STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911132	11/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCEAN VIEW MANOR	624 S ATLANTIC AVENUE DAYTONA BEACH, FL 32118

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

0000 Initial Comments

A complaint investigation (CCR 2015010100) was conducted at Ocean View Manor on 2015. Ocean View Manor had deficiencies at the time of the investigation.

0025 Resident Care - Supervision

Based on record review and staff interview, the facility failed to maintain a written record of changes for a resident with a decline in health and follow physician orders for a medication for 1 of 25 sampled residents, Resident #22.

The findings include :

Review of the clinical record for Resident #22 revealed an Observation Log dated that the resident was taken to the hospital with issues with walking. He was slow and he would catch himself as if his knees were to buckle. His was also low at . He was checked into the emergency 11:30 a.m.

The hospital discharge instructions revealed a diagnosis of hyperammonemia with instructions for 30 milliliters by mouth three times a day for 7 days. Side effects of hyperammonemia can include , lethary, and decreased muscular strength.

Review of the 2015 Medication Observation Record did not reveal this medication. The Administrator on / at 12:05 p.m. confirmed the resident did not receive this medication to treat the hyperammonemia.

On / , a lab draw was attempted on Resident #22 and the technician was unable to obtain it. The resident was unable to remain still and he was very because his veins were not prominate.

On the resident was very and did not remember his . He also appeared to be sleeping a lot in the living . His balance seemed to be off and was stumbling around a lot.

The next note was not until when the resident was found near the laundry the ground.

On , the resident was found to be leaning to the right side , disoriented and he could not hold

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his head up stating, "I can't it hurts". The resident was transferred non- emergency to the hospital.

The clinical record revealed a hospital discharge record on for , minor head injury and follow up with the primary physician. Another hospital discharge was noted on / for a and follow up with physician within 1 day. Neither of these events had observation log notes to describe what happened to the resident requiring him to be transferred to the hospital for treatment.

The resident's primary doctor had two progress notes, dated and //. Neither one addressed his change in condition/ .

Class III

0027 Resident Care - Arrangement for Health Care

Based on record review and staff and resident interview, the facility failed to assist Resident #10, 1 of 25 sampled residents, in obtaining further treatment for his broken arm.

The findings include:

Resident #10 was interviewed on // at 8:15 a.m. He stated he had been at this facility for about 4-5 months. He came here after his car accident. He stated he needed to see the doctor for pain in his left arm.

Review of the resident's clinical record revealed a orthopedic note revealing he had a left Olecranon (elbow) and . The doctor ordered physical 2-3 times a week for 6 weeks. A soft removable was placed on the left arm and only to be removed by physical staff. A resident observation log of revealed the resident went back to the orthopedic doctor who removed the and a Physical assessment was scheduled for , 2015 to determine how many days per week to continue . The next observation note revealed the appointment was canceled due to insurance coverage. The note also revealed there was no Physical Provider in the immediate area.

Employee C on / at 8:53 a.m. stated she spoke with the managed care company who stated there was no close by. The resident refused to go out of town for these services. She confirmed she did not document who she spoke with at the managed care company. She did not document the resident's refusal either.

On / at 9 a.m., a Representative from the managed care company was called regarding

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Resident #10. She stated that service providers can vary but if a patient required services out of town, they would supply transportation. The representative stated that they did not receive any request for this type of service for this resident back in / 2015.

The clinical record did not have documentation that the resident refused to travel out of town for services.

On / at 10:45 a.m., Resident #10 stated he does not know who his case manager was and did not explain anything to him about his or coverage. He never refused to go out of town for services.

Class III

0052 Medication - Assistance with Self-Admin

Based on record review and staff interview, the facility failed to provide assistance with self administration of medications per physician orders for Resident #22 and failed to assist with self-administration with medications in accordance with procedures described in F.S. 429.256 residents #6. #7, #8, and #9, 5 of 25 sampled residents.

