STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911900	**04/14/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
BEAR LAKE RETIREMENT HOME	**1525 BEAR LAKE ROAD APOPKA, FL 32703**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

The re-licensure survey was conducted on . Bear Lake Retirement Home Assisted Living Facility had deficiencies found at the time of the visit.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and interview the facility did not obtain a complete and accurate medical examination within 30 days of admission and after a significant change for 2 of 2 sampled residents (#1 and #2).

Findings:

1. Record review for Resident #1 revealed an updated Resident Health Assessment Form (1823) that was required after a hospital admission was dated . and had diagnosis that included Hard of hearing, . The type of assistance she required with Medications was left Blank.

2. Record review for Resident #2 revealed she was admitted to the facility on . The record contained a 1823 that was dated . (the wrong year was noted) with diagnosis that included . Major, Mental , and Type II . The type of assistance she required with Medications was left Blank.

During an interview with the facility's manager on . at 1:30 PM, she stated she did not realize the forms were not accurate.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review and interview the facility failed to maintain a written record of significant changes, illnesses which resulted in hospital admissions and the family and health care provider were notified for 1 of 2 sampled residents (#1).

Findings:

During an interview with Resident #1's family member on . at approximately 10:30 AM, she stated Resident #1 was admitted to the hospital in .

Record review for Resident#1 revealed there were no notes available for review that documented what had transpired requiring the resident to be transported to the hospital and that the family and health care provider were notified.

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0025 Continued From page 1

The facility's manger provided a spiral note with the daily activities. The staff noted on that the resident went to the hospital. There was no documentation noting the reason for the hospital admission and that the family and health care provider were notified.

During an interview with the facility's manager on at 1:30 PM, she stated she did not write notes when residents went out to the hospital.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28 FS

Based on observations and interview the facility failed to honor the Residents Bill of right to be treated with consideration and respect with due recognition of personal dignity and the need for privacy and did not comply with the Resident Bill of rights regarding at least 45 days' notice of relocation or termination of residency from the facility for 1 of 2 (#2).

Findings:

Observations on at 12:15 PM revealed Resident #1 was sitting at the dining There was also 6 other residents sitting at the table eating their lunch. The manager conducted a Sugar Test at the table because Resident #1 stated she did not feel good. After she obtained the results from the Glucometer, she stated what the results were and went to get the syringe out of the refrigerator. The manager handed the prefilled syringe to the resident, the manager assisted Resident #1 in pulling up her shirt and her stomach was exposed, the resident injected the The resident was in plain view of the other residents, injecting her in their presence at the table.

Further observations at 12:30 PM revealed there were two prescriptions with the names of residents and their medications posted on the board next to the kitchen. This could be observed by anyone that entered the facility.

During an interview with the facility's manager on at 1:30 PM, she stated that the facility was like home and should had given Resident #1 her in private and she removed the prescriptions from the board.

Review of the contract for Resident #1 revealed it noted: "The entire agreement may be terminated by written request of the resident or responsible party at the request of the facility with a 30 day notice." (The facility must give a 45 day notice).

During an interview with the facility's manager on at 1:30 PM, she stated that the facility was like home and should had given Resident #1 her in private and she removed the prescriptions from the board. She further stated the contracts would be updated.

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0030 Continued From page 2

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on review of the Medication Observation Record (MOR) and interview the facility failed to obtain a State Clinical Laboratory License and a have nurse available to administer ..... and conduct ..... glucose testing for 2 of 2 sampled residents (#1 and #2).

Findings:

During an interview with Staff B (caregiver) at 11:20 AM, she stated she would check Resident#1 and #2 ..... Sugar Levels (BS). She stated Resident #1 received ..... based on a sliding scale. She explained when she obtained the results of the BS from the Glucometer and according to the results she would get the prefilled ..... that was bagged separately according to the units and hand it to Resident #1 for her to inject herself. She stated Resident #1 could not see well. She further stated resident #2 had prefilled syringes and took ..... daily. She would get the ..... and the Resident would inject it herself.

