STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964280	07/08/2014
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 - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0090 - 58a-5.0191(11) Fac - Training - S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0165 - 429.23(1-4 & 6-10) Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D
St - A - N276 - 58a-5.031(1) Fac - Lns - Nursing Services S-S= D
St - A - N277 - 58a-5.031(2) Fac - Lns - Resident Care Standards S-S= D

Specific Tag Findings:

0000-Initial Comments
A biennial relicensure with Limited Nursing Services survey was conducted on . 2014. Forest Lake Manor had Licensure deficiencies found at the time of the visit.

0054-Medication - Records 58A-5.0185(5) FAC
Based on record review and staff interview, the facility failed to maintain accurate medication observation records (MORs) for 3 of 15 sampled residents, Residents #2, #6, and #14.

The findings include:

Review of 2014 MOR for Resident #2 revealed a order for instill one drop in the right eye four times a day. It was not signed off as given. It was blank. The Director of Nursing on at 10:35 a.m. confirmed that the MOR was not filled out correctly for this medication.

Review of the 2014 MOR for Resident #6 revealed a order for Cream apply head to toe, wash off after 8 hours. It was not signed off as given. It was blank. The Director of Nursing on at 10:32 a.m confirmed that it was not signed off as given on the MOR but the resident received this on 2014.

Review of the 2014 MOR for Resident #14 revealed two creams, and was ordered on to be given twice a day. There were several blanks or circles that it was not given with no explanation why. Another cream, Betamet was ordered on to be given twice a day and there were many blanks. The Director of Nursing confirmed this on at 10:35 p.m.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observation and staff interview, the facility failed to store medications in a secure location at all times for 1 of 52 (facility census) sampled residents, Resident # 8.

The findings include:

On at 839 a.m., a bottle of Levothyroxin tab 175 micrograms (mcg) medication was observed on one of the medication carts in the facility hallway. It belonged to Resident #8. There were 21 pills in it. Employee C, a

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Licensed Practical Nurse on [redacted] at 8:43 a.m. stated she just left it up there because a new dose was ordered. She stated she should not have left it there.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on observation, record review, and staff interview, the facility failed to refill medications in a timely manner for 3 of 15 sampled residents, Residents #2, #6, #14.

The findings include:

On [redacted] at 9:21 a.m., Employee A was observed to assist with self-administration of medication for Resident #2. The resident stated she had pain in her hands around a level of 5-6 on a 1-10 scale. Employee A gave her two [redacted]. Review of the [redacted] 2014 Medication Observation Record revealed an order for Norco, take one tablet orally every six hours as needed for pain. Employee A stated the facility did not have this medication in the her cart. She stated she reported it to the Director of Nursing and they knew they did not have the medication.

On [redacted] at 8:44 a.m., Employee B was observed to assist with self-administration of medication for Resident #6. Employee B stated that she could not give her [redacted] (three times a day) because she did not have any to give her. She also stated that they did not have [redacted]. The Director of Nursing stated on [redacted] at 10:32 a.m the pharmacy would not deliver the over the counter medications until the resident paid her bill. She stated she did not tell the doctor that the resident was not receiving her medications.

Review of the [redacted] 2014 Medication Observation Record for Resident #14 revealed one medication dated [redacted] take one tablet orally every night at bedtime. Per documentation, it was not given from [redacted] 1-7th because it was on order. Another medication, [redacted] also was not given this month with no explanation why. The Director of Nursing on [redacted] at 10:30 a.m. confirmed these medications were not delivered from the pharmacy.

Class III

0078-Staffing Standards - Staff 58A-5.019(2) FAC
Based on employee record review and staff interview, the facility failed to ensure that Employee I, 1 of 4 sampled employees, had a free of communicable [redacted] statement and negative [redacted] test within 30 days of employment.

The findings include:

Review of the employee record for Employee I revealed she was hired as a nurse on [redacted] There was not a free of communicable [redacted] statement or [redacted] test in her file. The Business Office Manager on [redacted] at 4:15p.m. stated that the employee was bringing in this information but confirmed they did not have it.

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC
Based on record review and staff interview, the facility failed to ensure that Employee G , 1 of 4 sampled employees, received training on elopement within 30 days of employment.

The findings include:

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Employee record review for Employee G revealed she was hired on as a nurse. There was no elopement training in her file. The Business Office Manager on at 4 p.m. stated that staff were supposed to complete trainings online through Redilearning. They confirmed this employee did not do it.

Class III

0090-Training - 58A-5.0191(11) FAC
Based on employee record review and staff interview, the facility failed to ensure that Employee E, 1 of 4 sampled employees, received training in within 30 days after employment.

The findings include:

Review of the employee record for Employee E revealed she was hired as a caregiver on There was no documentation of training in her file. The Business Office Manager on at 4:16 p.m. confirmed there was no training in Employee E's file.