The findings include:

1. Review of the clinical record for Resident #22 revealed an Observation Log dated that the resident was taken to the hospital with issues with walking. He was slow and he would catch himself as if his knees were to buckle. His , was also low at . He was checked into the emergency 11:30 a.m.

The hospital discharge instructions revealed a diagnosis of hyperammonemia with instructions for 30 milliliters by mouth three times a day for 7 days. Side effects of hyperammonemia can include , , and decreased muscular strength.

Review of the 2015 Medication Observation Record did not reveal this medication. The Administrator on / at 12:05 p.m. confirmed the resident did not receive this medication.

2. On / at 8:35 a.m. Employee B, a certified nursing assistant was observed to assist with medication administration for residents #6, #7, #8, and #9. For each resident, she removed the medications from their medication cards and popped them into a plastic medication cup and handed

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them to each resident. Employee B did not read each label out loud in front of the resident and explain what she was assisting with.

On /[redacted] at 8:39 a.m., Employee B confirmed she did not read the label out loud and explain to the residents what she was assisting with.

Class III

0079 Staffing Standards - Levels

Based on facility staffing schedule records and staff interview, the facility failed to maintain an accurate 24 hour staffing pattern with specific days.

The findings include:

The Administrator was asked for a 6 month staffing schedule. She stated they were electronic and would print them. She produced a list of employees with a week on them (Monday through Sunday) but it did not have the specific numeric date. She stated everyone pretty much had the same schedule and then after the week she adjusted them in the computer. The most recent schedule she produced she hand wrote the dates of [redacted]26 until [redacted]8 on it. She stated this week would be the same, starting on Monday, [redacted], 2015 until Sunday, [redacted], 2015. She had three persons listed on this schedule who were scheduled to work today on Thursday, [redacted], 2015. They were Employee J, Employee H, and Employee I. None of these employees were at work.

The Administrator on /[redacted] at 1:15 p.m. stated the current schedule was not correct. Employee J was a housekeeper who was on vacation this week, Employee H , a resident aide just quit on Tuesday, and Employee I was the owner who was scheduled from 11am-6pm on Monday-Friday did not show up yet. She stated she would not meet her numbers this week of 498 hours for 83 residents.

Class III

0092 Food Service - General Responsibilities

Based on observation, staff interview and review of the approved menu, the facility failed to provide a nutritional meal that meets the nutritional needs of the 83 residents residing at the facility.

The findings include:

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Observation in the kitchen on 1/ at 7:40 AM found several trays of cups pre-poured with milk. During an interview with the cook (Employee F) at the time of observation he stated he was serving four ounces of milk and used a point on the cup to determine how much milk to put in each cup.

Record review of the menu for breakfast on 1/ found the amount of milk to be served was 8 ounces. A measuring cup was used to put 8 ounces of water in one of the cups used by the facility. In comparison of the cups pre-poured with milk the facility was 3-4 ounces short.

Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observation and resident and staff interview, the facility failed to maintain a safe and sanitary environment. This had the potential to impact all 83 residents at the facility.

The findings include:

Observations in the facility on 1/ at 7:30 AM until 11:00 AM found the following:

1. Observation in the ' ' by resident #21 and two other residents revealed the first set of window blinds had an area approximately 2 inches by 3 inches that contained a brown/black covered thick substance. In the the same , a trash can with used briefs was observed and above the trash can a swarm of black flying insects. Also observed was brownish colored spatters on the walls in the , brown colored substances on the wall and floor in the a splattered reddish brown substance covering a 4 inch area on a wall near the entrance to the . Resident #21 stated during an interview at the time of observation, that he smashed a roach on the blinds. He stated that the roach splatter has been on the blinds for over a week. He said one of the two housekeepers that cleans at the facility quit about a week ago and there is no one downstairs to clean. He stated he tries to help out by keeping the ' . He also stated that it was difficult to keep the because one of the residents in the and leaves his used briefs in the , which results in insects. (Photographic evidence obtained)