Observations on ..... at 12:15 PM revealed Resident #1 was sitting at the dining ..... The manager was trying to get her ..... sugar readings because she stated she did not feel good. The manager took the ..... Pen and placed it in the resident's hand and told her to press. The resident did not press. The manager pressed the Pen, squeezed the resident's finger to obtain the ..... and placed the ..... on the glucose machine. The manager stated what the results were and went to get the ..... out of the refrigerator. The manager handed the prefilled ..... syringe to the resident, the staff assisted her in pulling up her shirt and the resident injected the .....

During an interview with Staff C (caregiver) on ..... at 12:20 PM, she stated she conducted the BS test for both Residents #1 and #2. She stated resident #1 received her ..... according to her BS results (sliding Scale). She would determine the results and get the prefill ..... syringe, they were separated in a bag according to the units. She would provide the ..... syringe according to the units needed based on the BS results. She stated the resident would inject her own ..... She stated for resident #2, she could not inject her own ..... and she had to do it sometimes. She stated she was trying to train Resident #2 how to inject her ..... without assistance.

Record review for Resident #1 revealed a Resident Health Assessment Form (1823) that was dated ..... had diagnosis that included Hard of hearing, ... The type of assistance she required with Medications was left Blank.

The facility provided a sheet that they logged the BS results each time, the amount of ..... provided according to the sliding scale was not noted. The manager provided a sheet that was provided to them by the resident's daughter that noted the following:
150-200-2 unit
201-250=4 units

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0053 Continued From page 3

251-300-6 units
301-350-8 units
351-400-10
Greater than 400 call your doctor
Review of the [illegible] Medication Observation Record (MOR) revealed
Lantus 100 units inject 5 units in the morning and 20 in the evening. The sliding scale was not listed. The unlicensed staff initials were on the MOR for the Lantus as providing it to the resident.

Record review for Resident #2 revealed a Resident Health Assessment Form (1823) that was dated [illegible] (the wrong year was noted) with diagnosis that included [illegible] Major, Mental [illegible] and Type II [illegible]

Review [illegible] MOR for resident #2 revealed it noted Lantus 100 units every night The unlicensed staff initialed the MOR daily as providing the mediation.

During an interview with the facility's manager on [illegible] at approximately 1:30 PM, she stated she was not aware staff could not assist with the [illegible] She stated they would conduct the BS test and provide [illegible] according to the results for Resident #1 and she would inject it herself. She stated there were no nurses at the facility.

The unlicensed staff conducted BS test and made judgement on the amount of [illegible] required for Resident #1, Staff C stated he also was training Resident #2 to inject her [illegible] All of these services are considered nursing services and should be conducted by a nurse.

Observation revealed there also was no Copy of the State Clinical Laboratory License available for review that would be required for the license staff to conduct the [illegible] Glucose test.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observations and interview the facility failed to ensure medications that were kept refrigerated were in a locked container or that the refrigerator was locked at all times.

Findings:

Observations on [illegible] at approximately 11:30 AM revealed there was medication in the Refrigerator for resident #1 that was not in a locked container as follows:

[illegible] Prop; [illegible] eye drop; Dorzodamide eye drops and [illegible]
Eye ointment. The refrigerator was not locked and the area where the refrigerator was located was not secured.

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During an interview with the Facility's manager, she stated she was not aware the nose spray and eye drops kept in the refrigerator needed to be in a locked container.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on observations and interviews the facility failed to ensure medications were kept in their properly labeled medication containers.

Findings:

Observations on , at approximately 12:45 PM, revealed there were 2 pens that contained Lantus 100 units stored with Resident #1's pre-filled syringes. Further review of the pens revealed there was no way to determine who they were prescribed for. There was no prescription labeled container.

During an interview with the administrator at approximately 12:45 PM, she stated the boxes with the prescriptions labels on them were thrown out.

