STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953545	06/13/2014
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:
0054-Medication - Records-06/13/2014

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:
0008-Admissions - Health Assessment-58a-5.0181(2) Fac
0052-Medication - Assistance With Self-Admin-58a-5.0185(3) Fac
0077-Staffing Standards - Administrators-58a-5.019(1) Fac
0091-Training - Documentation & Monitoring-58a-5.0191(12) Fac
0093-Food Service - Dietary Standards-58a-5.020(2) Fac
Z815-Background Screening; Prohibited Offenses-408.809, 435.02(2), 435.06

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

The following citation was cleared: A0054. The following deficiencies were recited: A0030, A0056, and A0080 and the following new deficiencies were cited: A0052, A0077, A0091, A0093, and Z815.

The following is a description of the non-compliance:

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on observation, record review and interview, the facility failed to ensure a medical examination was completed after 1 (Resident #5) of 3 residents was admitted to the facility within 30 calendar days of the admission date.

The findings include:

An observation was conducted on at 8:00 a.m., during assistance with medications for Resident #5. The Assistant Administrator (AA) removed a plastic bin of medications from the laundry . He placed the bin on the kitchen table and informed Resident #5, who was seated at the dining , he would be giving him his medications. While the AA remained seated at the table, Resident #5 got up and walked away from the table, leaving the dining . The AA removec the medications out of the pill packs, calling them by name and placed the pills on top of a napkin at the kitchen table. The resident was not present while he was doing this. The AA was informed the resident was not present while he was calling out the names of the medications and then stopped. The AA called for the resident who then came and sat down at the kitchen table. Instead of repeating the medications he had already placed on top of the napkin on the kitchen table for the resident, he continued to remove medications from the pill packs, calling them out by name.

The AA was asked to provide the 1823 Health Assessment for review to determine what level of assistance Resident #5 required. The AA confirmed the resident was admitted on . The AA stated he did not have a completed 1823 for the resident.

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Information reviewed on from the behavioral healthcare center for the dates of revealed that it documents a single Caucasian male with no health care surrogate at this time. Medical history includes, but is not limited to, history of , brief as a child; history of

Interview with the AA on at 11:36 a.m., revealed he was not sent an 1823 from the behavioral unit and he has yet to get one completed. He stated Resident #5 was previously in jail for attempted on his father and was transferred to the behavioral center. The AA indicated he was going to "trial" the resident for 2 weeks and give him a 45 day notice if Resident #5 "didn't work out."

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation, record review and interview, the facility failed to provide access to adequate healthcare for 1 (Resident #1) of 3 sampled residents. The caregiver failed to ensure medications were properly identified to the resident prior to handing them to her. This failure contributed to the resident receiving the incorrect dose of a nasal spray medication. In addition, the resident misunderstood what type of medication she was receiving and the caregiver failed to correctly inform her of what she was taking.

The findings include:

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. The resident requires assistance with medications.

Observation on at 7:32 a.m., during assistance with medications for Resident #1: the Assistant Administrator (AA) removed a plastic bin containing medication cards out of a cupboard in the laundry . The AA removed the medication cards from the bin and handed medications one by one to the resident without identifying what the medications were. He then handed Resident #1 nasal spray and she instilled one spray to each nostril. Resident #1 and the AA were questioned on the amount of sprays the resident was supposed to receive and the resident stated, "This is how I always take it." The AA was not aware the label directed 2 sprays to be instilled. After asking the AA to read the label, the AA asked the resident to instill a second spray into each nostril.

The AA then handed another pill to the resident. He did not inform the resident what he was giving her. The resident was asked what medicine she thought she was receiving and stated it was Observation confirmed the medication given to her as "Levothyroxin." The AA failed to identify the correct medication he handed to her.

The AA stated he was not informing the resident of the names of the medications. With a furled , he angrily stated, "It's the most stupidest rule I've ever heard of. The bigger facilities have nurses and CNAs fill pill cups up and have residents lining up waiting for them and they get away with it."

