STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911637	06/11/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Lakehouse West	3435 Fox Run Road Sarasota, FL 34231	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D

Specific Tag Findings:
An unannounced Biennial survey was conducted on through at Lakehouse West, an Assisted Living Facility (ALF).

The following is a description of the non-compliance:

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observation, record review and interview, the facility failed to ensure 1 (Resident #7) of 2 residents reviewed who are receiving were provided adequate supervision. The facility failed to ensure they were aware of whether the resident could manage her independently and safely.

The findings include:

Record review on documents Resident #7 admitted to the facility on with diagnoses including, not limited to, , history of bowel obstruction, , seasonal and

During an observation and interview with Resident #7 on at 9:32 a.m., she stated she manages her own as the nurses at the facility "Aren't allowed to touch it." When asked about the regulator that controls the flow of the and amount delivered to the resident via the concentrator, she stated she didn't "Manage that knob; I don't know what it's for." The "knob" Resident #7 was referring to controls the level to be delivered to the resident.

Observation at this time confirmed the liter dose of being delivered to the resident was set at "2.5." The resident stated she did not know what liter flow rate was to be set on the concentrator.

An observation of Resident #7 was conducted on at 8:30 a.m. Resident #7 was observed seated in her motorized wheelchair at the nurse's station waiting for her medications. A small portable canister was observed inside of a basket attached to her wheelchair. The liter dose of on the canister was set at "3" liters. The resident stated it was the proper setting of on the small canister.

Record review on documents physician's orders which include: "...has O2 at 2 l/min all the time. Concentrator at night and portable during the day..."

Neither the portable canister or concentrator in Resident #7's set to the proper liter dose ordered by the physician.

(In some individuals, the effect of too much in causes increased retention, which may cause drowsiness, and in severe cases lack of which may lead to

In an interview on at 11:38 a.m. with the Director of Nursing (DON), and Staff "A", who is a Licensed Practical Nurse (LPN); they indicated they were not aware of the liter dose the resident was supposed to receive. Staff A stated, "We don't touch the she manages it herself." They stated they would call the doctor to ensure the accuracy of the liter dosage and then assess the resident's ability to safely manage the on her own.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911637	**06/11/2014**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Lakehouse West	**3435 Fox Run Road Sarasota, FL 34231**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Lakehouse West
3435 Fox Run Road
Sarasota, FL 34231

Dear Administrator:

This letter reports the findings of a Biennial survey that was completed 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 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 (239) 335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

sh
Enclosure: State Form

Fort Myers Field Office
2295 Victoria Avenue,
Fort Myers, FL 33901
Phone:(239) 335-1315; Fax:(239) 338-2372
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida