STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964280	
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Forest Lake Manor	**252 Forest Lake Blvd Daytona Beach, FL 32119**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0079 - 58a-5.019(3) Fac - Staffing Standards - Levels S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced complaint survey CCR#2014003618 was conducted on , 2014 at Forest Lake Manor in Daytona Beach Florida. Deficiencies were identified during the visit.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on record review, observations and interviews the facility failed to ensure adequate supervision to provide care for 3 of 3 sampled residents. (Residents #8, 9, 10)

The findings include:

1) Record review for Resident # 8 revealed male admitted with diagnosis of and
Review of the Resident Health Assessment (1823) revealed Res #8 was independent with ambulation, required assistance with bathing and dressing and supervision with transfers and toileting. Resident #8 was observed on at 10:05am. Upon entering his , there was a pungent odor of . The residents was not present at the time. Resident #8 was lying in bed, alert but not oriented. There were disposable bed pads observed in the trash can.

An interview was conducted with the Certified Nursing Assistant (CNA) on at 10:30am. He was asked if Res #8 needed assistance with toileting. He stated the resident is of and wears briefs. He reported that the resident was and will take off the briefs and urinate in the bed or on the floor which is carpeted. He said he tried to check on him frequently however there are only two aides during the day to assist with bathing, dressing, showers and toileting including changing the residents. When asked if the caregivers had regular assignments, he stated " no " there are only two of us and we help whoever needs assistance. When asked about the strong odor in the residents , he stated it usually smells of . He did not know how often they cleaned the carpets.

On at approximately 10 AM, the Administrator reported that there are 33 out of 52 residents at the facility who require care.

2) Record review of Resident #9 revealed she was admitted to facility on . Her diagnosis include , and . She required assistance with all activities of daily living (ADL), she was of bowel and and she was non-ambulatory and non verbal. She was also receiving hospice services.

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A review of ADL book for , 2014 revealed brief change documentation for Resident #9 on 12, 21 & 22. May 2014 revealed brief change on May 2, 2014.

On at 2:20pm, an interview was conducted with Certified Nursing Assistant (CNA) Employee #4. When asked if Resident #9 needed assistance with toileting he stated, " yes " she is . When asked how often she was toileted, he stated usually three times during his shift. When asked about the strong odor in the , he stated that most mornings when comes in the resident and her are found with briefs so saturated the bed sheets are soaked. He stated he has reported this to the nurse on many occasions, however nothing has changed. He stated he found her that way this morning. When asked how many caregivers were assigned on the night shift, he stated two, same amount as the facility has in the daytime.

Observation of Resident #9 ' s at 11am and 4:30pm revealed very strong odor of .

3) Record review for Resident #10 revealed she was admitted to facility on . Diagnosis include and .
Review of the nursing monthly summaries included the following: resident alert with and oriented to person only, required assistance with all ADL ' s except eating and of bowel and .

On at 2:20pm an interview was conducted with Certified Nursing Assistant (CNA) Employee #4. When asked if Resident #10 needed assistance with toileting he stated, " yes " she is . When asked how often she was toileted he stated usually three times during his shift. When asked about the strong odor in the , he stated that most mornings when comes in the resident and her are found with briefs so saturated the bed sheets are soaked. He stated he has reported this to the nurse on many occasions, however nothing has changed. .

A review of ADL book for Resident #10 for 2014 revealed one brief change for 24 7a-3p shift. Hand written note at the bottom of the page read "Resident refused brief change on ." There was no documentation for brief changes on any shift for 2014.

Observation of Resident #10 ' s at 11am and 4:30pm revealed a very strong odor of .