Review of the physician's orders dated document the following: 50 mcg/actuation nasal spray, suspension...2 sprays in each nostril once daily..."

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The AA failed to ensure he was identifying the medications to Resident #1 while handing them to her. He indicated the "rule" was stupid. He did not correctly identify the Levothyroxin when handing it to Resident #1 and she thought she was taking . He failed to read the label on the Fluticsone nasal spray and failed to ensure Resident #1 was aware she needed to instill the correct amount of medication into her nose. Because he failed to read the label prior to assisting the resident, he was not aware she was not receiving the correct amount of the medication.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on interview, the facility failed to ensure staff were assisting 2 (Residents #1 and #5) of 4 residents who require assistance with self-administration of medication according to Section 429.256 (3).

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. The resident requires assistance with medications.

Observation on at 7:32 a.m., during assistance with medications for Resident #1, the Assistant Administrator (AA) removed a plastic bin containing medication cards out of a cupboard in the laundry . The AA removed the medication cards from the bin and handed medications one by one to the resident without identifying what the medications were. He then handed Resident #1 nasal spray and she instilled one spray to each nostril. Resident #1 and the AA were questioned on the amount of sprays the resident was supposed to receive and the resident stated, "This is how I always take it." The AA was not aware the label directed 2 sprays to be instilled. After asking the AA to read the label, the AA asked the resident to instill a second spray into each nostril.

The AA then handed another pill to the resident. He did not inform the resident what he was giving her. The resident was asked what medicine she thought she was receiving and stated it was Observation confirmed the medication given to her as "Levothyroxin." The AA failed to identify the correct medication he handed to her.

The AA stated he was not informing the resident of the names of the medications. With a furled he angrily stated, "It's the most stupidest rule I've ever heard of. The bigger facilities have nurses and CNA's fill pill cups up and have residents lining up waiting for them and they get away with it."

Review of the physician's orders dated document the following: 50 mcg/actuation nasal spray, suspension...2 sprays in each nostril once daily..."

The AA failed to ensure he was identifying the medications to Resident #1 while handing them to her. He indicated the "rule" was stupid. He did not correctly identify the Levothyroxin when handing it to Resident #1 and she thought she was taking . He failed to read the label on the Fluticsone nasal spray and failed to ensure Resident #1 was aware she needed to instill the correct amount of medication into her nose. Because he failed to read the label prior to assisting the resident, he was not aware she was not receiving the correct amount of the medication.

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2. An observation was conducted on [redacted] at 8:00 a.m., during assistance with medications for Resident #5. The AA removed a plastic bin of medications from the laundry [redacted]. He placed the bin on the kitchen table and informed Resident #5, who was seated at the dining [redacted] that he would be giving him his medications. While the AA remained seated at the table, Resident #5 got up and walked away from the table, leaving the dining [redacted]. The AA removed the medications out of the pill packs, calling them by name and placed the pills on top of a napkin at the kitchen table. The resident was not present while he was doing this. The AA was informed the resident was not present while he was calling out the names of the medications and then stopped. The AA called for the resident who then came and sat down at the kitchen table. Instead of repeating the medications he had already placed on top of the napkin on the kitchen table for the resident, he continued to remove medications from the pill packs, calling them out by name.

The AA was asked to provide the 1823 Health Assessment for review to determine what level of assistance Resident #5 required. The AA confirmed the resident was admitted on [redacted]. The AA stated he did not have a completed 1823 for the resident.

The AA failed to consistently identify the medications he was providing in the presence of Resident #5.

Class III

0054-Medication - Records 58A-5.0185(5) FAC

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:

1. During the record review on [redacted], Resident #1's Resident Health Assessment AHCA Form 1823 was documented as completed on [redacted]. The resident was admitted on [redacted] with diagnosis including: [redacted], eating [redacted] and scoliosis. The resident requires assistance with medications.

