STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964280	08/22/2014
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 - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0027 - 58a-5.0182(3) Fac - Resident Care - Arrangement For Health Care S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records 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 - N276 - 58a-5.031(1) Fac - Lns - Nursing Services S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced complaint survey, CCR #201400717, was conducted on , 2014. Forrest Lake Manor had deficiencies found at the time of the visit.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on record review, staff and resident interview, the facility failed to notify the physician and resident representative for 1 of 9 sampled residents (Resident #1), in a timely manner after a medication error.

The finding include:

1. Review of a Medication Error Report revealed Resident #1 had a medication in his drawer and it was labeled wrong by the pharmacy, 11 pills were missing from the pill package. Review of the resident's clinical record did not reveal documentation that the resident's physician and resident representative was notified of this incident.

The Director of Nursing (DON) was interviewed on at 11:30 a.m. and confirmed there was no documentation that the physician or resident representative was notified of this incident.

Class III

0027-Resident Care - Arrangement for Health Care 58A-5.0182(3) FAC
Based on record review and interview, the facility failed to assist 1 of 9 sampled residents (Resident #6) in obtaining an appointment with physical , as ordered by the physician.

The findings include:

On at 10:15 a.m., Resident #6 was in her on her bed. She stated that she the day before yesterday and told the nurse but the facility did not do anything about it. She stated she has not had any services since being here. Review of her clinical record revealed she was admitted on . There was a physician progress note that revealed the resident had , history of , and required 24/7 supervision. There was a a physician order for Physical and Occupational services.

The resident had a Health Assessment (1823) revealing a diagnosis of accident,

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in right eye, and in leg. The 1823 refelcted that she needed assistance with ambulation. The Resident's clinical record revealed she had two since admission, on and . There was an incident/ accident report dated revealing the resident stated she was in her when she on her right side and she had pain on that side. The report revealed the resident's representative was notified and the physician was notified (by fax) but no new orders were seen.

Further review revealed a fax to Resident #6's doctor that the resident complained of knee pain affecting ambulation. The physician was asked for an order for home health/ physical and pain medications? This was faxed to the doctor on and again on with no response from the doctor.

Interview with Employee E on revealed a home health agency did receive the order for service on but the resident's demographic page had incorrect insurance information so the resident did not receive these services.

The DON was interviewed on at 4 pm stated it was facility procedure that for any incidents, the nurses were to notify the doctor via a fax and wait for a response. If no response was heard within 24 hours, they were to call the doctor. There was no documentation in the clinical record for Resident #6 that the doctor was ever called to notify him of the resident's pain or and obtain any further orders. She also confirmed that the resident had not received services per physician order.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on record review and staff and resident interview, the facility failed to respond to a resident grievance of a scooter for 1 of 4 sampled residents, Resident #7.

The findings include:

Employee F, the Maintenance Supervisor was interviewed on at 245 pm. He stated that he does assist residents with their personal motorized wheelchairs (scooters) if they break. At first he did not know how to repair them, but now he was becoming an expert at them. He stated there were about 4 residents with motorized wheelchairs. He reported that he just fixed Resident #2's scooter. He reported that he did hear something about Resident #7 having a broken scooter, but stated he did not go to the resident to ask him if he needed help. When he was asked why not, Employee F stated that if no one puts the request in his maintenance book, he does not pursue it.

Employee C, the resident's care assistant, was interviewed on at 2:55 pm. He also confirmed that he heard that his scooter was not working, but he knows it was working now because he saw him using it today.

Resident #7 was interviewed on at 3pm. He stated that he was without his motorized wheelchair for about 3 weeks. He stated he told one of the nurses it was not working, but no one offered to help him. He reported that he independently contacted an outside company who came in and fixed it. He was not aware that there was a Maintenance person that could help him.

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The Executive Director on at 5 p.m. stated that Resident #7 would speed up and down the hall with his electric wheelchair and she has told him that she would take it from him if he did not slow down, he could really hurt someone. She confirmed that Resident #7's grievance had not been responded to. The facility failed to put in writing, a request for the maintenance director to look at the broken scooter.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on record review and staff and resident interview, the facility failed to have qualified staff assist with a treatment for Resident #2 and failed to give a ( ) medication based on physician ordered parameters for Resident #3, 2 of 9 sampled residents.

The findings include:

1. On at 10:17 a.m., Resident #3 stated her have been high and the staff were not giving her medications. Review of the Resident's 2014 Medication Observation Record(MOR) revealed the facility staff was taking the resident's daily at 9 a.m. There was a physician order dated for (medication) 10 milligram give one tablet by mouth as needed for over 160 or diastolic above 100. There were several dates when the resident's exceeded these parameters: On 8/8, the was , on 8/9 it was , on it was , on it was , on it was , on it was , on it was , and on it was . The MOR did not have any documentation that any was given.

