STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911900	09/22/2015
NAME OF PROVIDER OR SUPPLIER **BEAR LAKE RETIREMENT HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **1525 BEAR LAKE ROAD** **APOPKA, FL 32703**	

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

0000 Initial Comments

A complaint investigation (CCR 2015007750) was conducted at Bear Lake Retirement Home in Apopka, Florida on / . Deficient practice was found at the time of the investigation.

0025 Resident Care - Supervision

Based on record review and interviews, the facility failed to provide notification to a licensed physician for 1 of 4 residents (Resident #5) following the resident exhibiting signs of or . The facility failed to maintain a written record of significant changes for 1 of 4 residents (Resident #5).
Findings:

1- On / , during a record review of a local law enforcement report completed on / , it was documented that Resident #5 left the facility and was found wandering the streets by local fire and rescue personnel at 1:31 AM on / .
2- On , during a continued record review of local law enforcement report which was completed on , it was documented by a law enforcement investigator that Resident #5 was unable to provide any useful information beyond his name when interviewed on .
3- On / , during a record review of a state report it was indicated that Resident #5 lacked the capacity to consent when interviewed at a local emergency / / .
4- On / , during a record review of the facility's adverse incident filed to the agency on / , it indicated on the adverse incident report that the facility had made notification to Resident #5's family. The facility documented on the adverse incident report that the family of Resident #5 stated to the facility that Resident #5 had a similar incident the week prior while on vacation with the family.
5- On / , during a continued record review of Resident #5's file, the file did not contain nursing or progress notes related to Resident #5.
6- On / at 11:36 AM, in an interview with Resident #5, Resident #5 was able to state that he lived at the facility, he could provide his name and Resident #5 stated that he liked his sister. Resident #5 was unable to remember his sister's name, the name of the facility or his date of birth.
7- On at 1:20 PM, in an interview with the facility administrator, the facility administrator was asked based on the change in the behavior of Resident #5 if she had contacted the primary care physician for Resident #5 to report these changes. The facility administrator stated no.
8- On / at 1:20 PM, in a continued interview with the facility administrator, the facility administrator was asked to show the documentation in the communication log relating to Resident #5 ' s elopement on / . The facility administrator stated the communication log did not have any written documentation of the incident related to Resident #5 leaving the facility.
9- On / at 1:20 PM, in a continued interview with the facility administrator, the facility

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administrator was asked to show documentation of informing Resident #5 ' s family of the elopement on / / . The facility administrator stated that she did not have any written documentation that she had contacted the family of Resident #5.
Class III

0055 Medication - Storage and Disposal

Based on observation and interviews, the facility failed to maintain centrally stored medication in a locked cabinet.
Findings:
1-On / at 10:40 AM, during a tour of the facility it was observed that the medication cart used for medication storage had two drawers standing open. It was observed that both open drawers contained medication bottles and bingo packs of medication belonging to residents living at the facility.
2- On at 10:40 AM, during a continued tour of the facility, it was observed that the residents of the facility were starting to gather around the medication cart.
3-On / at 10:45 AM, in an interview with staff I, staff I stated that when asked why the medication cart was left open, staff I stated that she opens it and then goes and gets the Medication Observation Records.
4- On / at 10:45 AM, in an interview with the facility administrator, the facility administrator stated they always open up the medication cart and then go and get the Medication Observation Records so they can provide the residents with their medication.
Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observation and interviews, the facility failed to maintain a safe living environment that is free of hazards for 12 of 12 residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11 and #12).
Findings:
1- On / at 10:40 AM, while touring the facility is was observed that the north exit door to the facility had to be pushed open. It was observed that the exit door had to be forced open because it was blocked by a stack of mattresses and sand bags.
2- On at 10:40 AM, while continuing the tour of the facility, it was observed that a red storage can was sitting next to the exit. As the red storage can was examined, the top was removed and it contained a liquid that smelled like gasoline. It was also observed cigarette buds were left on the ground next to the red storage can.
3- On at 10:40 AM, while continuing the tour of the facility, it was observed that a wall mount air conditioning unit, which was in disrepair, was being stored in a table in the middle of the gazebo which is used by residents.

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4- In an interview with the facility administrator on at 11:00 AM, the facility administrator stated she could not explain why the mattresses were stacked behind the exit door. The facility administrator stated that the sand bags were used to keep water from running into the building. The facility administrator confirmed that the exit door is a fire exit for residents living in the building. The facility administrator stated that the red storage can was used for the storage of gasoline for their lawn maintenance equipment. The facility administrator stated she could not provide an explanation why it was left in an area used for smoking.

Class III

0165 Risk Mgmt & QA: Adverse Incident Report

Based on record review and interviews, the facility failed to file an adverse incident report for a resident elopement that left the resident at risk of harm and was investigated by local law enforcement for 1 for 12 residents (Resident #5).

Findings:

1-On , a record review was conducted of local law enforcement report regarding an elopement of Resident #5. It was confirmed in the law enforcement report that Resident #5 on at 1:31 AM, was found wandering the streets by local fire and rescue personnel. The report, related to Resident #5's elopement was assigned to a local law enforcement investigator for investigation.

2- On , in a continued record review of a local law enforcement report, it was documented by a law enforcement investigator that Resident #5 was unable to provide any useful information beyond his name.

3- On / , in a record review of a state report, it indicated that Resident #5 while interviewed at a hospital emergency not have the capacity to consent.

4- On at 11:20 AM, in an interview with staff J and the facility administrator, the facility administrator stated that she had not completed an adverse incident report regarding the elopement of Resident #5 on / .

5- On at 11:20 AM, in a continued interview with staff J and the facility administrator, the facility administrator stated that law enforcement was involved with the elopement of Resident #5 on / . The facility administrator stated that on , an investigator from local law enforcement had contacted her twice to determine if she was missing any residents. The facility administrator stated during the second call from law enforcement, she (the facility administrator) checked all of the residents and discovered that Resident #5 was not in his .

6- On at 11:20 AM, in a continued interview with staff J and the facility administrator, the facility administrator was asked if Resident #5 was at risk when he eloped on / / and she stated yes.

7- On at 9:51 PM, a record review was conducted of the adverse incident report that was e-mailed to the state on / , past the 1 day requirement. The adverse incident report confirms that

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Resident #5 eloped from the facility on at 1:00 AM. The record review of the adverse incident report states that the facility had two calls from local law enforcement before the facility realized that the Resident #5 was missing.
Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

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

RE: CCR #2015007750

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 -2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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