Observation on [redacted] at 7:32 a.m., during assistance with medications for Resident #1, the Assistant Administrator (AA) removed a plastic bin containing medication cards out of a cupboard in the laundry [redacted]. The AA removed the medication cards from the bin and handed medications one by one to the resident without identifying what the medications were.

Included in the medications was a bottle of [redacted]. The label on the [redacted] read, [redacted] 800 mg. take one tablet by mouth "four" times a day as needed." The [redacted] 2014 Medication Observation Record (MOR) documented, "[redacted] 800 mg. take one tablet by mouth "twice" a day as needed for pain-take with food." Review of the physician's orders dated [redacted] documented, [redacted] 800 mg. take one tablet twice a day as necessary, take with food, use prn (as needed) for pain."

The label on the [redacted] was not in accordance with the physician's orders and subsequently did not concur with the MOR. The label indicated the resident was to take the [redacted] "four times" a day as needed which was not in accordance with the physician's orders indicating it was to be taken "twice" a day.

Interview with the AA at the time of this observation confirmed there was no alert label on the bottle of the

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indicating a dosage change.

Class III

0077-Staffing Standards - Administrators 58A-5.019(1) FAC
Based on record review and interview, the Administrator failed to maintain the 12 hour continuing education every two years as required. The Administrator failed to retake the ALF CORE training and pass the competency test. The Administrator failed to ensure staff in the facility was following Part I of Chapter 429, F.S. as indicated by ensuring staff had proper background screening results and were adequately educated regarding compliance as it relates to freedom from communicable including .

The findings include:

1. Observation on at 7:07 a.m., confirms the Assistant Administrator (AA) and a second caregiver at the Assisted Living Facility (ALF).

During an interview with the AA at the time of this observation, he stated there are 4 residents living at the facility. He stated he does not "pay" the other caregiver, that she only "helps him." He stated she has come over from Hungary and has been in the U.S. since . She is not on the work schedule. The AA stated she is not a "paid worker, but, lives at the facility and will help him" as he directs with the residents and the housekeeping.

During an observation at 7:30 a.m., while touring the facility, Resident #1 was seated at the kitchen table getting served breakfast (bowl of cereal and coffee) by the "unpaid" caregiver. The "unpaid caregiver" was then observed cleaning the kitchen.

An observation on at 8:40 a.m. was made and confirmed the "unpaid caregiver" walking side by side with Resident #6. The "unpaid caregiver" was observed holding Resident #6's right arm for support as she assisted Resident #6 outside the front door and onto the porch to smoke.

At 8:52 a.m., the AA verbally directed the "unpaid caregiver" to provide breakfast to Resident #6. The "unpaid caregiver" served a bowl of cereal to Resident #6. She then went over to Resident #2's knocked on the door and asked Resident #2 to come out of her then poured a bowl of cereal for Resident #2.

At 9:00 a.m., the "unpaid caregiver" was observed assisting Resident #6 back to her holding onto the resident's left arm and walking side by side with her to her

At 10:50 a.m., the "unpaid caregiver" was observed walking side by side while holding onto the resident's left arm in order to escort her out to a table by the pool. The "unpaid caregiver" then was observed walking back inside the facility to the Resident #6's she retrieved the resident's cell phone for her and walked back outside and handed it to Resident #6.

Interview with the AA on at 10:51 a.m., confirmed the "unpaid caregiver" assists the residents. When asked about her background screening, he stated she did not have one yet. He stated as soon as he gets everything in order; he will put her on the books but hasn't gotten everything in order because she's only been in the U.S. for a week. He stated she lives in the facility 24 hours a day in one of the back When asked about a freedom from communicable statement and screening, he provided illegible documentation by

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her doctor from Hungary. The AA stated they planned on using her non-English Hungarian results related to communicable and from the doctor she saw in Hungary before coming to the states. An attempt was made to explain the Florida statutes to the AA related to background screening and health screenings results to be read by a healthcare practitioner. The AA stated he would interpret the results by the Hungarian physician for AHCA or AHCA could go on-line to have the results "translated" as he was not going to send the "unpaid caregiver" to the local health department because that would cost him $150.00.

