STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953545	12/23/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sea View Inn At Forest Lakes	3548 Sea View Street Sarasota, FL 34239	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Revisit Corrected Tags:
0010-Admissions - Continued Residency-12/23/2013
0050-Medication - Self Administered Medications-12/23/2013
0052-Medication - Assistance With Self-Admin-12/23/2013
0085-Training - Nutrition & Food Service-12/23/2013
0090-Training -

Revisit Repeat Tags:
0030-Resident Care - Rights & Facility Procedures-58a-5.0182(6) Fac; 429.28 Fs
0056-Medication - Labeling And Orders-58a-5.0185(7) Fac
0080-Training - Core & Competency Test-58a-5.0191(1) Fac

Revisit New Tags:
0054-Medication - Records-58a-5.0185(5) Fac

Specific Tag Findings:
An unannounced follow-up to the Biennial survey was conducted on 12/23/13 at Sea View Inn at Fountain Lakes, an Assisted Living Facility (ALF) with a licensed capacity of 6 residents.

The following citations were cleared: A 0010, A 0050, A 0052, A0085 and A 0090. The following deficiencies were recited: A 0030, A 0056 and A 0080 and a new deficiency was cited: A 0054.

The following is a description of the noncompliance:

0010-Admissions - Continued Residency 58A-5.0181(4) FAC

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on record review and interview, the facility failed to ensure 1 (Resident #1) of 4 resident records reviewed demonstrated access to adequate and appropriate health care consistent with established and recognized standards within the community. The facility failed to ensure active communication and a plan of care was exchanged between the resident and her physician or psychiatrist related to her eating and failed to ensure her psychiatrist was aware of her refusals of an medication.

The findings include:

1. During the record review on Resident #1's Resident Health Assessment AHCA Form 1823 was documented as completed on The resident was admitted on with diagnosis including: eating and scoliosis. There was nothing in the resident's record to document how the facility should handle a resident with an eating There was no communication with the resident's physician or psychiatrist on the plan for this type

During the follow-up survey conducted on Resident #1's record was reviewed. A new 1823 Health Assessment was conducted on which failed to document the resident as having an eating

A telephone interview was conducted with Resident #1 on at 10:46 a.m. During this interview, she stated she has a long standing history of an eating which she stated was diagnosed as

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over eating" and When asked how the facility is helping her with this, she stated, "They give me what I want."

The Administrative Assistant (AA) was interviewed on at 10:30 a.m., who confirmed the resident with an eating . She was asked whether there was a "plan" to assist the resident while at the facility with this . She indicated the resident was sent out to the hospital back in and when she came back, there was nothing documented about the . She stated the current 1823 does not reflect it because it was completed by the physician at the hospital and not her psychiatrist and she is still waiting for paperwork from him as of to reflect what her eating is. She confirmed they still do not have a specific plan outlined as to how the facility is going to help her with this problem.

2. Observation during medication observation for Resident #1 on at 7:07 a.m., revealed the AA handing medications to the resident during assistance with self-administration of medications. Included in the morning medications was an medication used in the treatment of .

The 1823 Health Assessment dated documents the resident with history of and paranoia.

Record review on revealed a physician's order for 100 mg. tablets, take 2 tablets (twice daily) and 6 tablets at hs (hour of sleep).

The Medication Observation Record (MOR) for documents the was scheduled to be taken at 8:00 a.m., 12:00 p.m. and at 8:00 p.m. Further review of the MOR revealed the resident refused her 12:00 p.m. dose of the medication beginning through a total of 12 missed doses.

In an interview with the AA on at 11:00 a.m., she stated the resident said she wasn't going to take it so she documented her refusal (one time) on the back of the MOR. When asked if she notified the physician the resident had been refusing her 12:00 p.m. dose, she confirmed she hadn't.

During an interview with the treating psychiatrist on at 11:52 a.m., he confirmed he was never made aware the resident was refusing her 12:00 p.m. medication dose of the medication.

Class III

0050-Medication - Self Administered Medications 58A-5.0185(1) FAC

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC

0054-Medication - Records 58A-5.0185(5) FAC
Based on observation, record review and interview, the facility failed to keep an accurate and up-to-date Medication Administration Record (MOR) for 1 (Resident #1) of 3 resident MORs reviewed.

The findings include:

Observation during medication observation for Resident #1 on at 7:07 a.m., revealed the Administrative Assistant (AA) handing medications to the resident during assistance with self-administration of medications. Included in the morning medications was an medication used in the treatment of

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In an interview with the AA on at 11:00 a.m., she stated the resident said she wasn't going to take it so she documented her refusal (one time) on the back of the MOR.

The AA confirmed she failed to keep an accurate and up to date MOR related to resident's refusal of

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on observation and interview, the facility failed to ensure prescription medications were properly labeled for 1 (Resident #1) of 3 residents reviewed.

The findings include:

During medication observation for Resident #1 on at 7:07 a.m., the resident was observed to place Saphris 10 mg. 1 tablet under her tongue. After doing so, the Administrative Assistant (AA) who was assisting the resident with self-administration of medications, encouraged the resident not to eat or drink for 10 minutes after placing the medication under her tongue.

The AA removed the sample packages of the medication which revealed one package labeled Saphris 10 mg. Handwritten in black magic marker on the outside of the box was "1 tablet 8:00 a.m." Observation revealed "1 tablet 8:00 p.m." handwritten in black magic marker on the outside of Saphris 5 mg. The resident's name, practitioner's name and the date they were dispensed were not visible on the sample packages.

Interview with the AA on at 11:46 a.m. confirmed the medications were not labeled correctly.

Class III

0080-Training - Core & Competency Test 58A-5.0191(1) FAC
Based on record review and interview, the Administrator (Staff B) failed to ensure she had verification of passing the ALF CORE competency test and failed to maintain the 12 hour continuing education every two years as required. Failure to maintain the 12 hours of CEUs requires the administrator to retake the ALF CORE training and retake and pass the competency test.

The findings include:

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Employee record review during the follow up to the biennial survey on revealed Staff B had taken ALF CORE training on as evidenced by a certificate. There was a copy of the certificate for passing the CORE competency test as required.

It was identified during the biennial survey conducted on that Staff B had 6 hours of continuing education in 2003; 13.25 hours in 2004; 5 hours in 2008 and 1 hour in 2011. The administrator lacked proof of 12 hours of CEUs for ; ; and .

On after the survey, the Owner faxed to the surveyor educational certificates from Pulse Learning with no date of training but hand written in dates. The certificates equaled 11.9 hours in 2012 and 5.5 hours for 2013.

On at 9:30 a.m., the Administrative Assistant (AA-Staff "A") stated the Administrator (Staff B) was out of the country and she could not assist with gathering the information to validate her (Administrator) CEUs were in the file. She stated she would not be back until after the year and the surveyor needed to wait until then to obtain the information.

Class III

0085-Training - Nutrition & Food Service 58A-5.0191(6) FAC

0090-Training - 58A-5.0191(11) FAC

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Sea View Inn At Forest Lakes
3548 Sea View Street
Sarasota, FL 34239

Dear Administrator:

This letter reports the findings of a Biennial Revisit Survey conducted on 23, 2013 by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than 2014.**

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 (239) 335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

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Enclosure: State Form

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