STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963950	**08/24/2016**
NAME OF PROVIDER OR SUPPLIER **BENEVA LAKES ASSISTED LIVING CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **743 S. BENEVA ROAD SARASOTA, FL 34232**	

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

0000 Initial Comments

An unannounced change of licensure (CHOW) survey was conducted through at Beneva Lakes, an Assisted Living Facility, (license # 6563) in Sarasota, Florida.

The following is description of the deficiencies.

0025 Resident Care - Supervision

Based on record review and interview, the facility failed to obtain a complete medical record updated as needed including changes in direction of medications for 1 (Resident #1) out of 2 residents record reviewed.

The findings included:

Record review for Resident #1 found an order dated for Bactimar 800 milligrams (mg) twice a day ( ) for 10 days. Record review for Resident #1 found no supporting diagnosis for the prescribed .

Further review found additional order dated / for Clidomycin 300 mg, 3 times a day for 10 days. Record review for Resident #1 found no supporting diagnosis for the prescribed .

During an interview conducted on at 2:57 p.m. the facility's Director of Nursing (DON) said she did not know exactly the specifics since she had been working there only for three weeks. She did not know why resident was prescribed .

During an interview on at 8:20 a.m. the executive director said Resident #1 received for issues related to cellulite at the lower left ligament and . The executive director said staff A had the specifics.

Record review for Resident #1 found no diagnosis of or . The only diagnosis listed at residents Health Assessment 1823 form was unspecified , long term use of .

During an interview with Staff A (Practical Nurse) on at 9:42 a.m. she said Resident #1 received both for the same issue. His at the left lower ligament. The Nurse practitioner told her so. Staff A started looking at the resident's record, but she was unable to find a notation indicating Resident #1's diagnosis of . She said the Nurse Practitioner usually sends out the

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communication form so they are all in the same page. She said she did not know why the forms were not completed. She said she though the resident had .

Class III

0030 Resident Care - Rights & Facility Procedures

Based on resident contracts reviewed, observations, resident and staff interviews, the facility failed to ensure Residents #1, #4, #19, #7, and #15's rights were being protected.

The findings included:

1. Observation on at 9:10 a.m. revealed a sheet of paper taped on the front door of Resident #4's door. On this sheet of paper was Resident #4's name and . It also indicated that she has a doctor's appointment, showing the physician's name and address as well as the date and time of the appointment.

Observation of Resident # 19's front door of his a sheet of paper taped on the door. It has the resident's name, , physician's name and address, the appointment time and date.

An interview was conducted with the Executive Director at 3:30 p.m. on . She stated the med techs on the night shift tape these sheets of papers on the residents' doors to remind the residents of their doctor's appointments. She felt this was a HIPPA violation and will correct this.

2. Observation at 9:10 a.m. on revealed Resident #4 sitting in her electric chair. She had a seat belt wrapped around her waist. She said she can unclip the belt but staff clip it for her. The belt is too short and her son is buying an extension so she will be able to clip it. At that time the surveyor asked her to unclip and clip the seat belt. She was able to unclip the belt but could not clip it back. She said she uses the seat belt so she does not out of the chair.

Interviews were conducted with the nurse supervisor and Staff G at 1:25 p.m. on . Staff G stated Resident #4 can't reach the seat belt if it to the side of the chair. Her arms are too short. Staff have to clip the belt for her. Also, the seat belt is too short for her to clip the belt. She wants to use the seat belt so she does not out of the chair.

3. A review of Resident #4's contract shows it was executed on and Resident #1's contract was executed on . These contracts indicated the facility can give a resident less than a 45-day discharge notice if the resident lives in the facility for less than 30 days.

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An interview was conducted with the Administrator on at 9:35 a.m. He stated he was not aware of this statement in the contract.

4. An interview was conducted with Resident #7 on at 12:17 p.m. She stated she has not been asked if she wants soup yet. Observation during the lunch meal on showed several residents were eating soup. Resident #7 also stated she does not like that she has to be served her food last every day. She has an assigned table. The place mat has her name on it and that is where she was told she has to sit. She and her table mate have both have asked if the staff can alternate the serving so they don't have to be served last every day. But they are still being served last. She feels she is not being treated fairly.