Class III

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on observation and staff interview, the facility failed to provide menu items of comparable nutritional value for residents selecting the alternant menu for one of one meal observed and failed to maintain a 3 day emergency supply of non-perishable food for 52 residents.

The findings include:

During a dining observation in the main dining at noon, a staff member was observed asking residents if they would like chicken or an Italian sub for lunch. Resident that selected the chicken were served a chicken quarter, mashed potatoes with gravy, peas, and roll with butter. Residents served the sub were served chips as a side.

During an interview with the Kitchen Manager on at 2:00 p.m. and he stated he makes sure the alternate has the same amount of protein, such as the ounces of cheese and meat for the chicken , and potato chips for the mashed potatoes. He stated the residents with the Italian subs should have been served peas. He stated he did observe the dining and would check with the chicken. He confirmed the peas were not served.

During an observation of the emergency food supply with the Kitchen Manager on at approximately 4:00 p.m. a fifty pound bag of powdered non fat milk dated with an ordered date of was observed with the facility's emergency food. The Kitchen Manager was asked to contact the vendor to determine the expiration date of the milk. The Kitchen Manager returned and stated on at 4:51 p.m. the milk had expired by several months. He stated he told his lead cook to order more milk.

Review of the facility 3 day disaster menu found that dry cereal was on the menu for breakfast for the 3 days and dry milk was on the menu as a beverage for breakfast and dinner for the three days.

Class III

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0165-Risk Mgmt & QA; Adverse Incident Report 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC
Based on record review and staff interview, the facility failed to report an adverse incident for elopement for 1 of 15 sampled residents, Resident # 15.

The findings include:

On . . . . at 3:03 p.m. , Employee F stated there was a resident who wandered away from the facility about 2 months ago, Resident #15. She stated the Resident was at risk for elopement and had a monitoring bracelet in place. She was found up the street by a building and a visitor brought her back. The facility replaced her monitor on her ankle. The facility believed she followed another resident out the front door.

Review of the 1823 (Health Assessment) for Resident #15 dated revealed she had a diagnosis of . . . and to monitor whereabouts frequently throughout the day. An elopement risk was done on . . . . revealing the Resident was at risk for elopement. She wandered and has a history of elopements. The Resident's progress note on . . at 1530 revealed the Resident got out of the facility and staff went to find her. She was found wandering around the neighboring private residences. She was returned to the facility and monitor to residents left ankle was changed.

An interview was conducted with the Administrator on . . . . at 3:55 p.m. She stated she was not the Administrator at this time and was not aware of this. She did not see that an Adverse Incident was sent for this resident. She was in the process of redoing the elopement policy and procedure in the facility. She stated the nurse who wrote this note no longer works at the facility. She stated that they do not test the door or bracelets routinely to see that the system was working.

Class III

N276-LNS - Nursing Services 58A-5.031(1) FAC
Based on observation, record review and resident and staff interview, the facility failed to provide Limited Nursing Services (LNS) for 1 of 15 sampled residents, Resident #14.

The findings include:

On . . . . at 2:23 p.m., Resident #14 was observed sitting in his . . . . an . . . concentrator running and set at 2 liters per minute. His . . . . tubing was on the floor. The resident had normal socks on and rolled down exposing his . . . . , reddened legs. He stated that he should be wearing his . . . . and could not manage it on his own. He reported that staff helped him with it his . . . . He was not wearing a shirt and scabs could be seen across his chest. He stated that he does itch from a skin condition.

Review of the resident's . . . . Health Assessment revealed a diagnosis of . . . . condition. On . . . . , the . . . . . The clinical record revealed he was seen by a dermatologist for his skin condition. On . . . . , the Dermatologist noted the resident should have compression stockings on for 6 hours and then off for 6 hours. The clinical record did not have an order for the . . . .

On . . . . at 2:25 p.m., the Director of Nursing stated that the resident was not receiving LNS services for the . . . . or compression stockings. She did not know if the resident had these stockings yet. She confirmed they did not have an order for the . . . . for this resident.

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Class III

N277-LNS - Resident Care Standards 58A-5.031(2) FAC
Based on record review and staff interview, the facility failed to have on staff or contract, a Registered Nurse who could provide monthly nursing assessments for the facility's Limited Nursing Services (LNS) license.

The findings include

A biennial survey with Limited Nursing Services survey was conducted at the facility on . . . . . The Executive Director (ED) was asked for the agreement or contract for the Registered Nurse (RN) who would be providing the assessments to any potential LNS residents. In an interview with the ED on . . . . . at 1:05 PM, they confirmed that facility did not employ or have a contract with a Registered Nurse.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

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

Dear Administrator:

This letter reports the findings of a state biennial licensure with Limited Nursing Services 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 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 .

Sincerely,

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

NH/JM/sm
Enclosure

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