Class III

0076 - - 58A-5.0186 FAC

Based on record review and interview the facility failed to have accurate written policies and procedures, which delineate its position with respect to state laws and rules relative to

Findings:

Review of the Facility's Policy and Procedure revealed the policy did not include the required documentation to be given to the resident's or their representative at the time of admission. The Policy and Procedure did not include the following:
In the event a resident is receiving hospice services and experiences , facility staff must immediately contact the hospice. The hospice procedures shall take precedence over those of the assisted liv facility.

Record review for Residents #1 and #2 revealed that there was no documentation to confirm that they had provided the residents or their representative with the following information at the time of admission:

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1. A copy of Form SCHS-4-2006, "Health Care Advance Directives - The Patient's Right to Decide," effective 2006, or with a copy of some other substantially similar document which incorporates information regarding advance directives included in Chapter 765, F.S.

2. Written information concerning the facility's policies regarding and advance directives, including information concerning DH Form 1896, Florida Form, incorporated by reference in Rule 64 E-2.031, F.A.C.

3. Written information concerning the facility's policies respecting advance directives.

4. Documentation in the resident's record indicating whether a DH Form 1896 has been executed.
Record review for Residents #1, #2 and #3 revealed that there was no documentation to confirm that they had received the above information.

During an interview with the facility's manager on at 2 PM, she stated the above information was not provided to the residents.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview the facility staff performed duties that were not consistent with their level of education, training, preparation and experience in that unlicensed personnel assisted with administration and conducted glucose testing to 2 of 2 sampled residents (#1 and #2) who were and was unable to self- administer medication without assistance and did not

Findings:

During an interview with Staff B (caregiver) at 11:20 AM, she stated she would check Resident#1 and resident #2 Sugar Levels (BS). She stated Resident #1 received based on a sliding scale and when she obtained the Results of the BS from the Glucometer. According to the results she would get the prefilled that were bagged separately according to the units and hand it to Resident #1 for her to inject herself. She stated Resident #1 could not see well.
She stated resident #2 had prefilled syringes and took daily. She would get the and the Resident would inject it herself.

Observations on at 12:15 PM revealed Resident #1 was sitting at the dining The manager was trying to get her sugar readings because she stated she did not feel good. The manager took the Pen and placed it in the resident's hand and told her to press. The resident did not press. The manager pressed the

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Pen, squeezed the resident's finger to obtain the ..... and placed the ..... on the glucose machine. The manager stated what the results were and went to get the ..... out of the refrigerator. The manager handed the prefilled ..... syringe to the resident, the staff assisted her in pulling up her shirt and the resident injected the .....

During an interview with Staff C (caregiver) on ..... at 12:20 PM, she stated she took conducted the BS test for both Residents #1 and #2. She stated for Resident #1 received her ..... according to her BS results (sliding Scale). She would determine the results and get the prefill lin's, they were separated in a bag according to the units. She would provide the ..... syringe according to the units needed based on the BS results. She stated the resident would inject her own ..... She stated for resident #2, she could not inject her own ..... and she had to do it sometimes. She stated she was trying to train Resident #2 how to inject her ..... without assistance.

Record review for Resident #1 revealed a Resident Health Assessment Form (1823) dated ..... had diagnosis that included Hard of hearing, ... The type of assistance she required with Medications was left Blank.
The facility provided a sheet that they logged the BS results each time, the amount of ..... provided according to the sliding scale was not noted. The manager provided a sheet that was provided to them by the resident's daughter that noted the following:
150-200-2 unit
201-250=4 units
251-300-6 units
301-350-8 units
351-400-10
Greater than 400 call your doctor

Review of the ..... Medication Observation Record (MOR) revealed
Lantus 100 units inject 5 units in the morning and 20 in the evening. The sliding scale was not listed. The staff initials were on the MOR for the Lantus as providing it to the resident.
Record review for Resident #2 revealed a Resident Health Assessment Form (1823) that was dated ..... (the wrong year was noted) with diagnosis that included ..... Major, Mental ..... Type II .....
Review ..... MOR for resident #2 revealed it noted Lantus 100 units every night The unlicensed initialed the MOR daily as providing the mediation.