2. Employee record review during the follow up to the biennial survey on revealed Staff B (Administrator/Owner) 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

During the revisit follow-up on at 8:58 a.m., the AA indicated his wife, the Administrator, was out of the country.

Review of the Administrator's continuing education hours provided by the AA at the time of the revisit survey confirms no CEUs obtained by Staff "B" between Documentation shows 10 hours of CEUs for and 11 hours of CEUs for

The Administrator remains out of compliance as it relates to ensuring the necessary CEUs were obtained as provided under Section 429.52, F.S.

Because of the failure of the Administrator to ensure she maintained the necessary CEUs, the AA was asked if she had retaken the ALF core training and passed the competency test. The AA confirmed the Administrator did not retake the required core training and stated, "She already went, why she should have to go again?"

Class III

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

The findings include:

Employee record review during the follow up to the biennial survey on revealed Staff B (Administrator/Owner) 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

During the revisit follow-up on at 8:58 a.m., the Assistant Administrator (AA) indicated his wife, Staff "B", was out of the country.

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Review of Staff B's continuing education hours provided by the AA at the time of the revisit survey confirms no CEUs obtained by Staff "B" between _____. Documentation shows 10 hours of CEUs for _____, and 11 hours of CEUs for _____.

Staff "B" remains out of compliance as it relates to ensuring the necessary CEUs were obtained as provided under Section 429.52, F.S.

Because of the failure of Staff "B" to ensure she maintained the necessary CEUs, the AA was asked if Staff "B" had retaken the ALF core training and passed the competency test. The AA confirmed she did not retake the required core training and stated, "She already went, why she should have to go again?"

Class III

0091-Training - Documentation & Monitoring 58A-5.0191(12) FAC
Based on observation, interview and review of the personnel file for the Assistant Administrator (AA), the facility failed to provide evidence of the training program agenda for each of the trainings he received.

The findings include:

During an interview with the AA on _____ at 10:15 a.m., he confirmed he was the primary caregiver at the facility as well as the co-owner. The AA confirmed his date of hire as _____.

Review of the personnel file of the AA on _____ revealed that it includes documentation which was dated, signed and printed by the Administrator, who is the AA's wife, for the following trainings: "ADL and Behavior needs, Elopement response training, _____ training, Nutritional and Safe Food handling, Recognizing/Reporting _____, Neglect & _____ training, _____, Emergency preparedness & Evacuation training, Incident reporting training, Resident rights training."

As there was no agenda or information attached to these trainings, the AA was asked to provide evidence on which the trainings were based.

During the interview with the AA on _____ at 11:00 a.m., he stated that he had no agenda and no information to accompany the trainings. He stated, "We sit down and speak with each other as to what can I do or not do."

Class III

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on observation, record review and interview, the facility failed to provide a therapeutic diet as prescribed by the physician and reviewed by the registered dietitian for 1 (Resident #1) of 4 residents.

The findings include:

During the record review on _____, Resident #1's Health Assessment AHCA Form 1823 was documented as completed on _____. The resident was admitted on _____ with diagnosis including: _____, _____, eating _____ and scoliosis. Under "Special Diet Instructions", documentation indicates a "calorie controlled, low fat/low _____ diet." The assessment documents the resident needs a low calorie menu.

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Review of the physician's orders dated .. includes, "2 gm .. diet-2000 cal diet."

Documentation provided by the Assistant Administrator (AA) revealed an informal menu plan was devised for Resident #1 by the AA and not by a registered dietitian.