Employee C was the resident's care assistant this day. On at 10:22 a.m. Employee C confirmed was not given.

2. On at 10:22 a.m., Resident #2 stated that he got treatments four times a day. He stated he got his pills this morning, but not his treatment. He stated that facility staff bring in the medication, open it, pour it into the container, turn on the machine and then hand it to him. He reported that staff then come back later and turn off the machine.

Review of the resident's MORs revealed the none of his morning medications were signed as given.

Employee C, a resident care assistant (non-licensed staff) was responsible for assisting with medication administration for this resident was interviewed on at 10:30 a.m. He stated he did give the scheduled 9 medications just now but did not sign for them yet. He stated he did give him his treatment at 7 am this morning. He reported that the resident requested it early so he gave it to him. He did confirm that he did open the medication, pour it into the container, turn on the machine and then hand it to the resident. He thought he was able to assist with treatments even though he was an unlicensed staff.

Class III

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0054-Medication - Records 58A-5.0185(5) FAC
Based on record review and interview, the facility failed to immediately update the Medication Observation Record (MOR) after medication was given for 1 of 4 sampled residents (Resident #2)

The findings include:

On at 10:22 a.m., Resident #2 stated that he got treatments four times a day. He stated he got his pills this morning, but not his treatment. He stated that facility staff bring in the medication for his , open it, pour it into the container, turn on the machine and then hand it to him. He reported that staff then come back later and turn off the machine.

Review of Resident #2's 2014 MOR's on at approximately 10:20 AM revealed the none of his morning medications were signed as given.

Employee C, a resident care assistant (non-licensed staff) was responsible for assisting with medication administration for this resident was interviewed on at 10:30 a.m. He stated he did give the scheduled 9 medications just now but did not sign for them yet. He stated he did give him his treatment at 7 am this morning.

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC
Based on employee file review and staff interview, the facility failed to ensure that 1 of 6 employees received training in recognizing , neglect, and , resident rights, incident reporting, facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation, and elopement response policies and procedures. (Employee H)

The findings include:

Record review of the personnel file for Employee H (hired) could not locate evidence that Employee H received training in recognizing , neglect, and , incident reporting, resident rights, the facility emergency procedures, and the facilities resident elopement response policies and procedures.

The findings were confirmed by Employee H on at approximately 4:00 p.m. She stated she did not have any the training because could not get access to the facilities computer training.

Class III

0090-Training - 58A-5.0191(11) FAC
Based on employee file review and staff interview, the facility failed to ensure 1 of 6 employees received at least one hour of training in the facility's policy and procedures regarding .(Employee H)

The findings include:

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Record review of the personnel file for Employee H (hired) could not locate evidence that Employee received training on the facility's policy and procedures regarding .

The findings were confirmed by Employee H on at approximately 4:00 p.m. She stated she did not have any the training because could not get access to the facilities computer training.

Class III

N276-LNS - Nursing Services 58A-5.031(1) FAC
Based on record review and staff and resident interview, the facility failed to obtain a physician order for Limited Nursing Services to perform care and services for a for 1 of 9 sampled residents, Resident #4.

The findings include:

Review of the clinical record for Resident #4 revealed he was admitted to the facility on and was receiving home health services for management and education of .

The resident had an Health Assessment (1823) dated . It revealed the resident needed assistance with toileting and under treatment section of the form, it read " care each shift."

Resident #4 was interviewed on at 12:25 p.m. He stated that he could empty his himself. He showed the surveyor his bag on his right lower leg. He worried that if it leaked, he did not know where he would get another bag. He did state that staff at this facility help him with cleaning around the site. He stated it was a little red.

On at 12:30 p.m., a resident caregiver (unlicensed staff) , Employee B was interviewed. She stated that she did assist the resident with cleaning his .

There was a nursing note dated at 8 p.m. that revealed the following: cleaned site, flushed with normal . There was another nursing progress note dated at 6 p.m. It read assessed site, no redness.

Review of the Resident's Medication Observation Record (MOR) revealed a physician order for pubic care every shift. There were two shifts identified as 6-2 and 2-10 and staff signed as done on 18-22nd. There was no indication that night shift 10-6 performed this task or it was done from 2-17th.

The clinical record did not have a physician order for the resident to receive these services (Limited Nursing Services) by facility staff.

An interview with the Director of Nursing was conducted on at 12:45pm. She stated that Resident #4 was not receiving Limited Nursing Services because home health was following him and he can do it for himself. She also stated that she was not aware that her staff have been helping him.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

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

RE: CCR #2014007717

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 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

NH/JM/sm
Enclosure

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