An interview was conducted with the Executive Director (ED) on at 6:15pm .She was asked how often residents were provided care. She stated she was not a nurse but they should be checked every two hours. She stated the facility currently did not have a Director of Nursing and there had been a lack of accountability and supervision. When asked if she was aware that 33 of 52 residents required care and the facility had only 2 caregivers to provide the care. She stated there were also 2 medication technicians on duty but reported that their primary function was to assist with medications for 52 residents leaving little time to assist with personal care. She agreed that the facility had a higher than average number of residents and that more staff was needed.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation, record review and staff interview, the facility failed to provide appropriate health care consistent with recognized community standards for control procedures for resident with communicable (bed bugs and) for 5 of 13 sampled residents. (Bed bugs, Resident # 1, 4, 5) and (

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Resident # 2, 3)

The findings include:

1) An interview was conducted with Resident #1 on at 9:35am she reported that her room (118) had been cleaned because of bed bugs. When asked how was she made aware of the bed bugs, she stated someone from the facility, but not sure who. She was asked how the staff cleaned the ensure the bedbugs did not return. She stated the maintenance man had her and her leave the he sprayed in the the mattresses. When asked if her belongings were taken out of the the treatment, she stated " no " . She also said she was upset because she had her own reclining chair in the that it had been removed and was not returned. When asked if she had experienced any bites or itching, she stated she did, however she had none at this time.

Resident #1 ' s , Resident #14, confirmed that their (118) had bedbugs and the pest control company had been out several times. Res # 14 stated she hoped that was the last of the bed bugs and she could not understand where they came from. When asked if she had experienced any bites or itching, she stated she did, but not now. She was asked what the staff did to treat the problem. She stated the maintenance worker sprayed the .

Observation of on at 11:05am revealed multiple boxes and bags piled up on top of the dressers and furniture and stacked up along the walls. Resident #14 was present at the time. She stated the open space between the beds is where her chair used to be. The maintenance man took it away. When asked about the all the boxes and bags in the , she stated she did not have any space in her put her things.

On at 10:40am Resident #5 was observed cleaning her (116). An interview was conducted and she reported that she had a and bites all over her legs. She said she had purchased anti itching creams for months and had recently spent $10.00 on a can of Hotshot bed bug spray. Further interview revealed she had told staff about the itching but nothing had been done. She stated she had washed her own sheets and sprayed the baseboards herself. She stated she had a plastic cover on the mattress but it was torn up and she had to take it off. Resident #5 was asked if her been treated by the pest control company, she stated " no " .

An interview was conducted with the Executive Director (ED) on at 9:30am. When asked if the facility had been recently treated for bedbugs she stated " yes " . She stated the Health Department (HD) came to the facility on and confirmed the presence of bedbugs and to immediately call the pest control company. Prior to the HD visit the Maintenance Director (MD) had purchased some bedbug spray and applied the spray to . The ED provided copies of the pest control reports. Service calls were made on , , and . On bed bug activity was found in 106 and 118. On bed bug activity was found and recommended the reclining chair be removed and mattress bedbug covers needed to be replaced or repaired in . There was no cover for bed in 106 and recommended one be placed on the mattress. On pest control treated 106 and 118. Recommended encase box spring because it had rips and could possibly cause re-infestation. Informed MD to tape up the holes in the box spring in . On treatment was

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provided to rooms 106, 117 and 118. Bedbug activity was found in night stands in room 118.

The ED was asked how the staff and residents were notified of the presence of bed bugs and what instructions were given. She stated the staff knows to use protective gowns and equipment when needed. She was asked if the staff were using gowns and when going into the and disposing of them before leaving. She did not know. She stated the residents were not told because she did not want them to panic.

An interview was conducted with the MD on at 3:05pm He was asked when was he made aware of the presence of bed bugs. He stated early in . When it was reported to him, he did not immediately call the pest control service, instead he stated he went to home depot and purchased some spray and applied it to the whole . He said he removed everything from the . He thought that would be sufficient. However, on the Health Department came in on a complaint to inspect and found bed bugs in and 118. The facility was instructed to call for pest control service for treatment ASAP. Also to wash sheets and heat dry daily, put mattress cover bed bug proof on mattress and let the office know of 1st treatment and will need bed bug free certificate from pest control. The 1st treatment was done on . Second treatment on . When asked if the facility had obtained a certificate of bed bug free, he stated " no " as on there was still activity found.