5. During an interview conducted on at 12:32 p.m. Resident #15 said she is always the last one to be served in the dining . Said they always attend to her last. She said the only day that she got her meal second to last was today and she believed it was because the state was there.

Class III

0052 Medication - Assistance with Self-Admin

Based on record review, observation and interview, the facility failed to properly assist with self-administration of medication for 1 (Resident 16) of 3 residents.

The findings included:

On at 10:58 a.m., Staff B (med tech) was observed assisting Resident 16 with 11 a.m. medications. Resident 16 was given Tab 10 mg, tab 250 mg, Trihexyphen tab 2 mg, and Tab 50 mg.

Review of Medication Observation Record (MOR) revealed is to be given once a day at 8:00 a.m. and had already been given at 8:00 a.m. that day. The MOR also indicated was ordered twice daily at 8:00 a.m. and 5:00 p.m. The 8:00 a.m. dose was already documented as being given and the next dose was not due until 5:00 p.m.

On at 11:02 a.m. Staff B said he was nervous and doing things out of his regular sequence which caused him to make the error. At 11:05 a.m. Staff A (LPN) was informed and called Staff D (LPN Supervisor). Staff D arrived and said she would call the family, the doctor and complete an incident report.

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Class III

0056 Medication - Labeling and Orders

Based on record review and interview, the facility failed to refill mediations on a timely manner for 1 (Resident #1) out of 2 resident records reviewed.

The findings included:

During an interview on at 9:20 a.m. Resident #1 was asked if he ever missed any of his medications. He stated, "It was only for 1 day because it was a 31-day month and gave me a 30-day supply. I think I missed a total of 120 milligrams. I take it twice a day. I wish that didn't happen. See I have at my lower leg due to my recent ( ) I like to take my pills daily."

Medication Record review (MOR) review for Resident #1 found that on / Resident #1 was supposed to receive two doses ( ) of , 40 milligrams (mgs) each. Further review, found documentation in the back of the MOR stating that both doses were not given due to the fact that medication was not on the cart.

During an interview on at 11:55 a.m. the Director of Nursing (DON) said that the norm is that they will send out the refill requests seven days prior. She was asked if she had a refill request for Resident #1's . She said she did not have a way of finding that. She said sometimes medications come in cycles and they do not have a tentative date of delivery. It depends of the pharmacy that resident uses. The DON was unable to provide documentation of refill order for Resident #1's medication.

The facility's policy in reference to refilling medicationsfacility states the facility is to request refill 7 days prior. The facility also provided the pharmacy's policy and per this policy medications are to be delivered 5-7 days prior.

The executive director acknowledged on at 9:10 a.m., that the facility did not follow its policy on refilling medications in a timely manner.

Class III

0078 Staffing Standards - Staff

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Based on record review and interview, the facility failed to obtain a written statement from a health care provider documenting that newly hired staff does not have any signs or symptoms of communicable within 30 days of beginning employment for 2 (Staff E and F) of 4 staff reviewed.

The findings included:

Record Review of Staff E's employee file on / revealed a hire date of as a resident aide/med tech. This personnel file contained no written statement from a health care provider documenting that Staff E does not have any signs or symptoms of communicable .

Record review of Staff F's employee file on revealed a hire date of as a resident aide/med tech. This personnel file contained no written statement from a health care provider documenting that Staff F does not have any signs or symptoms of communicable .

On at 11:45 a.m., the Administrator and Executive Director agreed this documentation was missing and would correct this.

Class III

0081 Training - Staff In-Service

Based on record review and interview, the facility failed to ensure that staff who provide direct care to residents receive in-service training within 30 days of employment that covers 1 hour of Emergency Preparedness and Evacuation Training, 1 hour of Resident Rights training and 1 hour of Nutritional and Safe Food Handling Training for 3 (Staff B, E, and F) of 3 staff reviewed.

