grievance policy was reviewed, which stated all concerns would be reviewed and signed by the Administrator within 30 days of the report. The grievance log was reviewed and found no grievance filed on behalf of Resident #1 or Resident #3.

An interview with the Administrator at 9:30 am on found she handled all grievances and, depending on the situation, would also document discharged resident's concerns on a grievance form.

A record review for Resident #1 found he was admitted to the facility on and discharged under the on . There was no information detailing the events surrounding his discharge in Resident #1's record. Resident #1 had diagnoses including affective and He was independent with activities of daily living (ADLs) and his family handled his finances and personal affairs.

The Resident Agreement dated and signed by the resident and a facility representative noted 'The facility, by law, may retain any unused portion of the advance payment for outstanding resident charges, and abnormal damages to the facility by the resident prior to refunding the balance. Written notice of deduction from the refund will be given to the resident and the responsible party'.

A review of the facility's In House Resident Banking account revealed that on Resident #1 had a balance of $0.00. On a deposit of 25.00 was made, and on the resident withdrew, and signed for, $5.00, leaving a balance of $20.00 in his account. On the remaining 20.00 was withdrawn from his account by a representative of the facility for damages. There was no receipt and no itemized list of damages the resident was

to reimburse.

An interview was conducted with the FRO at 11:00 am on . He confirmed he withdrew Resident #1's last 20.00 to reimburse the facility for damages for a broken fire extinguisher. He stated he spoke to Resident #1 ' s mother via telephone, who was not happy about the facility keeping the $20.00. She insisted there was more money than $20.00 in Resident #1's account. She threatened to "get a lawyer", that was the last he heard from her.

2. A record review was conducted for Resident #3, and found he was admitted to the facility on . A Resident Health Assessment (AHCA form 1823) dated noted Resident #3 had a diagnosis of . He was independent with activities of daily living with some supervision, and required assistance with handling personal and financial affairs. He required daily oversight for observation of his wellbeing, his whereabouts and reminders for important tasks.

A resident agreement dated and signed by Resident #3 and a representative of the facility revealed the facility's refund policy, which stated: 'Without a 30 day notice, no refund will be given. A refund of the advance payments for housing, food services and personal services will be given (pro-rated daily basis) if the resident must vacate the assisted living facility (ALF) because of illness, transfer to nursing home, closure of the ALF or transfer of ownership. The facility, by law, may retain any unused portion of the advance payment for outstanding resident charges, and abnormal damages to the facility by the resident prior to refunding the balance. Written notice of deduction from the refund will be given to the resident and the responsible party. ... reimbursements will be paid within 45 days of receipt of the written notice of termination, or after the unit is vacated of all personal items (except in the case of or permanent discharge to nursing home). Minimum of 30 day notice must be given by the resident in writing to terminate the lease. If failure to do so, you will be charged an additional month ' s rent. (The facility) must give the resident or responsible party 45 days notice to terminate the lease and vacate the property'. The bed hold policy included in the resident agreement stated the facility would 'hold a bed while a resident was hospitalized or temporarily placed in a skilled nursing facility for the period of time the resident is current on the monthly fee, and the physician certifies the resident is appropriate to return to the facility. If determined the resident is inappropriate, the resident shall be charged on a pro-rated basis for the amount of days the resident's belongings remained in the . The undersigned agrees that if the resident manifest in such a degree of behavior that he/she is a danger self, or if the behavior is so unacceptable or disturbing as to interfere with the wellbeing and safety of the other residents, then (the facility)shall not allow the resident to remain at the facility and, the undersigned releases (the facility) from further responsibility toward the resident, and waive the 45 day notice for terminating this lease'.

There was no information in the resident record regarding the events surrounding his discharge from the facility.

A review of the facility's admission and discharge log revealed Resident #3 was jailed on and discharged under the on

An interview was conducted with the Administrator on at 11:20 am. She revealed the details of Resident #3's discharge. She referenced some hand-written notes from her personal binder, and recalled he was taken to jail on . The facility held his bed under the bed hold policy. He was then was released from the jail without notice (date unknown), and walked back to the facility. Within 30 minutes of his return, Resident #3 went to the hospital's emergency department for sores on his feet, and was while in the hospital, and transferred to the unit. His violence in the hospital did not subside. The hospital determined he was "not appropriate to return", and informed the Administrator he would be transferred to the State Hospital. The

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Administrator insisted the resident's bed was held until . She added bed holds were "indefinite" unless the resident, representative or hospital notified the facility the resident did not intend to return.