In an interview with the AA on .... at 10:25 a.m., he stated he went to the doctor with Resident #1 and spent 3 hours there with her and the doctor. Prior to this he faxed all of her doctors related to her eating and received an order for a 2,000 cal. diet from Resident #1's doctor. The AA confirmed he did not consult with a dietitian because "all she does is make up the menus." He stated he (himself) developed the weight loss program for the resident as he had no other help. The resident's "primary" doctor told Resident #1 to try to catch her (her .... doctor). The AA never got a hold of the .... doctor. So, he himself broke down a list of food and calories for lunch and dinner for Resident #1 and he stated he picks the "doses" of what she should eat. He also compromised a dietary weight loss plan for the resident which includes the pool and walking.

The AA was asked whether he consulted Resident #1's legal guardian and he stated, "No, he's a dentist and is very busy and lives over on the other coast."

Review of the facility's menu failed to reveal evidence of the therapeutic diet.

Class III

Z815-Background Screening; Prohibited Offenses 408.809, 435.02(2), 435.06
Based on record review and interview, the facility failed to ensure staff in the facility were following Part I of Chapter 435, F.S. as indicated by lack of obtaining proper background screening results on a staff member providing assistance with Activities of Daily Living (ADLs) for Residents #1, #2, and #6.

The findings include:

Observation on .... at 7:07 a.m., confirms the Assistant Administrator (AA) and a second caregiver at the assisted living facility. During an interview with the AA at the time of this observation, he stated there are 4 residents living at the facility. He stated he does not "pay" the other caregiver, that she only "helps him." He stated she has come over from Hungary and has been in the U.S. since .... She is not on the work schedule. The AA stated she is not a "paid worker, but, lives at the facility and will help him" as he directs with the residents and the housekeeping.

During an observation at 7:30 a.m. while touring the facility, Resident #1 was seated at the kitchen table getting served breakfast (bowl of cereal and coffee) by the "unpaid" caregiver. The "unpaid caregiver" was then observed cleaning the kitchen.

An observation on .... at 8:40 a.m. was made and confirmed the "unpaid caregiver" walking side by side with Resident #6. The "unpaid caregiver" was observed holding Resident #6's right arm for support as she assisted Resident #6 outside the front door and onto the porch to smoke.

At 8:52 a.m., the AA verbally directed the "unpaid caregiver" to provide breakfast to Resident #6. The "unpaid caregiver" served a bowl of cereal to Resident #6. She then went over to Resident #2's , knocked on the

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door and asked Resident #2 to come out of her [redacted] I then poured a bowl of cereal for Resident #2.

At 9:00 a.m., the "unpaid caregiver" was observed assisting Resident #6 back to her [redacted] holding onto the resident's left arm and walking side by side with her to her [redacted]

At 10:50 a.m., the "unpaid caregiver" was observed walking side by side while holding onto the resident's left arm in order to escort her out to a table by the pool. The "unpaid caregiver" then was observed walking back inside the facility to the Resident #6's [redacted] she retrieved the resident's cell phone for her and walked back outside and handed it to Resident #6.

Interview with the AA on [redacted] at 10:51 a.m., confirmed the "unpaid caregiver" assists the residents. When asked about her background screening, he stated she did not have one yet. He stated as soon as he gets everything in order; he will put her on the books but hasn't gotten everything in order because she's only been in the U.S. for a week. He stated she lives in the facility 24 hours a day in one of the back [redacted] An attempt was made to explain the Florida statutes to the AA related to background screenings; however, the AA insisted the caregiver was "not on the books therefore not considered an employee."

Unclassified

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 **second** Revisit Survey conducted on . . . . 13, 2014 by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiency that was corrected during the visit as well as the uncorrected deficiencies and 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. Your facility is required to be in compliance with all of the rules and regulations pertaining to Assisted Living Facilities in the State of Florida. The agency will conduct monitoring visits to your facility to ensure that you maintain compliance with these rules and regulations.

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 _____ /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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