The findings included:

1. Record Review of Staff B's employee file on / revealed a hire date of as a resident aide/med tech. Staff B's file did not contain documentation of Staff B completing 1 hour of Nutritional and Safe Food Handling Training.

2. Record Review of Staff E's employee file on revealed a hire date of as a resident aide/med tech. Staff E's file did not contain documentation of Staff E completing 1 hour of Nutritional and Safe Food Handling Training.

3. Record Review of Staff F's employee file on / revealed a hire date of as a resident aide/med tech. Staff F's file did not contain documentation of Staff F completing 1 hour of Nutritional

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and Safe Food Handling Training, Resident Rights Training, or Emergency Preparedness and Evacuation Training.

4. On at 10:00 a.m., the executive director said the staff were shown a 2-hour video that covers these and other topics when they are hired and the facility thought that would cover the requirement. The executive director said she would get the appropriate trainings completed.

Class III

0093 Food Service - Dietary Standards

Based on 12 of 17 resident interviews and food temperatures taken at the lunch meal, the facility failed to provide residents food served at safe and palatable temperatures resulting in Residents #5, #4, #15, #6, #18, #20, #3, #2, #11, #12, #13, and #14 making complaints concerning food being served .

The findings included:

1. On at 9:10 a.m., Resident #4 was interviewed. She stated the service in the dining slow and sometimes the food is by the time it gets to her.

2. Resident #5 was interviewed on at 9:22 a.m. He stated the service in the dining slow and when he gets his food it is .

3. On at 9:27 a.m., Resident #15 was interviewed. She stated it takes a long time to get her food served to her in the dining .

4. Resident #6 was interviewed on at 9:35 a.m. She said she waits a long time to be served her food in dining . Once she gets her food, it's .

5. Resident #18 was interviewed on at 10:00 a.m. She said the food is not good. She has to wait a long time to get her food and by the time she gets it, it's .

At 12:50 p.m. on Resident #20's meal was on a cart in the 400 hall.

Observation at 1:08 p.m. on a staff served Resident #22 her lunch in her .

6. An interview was conducted with Resident #20 at 1:20 p.m. on . She said her lunch was "luke warm."

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7. During an interview conducted on at 9:40 a.m., Resident #3 said the food served was . During a follow-up interview at 12:30 p.m., Resident #3 said he had to wait 27 minutes before his meal was served.

8. During an interview conducted on at 9:55 a.m. Resident #2 said the food was very .

9. During an interview conducted on Resident #11 said at 12:00 p.m., that the food was . Resident #11 stated, "They just bring me another out and it is again. The coffee in the common area is the same pot after 5 days, same coffee. Can you drink that? The water was polluted."

10. During an interview on at 12:28 p.m., Resident #12 said that he placed his order at 12:00 p.m. and the meal arrived at 12:28 p.m.

11. During an interview on at 12:32 p.m., Resident #13 stated, "Today that you are here we are the first to be served usually we are last, its horrible close to 40 minutes wait."

12. During an interview on at 12:32 p.m. Resident #14, who shares a table with Resident #13, said today it was the first day they did not they had to wait close to 40-43 minutes some days. We had to wait until everyone was served. Today the food is warm, but not the case before.

13. During an interview on at 12:40 p.m. Resident #15 stated she waited 20 minutes for her meal and there was too much breading, wonder if there is a pork chop there. It is the same since the new owner came in.

14. Test tray took place on at 12:34 p.m. Pork was 140 F, mashed potatoes 165 F, spinach 160 F.

Alternate test tray at 12 :40 p.m. Chicken was 130 F and was very dry, rice 128 F, tasted warm, spinach 130 F, mashed potatoes 148 F.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, , 2016

Administrator
Beneva Lakes Assisted Living Center
743 S. Beneva Road
Sarasota, FL 34232

Dear Administrator:

This letter reports the findings of a state licensure change of ownership survey that was conducted on , 2016 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 , 2016.** 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 (239) 335-1315.

Sincerely,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form

XG90

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