An interview with the facility owner was conducted on at 11:30 am. He stated he handled the refund concern for Resident #3. He explained he sent a prorated amount for the month of (after withholding board per the bed hold through 2013, the day of discharge), back to Social Security.

A telephone interview was conducted with Halifax Hospital ' s Unit's Charge Nurse at 2:36 pm on . She recalled the events of Resident #3's most recent stay by referencing the Social Worker's and hospital notes. She stated on Resident #3 arrived in the emergency department (ED) under an ex parte order obtained by the facility for medication non-compliance, alleged ingestion of rubbing , and increasing agitation with violence. Resident #3 was then transferred from the ED to the unit on Days later, the resident's sister phoned the hospital and stated the facility told her Resident #3 was not permitted to return to the facility. The hospital Social Worker (SW) phoned the facility on and spoke with the Administrator, who confirmed Resident #3 was not permitted to return.

On the Administrator agreed to come to the hospital to re-evaluate Resident #3 for possible return to the facility. On Halifax staff contacted the Administrator again, but was told no one was coming to evaluate Resident #3. On , Halifax contacted the facility again to see if he could be assessed for readmission. The facility said they could not come. On another telephone call was placed the facility, and the Administrator planned to evaluate the resident the next day. On the Administrator phoned the hospital stating she would not accept him back, as he was not stable.

The facility failed to resolve the concern regarding a refund owed to Resident #3 for bed hold monies unjustly held after the facility discharged the resident without notice on .

Class III

0126-Fiscal - Resident Accounting 58A-5.021(7) FAC
Based on a review of staff and facility records and interviews with staff, the facility failed to maintain a transaction record for 1 of 3 sampled residents (Resident #3) for whom the facility provided safekeeping of money.

The findings include:

A record review for Resident #3 found he was admitted to the facility on , and paid $975.00 per month in board, per the resident agreement dated this same day. Further record review found no Social Security Determination letter indicating the resident's current monthly benefit amount from the Social Security Administration.

A review of the facility's Personal Spending Account Book for Resident #3 found one ledger showing he received a distribution of his personal funds in the amount of $80.00 on A final entry dated documented another $80.00 withdrawal. Both ledgers entries were signed by the resident. There was no indication that Resident #3 received his personal funds from the facility on any other month in 2012 or 2013.

An interview was conducted with the Facility Relations Officer (FRO) at 11:00 am on He searched, but could not locate any other ledgers proving the monthly distribution of personal funds for Resident #3. He stated

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the owner of the facility gave Resident #3 his $80.00 each month, but he did not know where it was documented. He confirmed there was no proof of the monthly distribution of Resident #3's personal funds.

The owner was interviewed at 11:30 am on . He stated Resident #3 was very aggressive, demanded his monthly allowance of $80.00 on the same day each month. "He waited for me in the parking lot, and would stand in front of my car. I would have to give him his money right there." The owner insisted he told Resident #3 to "go sign the (Personal Spending Account) book for (the FRO) " each time he distributed Resident #3's funds; however, the resident refused. He confirmed he failed to document the distribution of personal funds to this resident, and that he had no proof Resident #3 received his monthly allowance.

Class III

0167-Resident Contracts 58A-5.025(1) FAC
Based on a review of resident records and interviews with facility staff, the facility failed to adhere to it's own refund policy for 2 of 3 discharged residents sampled (Resident #1,who had personal money withheld after discharge for facility damages; and Resident #3, who was discharged without notice, then charged a bed hold for 28 days).

The findings include:

1. A record review for Resident #1 found he was admitted to the facility on on and discharged under the on . There was no information detailing the events surrounding his discharge in Resident #1's record. Resident #1 had diagnoses including affective , and He was independent with activities of daily living (ADLs) and his family handled his finances and personal affairs.

The Resident Agreement dated and signed by the resident and a facility representative noted 'The facility, by law, may retain any unused portion of the advance payment for outstanding resident charges, and abnormal damages to the facility by the resident prior to refunding the balance. Written notice of deduction from the refund will be given to the resident and the responsible party.'

A review of the facility's In House Resident Banking account revealed that on Resident #1 had a balance of $0.00. On a deposit of 25.00 was made, and on the resident withdrew, and signed for, $5.00, leaving a balance of $20.00 in his account. On the remaining $20.00 was withdrawn from his account by a representative of the facility for damages. There was no receipt and no itemized list of damages the resident was to reimburse.