2..Observation in the ' ' by Resident #12 and three other residents found the trash in the

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overflowing on to the floor. There was a white substance on the floor of the shower, going up the walls of the shower, and the drain cover was off. There was specs of grayish brown substance on the . There was a dirt like substance on the floor of the closet, along the walls, and dirty laundry on the floor. There was also a dirt and dust like substance under the bed located under the window closest to the door and behind the TV stand. (Photographic evidence obtained)

3. The back hall of the downstairs of the facility found a bucket of dark brown water in a mop bucket. The tile floor on the back hall way and on the hallway that goes up to the dining observed to have black areas with the majority being along the walls. The blinds on the window in the back hallway of the downstairs of the facility was observed to be covered in a gray dust like substance and area at the bottom of the window was covered in brownish colored substance. (Photographic evidence obtained)

4. On / at 8:15 am, Resident #10 stated his ( ) was filthy, his hot and the fans in the covered with dust. An observation of the resident's conducted on / at 8:17 a.m. in . There was one empty bed with the linens removed and a big stain on it. There were three other beds in the each bed had dirt and debris under them, including cigarette butts and paper items. In the corner was a visible wads on hair on it. There were two areas where clothing was on the floor. Next to one of the beds there was a can of cheese wiz with the cap off and yellow/orange stuff on the top of the dispenser. On the wall was a 2 inch thin black/green debris. Over the two dressers and television there was a layer of dust. The flooring had missing tiles. One of the nightstands (with the television on top of it) had gray (cigarette ash like) substances to the corner and down by the floor. There was also white substance running down the night stand. There were two fans in the ' with dust/dirt. There was a of the had a like smell and in the drain area was visible dark hairs and a plastic medication cup in it. On the tiles had black mold like substances. The blinds in the had dirt/dust on them. One of the ceiling light fixtures had a large amount of dark debris in it.
The housekeeper, Employee D was interviewed on / at 8:30 a.m. She stated she was the only housekeeper in the building. The other one quit about 3 weeks ago. She worked from 6 a.m. to 2 p.m. Monday through Friday. There was not a housekeeper on the weekends. The resident aides would have to do it. She has about 24 upstairs and about 20 downstairs to clean as well as common hallways, , etc. She also was responsible for doing the laundry for 83 residents. She cleaned every . She stated she used a bleach solution on the floor and comet , lime remover, and window cleaner in the . She used the same cleaning cloth for each . She stated she was just getting ready to clean .
On / at 10 a.m. (after the housekeeper cleaned it) another observation of was conducted. There was still dirt under all of the beds, dirt under the furniture and corner of the , hair and medication cup in the drain, cigarette ash like substance on top of dresser and floor, cheese wiz

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on the floor, and dirty linen in two piles.
Employee D was interviewed again on / at 10:01 a.m. She confirmed that she had missed several areas of cleaning in the . She stated she does not do maintenance cleaning. Some of the dirt on the floor was impeded into the materials and she could not remove.
5. Another observation of the physical environment of was made on / at 10:55 am. The trash can in the overflowing. There was dirt under all of the 3 beds, a tea bag on the floor and pop corn debris next to one of the beds. Also there was two large stains by the door.
Resident #12 was in her (118) was interviewed at this time. She stated they only come in once a week to clean to the . They do not do a good job.
Resident #13 was in her (118) on / at 1100 a.m. She stated that the neighbor across the hall comes in the ' makes a mess. He was the one who spilled the popcorn and he spilled the coffee by the front door. He comes in and uses the and makes a mess. They always forget to take the trash from the . She sometimes would empty it. They used to come in daily. Now they come in once a week if you are lucky.
Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Ocean View Manor
624 S Atlantic Avenue
Daytona Beach, FL 32118

RE: CCR #2015010100

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on 2015 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. **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 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

LW/JM/sm
Enclosure
XG90

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