2) An interview was conducted with Resident #2 on at 10:45am. She stated both her and her Res #3 had been treated for last Friday. It started with her who had bites and was itching. Her went to the doctor and it was confirmed she had . Res #2 stated that she had been itching for a week and her doctor had seen her and thought it was a skin . When the facility informed the doctor of the confirmed diagnosis of the , he ordered treatment for . Both she and her where treated with a special cream that was applied and washed off after several hours and would be repeated in one week. When asked if she was still itching she stated "yes" and was applying cream and taking capsules twice a day

Res #2 was asked what type of cleaning procedures were done after they were treated for . She stated the bed sheets were changed and the clothes she was wearing were put in a plastic bag to be washed. When asked if the entire been cleaned, she stated " no ".

An interview was conducted on at 11:00am with Resident #3. She was asked if she had been treated for . She stated she had been itching and went to the doctor and after a skin test confirmed she had The doctor ordered a cream that was applied and washed off that evening. When asked if she still was itching, she stated it was better. She was asked if the staff had done any special cleaning in the she was treated. She stated they changed the linens on the bed and had her place the clothes she was wearing in a plastic beg to be washed separately. When asked if the pest control company used by the facility had come in and treated her stated "no". Res #2 stated that there was less staffing in the facility since there were budget cuts.

An interview was conducted with Certified Nursing Assistant (CNA) on at 2:30pm. When asked how the staff was informed if a resident has and what instructions are they given for providing care, he stated the nurse will tell them at the beginning of the shift. He was asked if he had been informed that Res #2 and 3 were

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treated for . He stated he was aware. When asked if he had been instructed to use protective equipment, he said there are isolation supplies in the closet including gowns, masks and . When asked if he had used the equipment when caring for the two with , he stated "no" they had already had their treatment applied and no longer required the use of the equipment.

An interview was conducted with the housekeeper on at 2:40pm. When asked what was the protocol for cleaning resident with or bed bugs., she stated she had been employed about a month and was not aware of any residents with . When asked if she cleaned as part of her assignment, she stated "yes". When asked if anyone had informed her residents in that been treated for last week she stated 'no". She was asked what was the protocol for cleaning of the when residents are treated for . She said she was not aware of any specific cleaning or products to be used.

Record review for Resident #2 revealed she went out to see her physician on . The resident had been complaining of itching and had bites on her arms. She returned with an order for cream ( ).

Review of the nursing notes found no documentation regarding itching, bites or treatment ordered and applied for .

Record review for Resident #3 revealed on nurse sent fax to the physician regarding resident had itching on her body at various locations. The nurse requested consult. When the physician faxed back on , he indicated she had been seen by a dermatologist and, ordered re-treat with 5% cream (treat of)apply now and repeat in 9 days.

Review of the nursing notes found no documentation regarding itching or treatment was ordered and applied for .

An interview was conducted with The ED on at 4:30pm.When asked who was responsible for informing the staff when bed bugs/ are reported, she stated it would be the Director of Nursing; however they do not currently have one. She was asked what was the facility protocol for cleaning the after bed bugs or were identified, she stated housekeeping cleans the however the MD did the cleaning of reported bedbugs . When asked how the cleaned after was identified, she stated she was not aware there was anything specific to be done. She was asked to provide copy of policies and procedures for bedbug/ management. The policy presented was entitled " ." . The policy read "ensure all residents exhibiting symptoms of /or residents exposed to suspected are treated/observed as required by physician orders to reduce/eliminate, when possible exposure or ." The procedure read "when resident exhibits symptoms of , a plan shall be developed and implemented to reduce/eliminate exposure." When asked if any plan had been developed or implemented, she stated " no " .

Class III

0079-Staffing Standards - Levels 58A-5.019(3) FAC

Based on record review, observations and interviews the facility failed to ensure adequate supervision to provide care for 3 of 3 sampled residents. (Residents #8, 9, 10)

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The findings include:

1) Record review for Resident # 8 revealed 78 year old male admitted 3/31/14 with diagnosis of and
Review of the Resident Health Assessment (1823) revealed Res #8 was independent with ambulation, required assistance with bathing and dressing and supervision with transfers and toileting. Resident #8 was observed on at 10:05am. Upon entering his , there was a pungent odor of . The residents was not present at the time. Resident #8 was lying in bed, alert but not oriented. There were disposable bed pads observed in the trash can.