An interview was conducted with the FRO at 11:00 am on He confirmed he withdrew Resident #1's last $20.00 to reimburse the facility for damages for a broken fire extinguisher. He stated he spoke to Resident #1's mother via telephone, who was not happy about him keeping the $20.00. She insisted there was more money than $20.00 in Resident #1 ' s account. She threatened to "get a lawyer", and that was the last he heard from her.

An interview was conducted with the facility owner at 11:30 am on He stated Resident #1 did a "ton" of property damage during his last incident, and the facility retained his remaining $20.00 for damages. He denied maintaining or sending any receipts or repair costs to the resident or his representative. The owner

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acknowledged he should have sent a written notice of the deduction from the resident's account to the resident or his representative after withholding his personal funds for damage reimbursement.

2. A record review for Resident #3 found a Resident Agreement dated , which was signed by the resident and a representative of the facility. The refund policy included in the agreement stated: "Without a 30 day notice (of discharge), no refund will be given. A refund of the advance payments for housing, food services and personal services will be given (pro-rated daily basis) if the resident must vacate the ALF because of illness, transfer to nursing home, , closure of the ALF or transfer of ownership..... reimbursements will be paid within 45 days of receipt of the written notice of termination, or after the unit is vacated of all personal items (except in the case of or permanent discharge to nursing home). Minimum of 30 day notice must be given by the resident in writing to terminate the lease. If failure to do so, you will be charged an additional month ' s rent. (The facility) must give the resident or responsible party 45 days notice to terminate the lease and vacate the property. The bed hold policy included in the resident agreement stated the facility would 'hold a bed while a resident was hospitalized or temporarily placed in a skilled nursing facility for the period of time the resident is current on the monthly fee, and the physician certifies the resident is appropriate to return to the facility. If determined the resident is inappropriate, the resident shall be charged on a pro-rated basis for the amount of days the resident ' s belongings remained in the The undersigned agrees that if the resident manifest in such a degree of behavior that he/she is a danger self, or if the behavior is so unacceptable or disturbing as to interfere with the wellbeing and safety of the other residents, then (the facility)shall not allow the resident to remain at the facility and, the undersigned releases (the facility) from further responsibility toward the resident, and waive the 45 day notice for terminating this lease.

A review of financial records for Resident #3 found a receipt from the Social Security Administration for the return of $356.00 for Resident #1 on The reason for payment was noted " money you saved for (Resident #3). " It was signed by a representative of the Social Security office and dated

A review of the facility's admission and discharge log revealed notes that Resident #3 was jailed on and discharged under the on There was no information in the resident record regarding the events surrounding his discharge from the facility.

An interview was conducted with the Administrator on at 11:20 am. She revealed the details of Resident #3's transfer and discharge. She referenced some hand-written notes she had in her personal binder, and recalled he was taken to jail on She insisted law enforcement initiated the not the facility. She said his bed was held per the bed hold policy. He was then released from the jail without notice (date unknown), and walked back to the facility. Within 30 minutes of his return, Resident #3 went to the hospital's emergency department for sores on his feet, and was while in the hospital. He was then transferred to the unit. She again insisted the was initiated by hospital staff, not the facility. Resident #3's violence in the hospital did not subside. The hospital determined he was "not appropriate to return" to the facility, and informed the Administrator he would be transferred to the State Hospital. The Administrator insisted the resident's bed was held until when she was told he was not appropriate to return. She explained that bed holds were "indefinite" unless the resident, representative or hospital notified the facility the resident did not intend to return.

An interview with the facility owner was conducted on at 11:30 am. He stated he had handled the refund concern for Resident #3, and sent a prorated amount of rent money back to Social Security after withholding board per the bed hold policy through 2013, the day of discharge.

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The facility continued to charge Resident #3 for a bed hold from until , after obtaining an ex parte order to have him removed from the facility on and verbally discharging him on .

Documentation from the Social Security Administration revealed that Resident #3 received $1,103 each month from 2013. Resident #3 was responsible for paying the assisted living facility $975 for board. Since the facility verbally discharged Resident #3 on , he was due a refund in the amount of $227.50 for the 7 days in of 2013, and $691.90 for the 22 days in . This does not include the $256 left over for both months from the Social Security Income. The total amount due to the resident equals $1,175.40.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Ocean View Manor
624 S Atlantic Avenue
Daytona Beach, FL 32118

Re: CCR #2013009606

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on 2013 by a representative 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. Should you have any questions please call this office at

Sincerely,

Keisha Woods, MPH
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

LL/KW/sm
Enclosure

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