During an interview with the facility's manager on ..... at approximately 1:30 PM, she stated she was not aware staff could not assist with the ..... She stated they would conduct the BS test and provide ..... according to the results for Resident #1 and she would inject it herself. She stated there were no nurses at the facility.

The unlicensed staff conducted BS test and made judgement on the amount of ..... required for Resident #1, Staff C stated he also was training Resident #2 to inject her ..... that were all nursing services.

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Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on personnel record review and interview the facility failed to ensure that 1 of 3 sampled unlicensed staff (B), who provided assistance with the resident's medications received 2 hours of continuing education training each year in providing assistance with self-administered medications and safe medication practices in an Assisted Living Facility (ALF).

Findings:

During an interview with Staff B on [redacted] at approximately 10 AM, she stated she provided assistance with the resident's medications.

Personnel Record review for Staff B revealed a four hour assistance with medication certificate that was dated [redacted] (due [redacted] and [redacted]. There was no documentation to confirm that she had obtained a 2 hour assistance with medication training annually.

During an interview with the facility's manager on [redacted] at approximately 2:45 PM, she stated she thought that Staff B had obtained the training.

Class III

0085 - Training - Nutrition & Food Service - 58A-5.0191(6) FAC

Based on review of personnel records and interview the administrator who was responsible for the facility's food service and the day-to-day supervision of food service staff failed to have evidence for a minimum of 2 hours continuing education each year in topics pertinent to nutrition and food service in an ALF.

Findings:

During an interview with the facility's manager on [redacted] at 2 PM she stated the Administrator/owner was responsible for the facility's food service. Personnel record review revealed that the only documentation to confirm that she had obtained the 2 hour nutrition course was dated [redacted] (due [redacted]

During an interview with the facility's manager on [redacted] at approximately 2:45 PM, she stated she thought the Administrator/owner had taken the 2 hour nutrition course.

Class III

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0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview the facility failed to obtain a copy of a living will and Power Of Attorney (POA) documentation for 2 of 2 sampled residents (#1 and #2) and Semi-Annual weight record for 1 of 2 sampled Residents (#1).

Findings:

Record review for Resident #1 and #2 revealed their contracts and documentation's in their files were signed by their family members.

Review of the Weights record for Resident #1 revealed the only weights available for review was for 1 in

During an interview with the facility's Manager on at approximately 2:45 PM, she stated both residents had POA's and she did not have a copy of it in their records. She further stated the weights were taken for 2014 and she could not locate them.

Class III

0167 - Resident Contracts - 58A-5.025 FAC

Based on resident record review and interview the facility failed to ensure that each resident contract contained the rights, duties and of residents, other than those specified in the Resident Bill of Rights for 2 of 2 sampled residents #1 and #2.

Findings:

Resident record review including contracts for residents #1 and #2 revealed
FS 429. 24 there was no provision that indicated that if after a contract was terminated, the facility intended to make a claim against a refund due the resident, the facility must notify the resident or responsible party in writing of the claim and must provide the said party a reasonable time period of no less than 14 calendar days to respond. Further review revealed the contract noted "the entire agreement may be terminated by written request of the resident or responsible party or the request of the facility with 45 day's notice." (The residents are only required to give a 30 day notice).

During an interview with the facility's manager on at approximately 2:30 PM, she confirmed the above findings.

Class

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Bear Lake Retirement Home
1525 Bear Lake Road
Apopka, FL 32703

RE: Biennial relicensure

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on l 14, 2015 by representative(s) 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 surveyor(s). Should you have any questions please call Lorraine Henry at .

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure
XG90

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