An interview was conducted with the Certified Nursing Assistant (CNA) on at 10:30am. He was asked if Res #8 needed assistance with toileting. He stated the resident is of and wears briefs. He reported that the resident was and will take off the briefs and urinate in the bed or on the floor which is carpeted. He said he tried to check on him frequently however there are only two aides during the day to assist with bathing, dressing, showers and toileting including changing the residents. When asked if the caregivers had regular assignments, he stated " no " there are only two of us and we help whoever needs assistance. When asked about the strong odor in the residents , he stated it usually smells of . He did not know how often they cleaned the carpets.

On at approximatley 10 AM, the Administrator reported that there are 33 out of 52 residents at the facility who require care.

2) Record review of Resident #9 revealed she was admitted to facility on . Her diagnosis include , and . She required assistance with all activities of daily living (ADL), she was of bowel and and she was non-ambulatory and non verbal. She was also receiving hospice services.

A review of ADL book for 2014 revealed brief change documentation for Resident #9 on , 21 & 22. 2014 revealed brief change on , 2014.

On at 2:20pm, an interview was conducted with Certified Nursing Assistant (CNA) Employee #4. When asked if Resident #9 needed assistance with toileting he stated, " yes " she is . When asked how often she was toileted, he stated usually three times during his shift. When asked about the strong odor in the , he stated that most mornings when comes in the resident and her are found with briefs so saturated the bed sheets are soaked. He stated he has reported this to the nurse on many occasions, however nothing has changed. He stated he found her that way this morning. When asked how many caregivers were assigned on the night shift, he stated two, same amount as the facility has in the daytime.

Observation of Resident #9 ' s at 11am and 4:30pm revealed very strong odor of .

3) Record review for Resident #10 revealed she was admitted to facility on . Diagnosis include and
Review of the nursing monthly summaries included the following: resident alert with and oriented to person only, required assistance with all ADL ' s except eating and of bowel and .

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On 05/05/14 at 2:20pm an interview was conducted with Certified Nursing Assistant (CNA) Employee #4. When asked if Resident #10 needed assistance with toileting he stated, " yes " she is . When asked how often she was toileted he stated usually three times during his shift. When asked about the strong odor in the , he stated that most mornings when comes in the resident and her are found with briefs so saturated the bed sheets are soaked. He stated he has reported this to the nurse on many occasions, however nothing has changed. .

A review of ADL book for Resident #10 for . 2014 revealed one brief change for 24 7a-3p shift. Hand written note at the bottom of the page read "Resident refused brief change on ". There was no documentation for brief changes on any shift for 2014.

Observation of Resident #10 ' s at 11am and 4:30pm revealed a very strong odor of .

An interview was conducted with the Executive Director (ED) on at 6:15pm .She was asked how often residents were provided care. She stated she was not a nurse but they should be checked every two hours. She stated the facility currently did not have a Director of Nursing and there had been a lack of accountability and supervision. When asked if she was aware that 33 of 52 residents required care and the facility had only 2 caregivers to provide the care. She stated there were also 2 medication technicians on duty but reported that their primary function was to assist with medications for 52 residents leaving little time to assist with personal care. She agreed that the facility had a higher than average number of residents and that more staff was needed.

Class III

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC
Based on observation and interviews the facility failed to provide a safe and sanitary living environment for 12 out of 46 . (104, 105, 109, 112, 116, 117, 118,120,121,138,147,148)

The findings include:

During the tour on at 9:00am the following was observed.

The hallway leading to the activity found to have a strong smell of . All hallways in the facility have carpeting. The activity 1 of 4 overhead lights were out. There was a large tear in the vinyl flooring under the table in the rear of the activity . Several of the hall lights were out and the overhead lights were flickering.

The 100 hallway was extremely which included Resident 103 thru 108.

On at 9:10am Observation of revealed an extremely temperature. The thermostat was not working. Observed several blankets thrown on the Resident ' s unmade bed. Food, paper, trash was noted on the floor, under the bed, on and under the bedside table. The dark and in need of cleaning.

On at 9:45am an interview with Resident #6, , revealed she had been asking to have her light bulbs replaced. She stated one was the the other on the living table had been out

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for days.

