STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11911132 Y1	A. Building B. Wing Y2	Y3

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0025	Correction	ID Prefix A0027	Correction	ID Prefix A0052	Correction
Reg. # 429.26(7) FS; 58A-5.0182(1) FAC	Completed	Reg. # 58A-5.0182(3) FAC	Completed	Reg. # 58A-5.0185 (3)	Completed
LSC		LSC		LSC	
ID Prefix A0079	Correction	ID Prefix A0092	Correction	ID Prefix A0152	Correction
Reg. # 58A-5.019(3) FAC	Completed	Reg. # 58A-5.020(1) FAC	Completed	Reg. # 58A-5.023(3) FAC	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
			[signature]	2-1-16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
11/13/2015	

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X3) DATE SURVEY COMPLETED
	AL11911132	R 02/03/2016
NAME OF PROVIDER OR SUPPLIER **OCEAN VIEW MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **624 S ATLANTIC AVENUE** **DAYTONA BEACH, FL 32118**	

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

0000 Initial Comments

A follow-up visit to a complaint survey (CCR #2015010100) was conducted at Ocean View Manor on . Ocean View Manor had deficiencies at the time of the visit

0054 Medication - Records

Based on a review of resident records, and interview with staff, the facility failed to maintain and complete medication observation records (MORs) recording each time the medication was taken, any missed dosages, or refusals to take medication as prescribed, for 2 of 3 sampled residents reviewed for medications (Residents # 29 and #30).

The findings included:

1. A record review for Resident #29 revealed a resident health assessment (AHCA form 1823) dated . Diagnoses included acute , and . This resident required assistance with the self-administration of medication. Resident #29's physician saw her on / and ordered (an) 500 milligrams (mg) three times daily ( ) for 1 week, and (syrup) 10 milliliters (ml) four times daily ( ) for 10 days for an acute ( ).

Review of the MOR for and 2016 found that ( ) syrup 10 ml by mouth was started on / . It was scheduled to be taken at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm each day. The medication stop date was . Closer observation of the MOR found the corresponding signature boxes for were not signed on / / at 12:00 pm or 4:00 pm, on / / at 12:00 pm or 4:00 pm, or on / and / at 4:00 pm. There were no explanations on the back of the MOR to explain if, or why, the medication was not given.

Resident #30's 500 mg was scheduled to be taken at 8:00 am, 12:00 pm, and 8:00 pm daily. The medication was started on / , and the stop date was / . The corresponding signature boxes for were not initialed, as given, on / / or / at 12:00 pm. There was no explanation on the back of the MOR to explain if, or why, the medication was not given.

2. Record review for Resident #30 found an 1823 dated . She had a diagnosis of , and required assistance with the self-administration of medication. She was seen by her physician on

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X3) DATE SURVEY COMPLETED
	AL11911132	R
NAME OF PROVIDER OR SUPPLIER **OCEAN VIEW MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **624 S ATLANTIC AVENUE** **DAYTONA BEACH, FL 32118**	

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

I/ for an 500 mg I for 10 days was ordered I/ / . Review of the MOR for Resident #30 found 500 mg was started on I/ and scheduled for administration at 8:00 am, 12:00 pm, and 8:00 pm. This medication was not signed as given on I/ or on I/ I/ at 12:00 pm.

An interview was conducted with Medication Technician A at 11:17 am on / /. She reviewed the MORs for Residents #29 and #30. She acknowledged the omissions on the MORs for both residents. She stated did not know if the medications were given as ordered, or not. Someone must not have signed the medications. Medication Technician A said if a medication had been refused, an "R" would be written in the initial box, and a note written on the back of the MOR explaining why the medication was not given. If a resident was out on leave, an "O" should be recorded, and the leave noted. She looked at the back of the MORs for Resident #29 and #30, and confirmed there were no notes for either resident.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

Re: CCR #2015010100

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2016 by a representative of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the new deficiencey identified during the revisit.

The deficiency shall be corrected no later than , 2016.

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. Should you have any questions please call this office at (904) 798-4201.

Sincerely,

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

LL/JM/sm
Enclosure

BBT7

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