On at 9:50am, observation of room 109 revealed several holes in the box spring mattress of the Residents bed. No protective vinyl covering noted on the mattresses.

On at 9:55am observation of revealed the front door frame was extremely gauged, scraped with chipped paint and in need of repair or replacement.

On at 10:00am observation of revealed the frame was heavily scraped, gauged and in need of repair and painting.

On at 10:10am observation of revealed heavily soiled carpet. Food and trash was observed all over the carpet, under the dresser and under the bed.

Observation of on at 10:20am, revealed a very pungent odor of .

On at 10:40 am, observation of revealed Resident # 5 cleaning her . An interview on at 10:40am with the Resident revealed that she had a and bites all over her legs. Further interview revealed she had purchased anti itching creams for months and had recently spent $10.00 on a can of Hotshot bed bug spray. The Resident stated she had told staff about the itching. She stated she had washed her own sheets and sprayed the baseboards herself. She does not have a plastic cover on her mattress. She stated she removed it because it had holes in it anyway. The cluttered with piles of clothing thrown over a chair and a large basket full of dirty laundry.

On at 10:55am observation of . The piles of the Resident ' s belongings in boxes and bags piled on top of all dressers and furniture. The closets were overflowing with piles of clothing, bags and boxes. There was no space along the walls. The only space in the between the two beds. The carpet was soiled and trash was noted covering the entire carpet. An interview was conducted on at 11:00am with Resident #14. The interview revealed that the been recently treated for bed bugs.

On at 11:05am was observed with a strong, foul odor. The carpet was noted with a large tear between the beds and was heavily stained. The walls were heavily scraped and gauged and needed re-painting.

Upon entering on at 11:10am, Resident #13 was observed beneath a pile of blankets and bedding. She stated she was too to get out of bed. When asked if she was able to control the temperature in the , she stated the thermostat does not work. The thermostat read 86 degrees. She stated she had complained about it but nothing was done.

On at 11:20am entered . The occupied by 2 male residents. Resident #8 was present at the time. The an overwhelming smell of . There was a disposable bed observed in the trash can. Attempted to interview the Resident regarding the cleaning of the , however the Resident

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was and said his wife cleaned every day.

On 05/05/14 at 11:30am observation of room 138. The carpet was noted with multiple large black stains by the back patio door, in front of the refrigerator and in-between the beds. The frame was gauged and heavily scraped. The wall by the closet was heavily scraped. The entire in need of painting. One nightstand table was heavily scraped and noted with large black stains.

On an Observation of at 11:45am found the . The male resident was under the covers and asked if the be made warmer. The thermostat in the not working. When asked if he had told the staff, he stated many times. Behind the door there was a large hole in the wall. The resident stated that was from the door handle going through the wall. The a stale smell and had crumbs all over the carpet, spilled liquid on the bedside table and stains on the carpet. When asked how often did housekeeping clean the , he stated they come every day and empty trash and sometime vacuum.

On at 11:50am observation of found huge stained area between the two beds. Also the carpeting was torn across the the first bed over to the door. On at 11:55am an interview with Resident # 13 revealed that the stain and torn carpet had been that way for a long time.

On at 12:05pm an interview was conducted with 2 female residents in , Residents #11and #12. They indicated they had been at the facility for several years and had noticed a steady decline in services. They both said that the building has not been maintained and needed repairs, including new carpeting. The carpet in the torn. Also there were some parts of the facility that smelled of .

On at 6:20pm an interview with the Executive Director (ED) revealed that when informed of concerns about physical plant, disrepair of the building and strong odors, she stated she was aware that the facility needed renovation and repairs. She was aware that several of the Resident were and the thermostats could not be controlled in the Resident . She also stated that he air conditioner had been recently serviced. She stated she had only noticed today that there was a odor in the hallway going to the activity . She thought it was two residents on that hall that are .

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Forest Lake Manor
252 Forest Lake Blvd.
Daytona Beach, FL 32119

Re: CCR #2014003618

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on , 2014 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 **, 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 surveyors. Should you have any questions please call this office at -4201.

Sincerely,

Jana Meyering, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

KJ/JM/sm
Enclosure

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