STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911992	R
NAME OF PROVIDER OR SUPPLIER **GULF WINDS**	STREET ADDRESS, CITY, STATE, ZIP CODE **2745 VENICE AVENUE EAST** **VENICE, FL 34292**	

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

0000 Initial Comments

An unannounced revisit survey was conducted from through at Gulf Winds, an Assisted Living Facility, (license #7804), in Venice, Florida. This is a follow-up to the monitoring visit survey completed on and revisit survey on through .

The following is a description of the deficiencies found at the time of this visit.

0078 Staffing Standards - Staff

Based on record review and staff interview, the facility failed to ensure that within 30 days after beginning employment, newly hired staff had a written statement from a health care provider documenting that the individual does not have any signs or symptoms or communicable for 1 (Staff Q) of 9 staff records reviewed.

The findings included:

Employee file review revealed that Staff Q was hired as a Certified Nurse Aide. Staff Q had no documentation of freedom from communicable .

In an interview on at 1:45 p.m. with the Administrator, she confirmed there was no documentation of communicable for staff Q found in the file and that she will follow up on this.

Class III

0120 Fiscal - Financial Stability

Based on records reviewed and staff interview, the facility failed to maintain accurate business records. The facility did not show 3 (Residents #2, #18 and #19) of 22 residents receiving refunds when they paid the facility more then what their contracts shows.

The findings included:

On , of the three residents owed refunds, only Resident #19 still resides in the facility. On financial statements were requested from the management company.

1. As reported in the prior survey on , Resident #2 overpaid the facility $7,200.00. There was no documentation showing the facility reimbursed Resident #2 the $7,200.00.

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2. As reported in the prior survey on , Resident #18 overpaid the facility $2,400.00. There was no documentation showing Resident #18 received a refund of $2,400.00.

3. As reported in the prior survey on , Resident #19 is owed $250.00. There was no documentation showing Resident #19 received a refund of $250.00.

4. On the management company provided a year-to-date Profit & Loss statement for the period through 2016. The statement reports only $500.00 has been expended for resident refunds. There was no detailed accounting of the disbursement.

Class II

0123 Fiscal - Resident Trust Funds

Based on resident records reviewed and staff interview, the facility failed to obtain/maintain a separate bank account for resident funds and co-mingled the resident fund with the facility funds for 1 (Residents #14) of 15 residents. The facility is acting as representative payee/cashier for and reviewed for safekeeping of funds.

The findings included:

In an interview on at 9:00 a.m., the on-site manger said that whenever she receives checks at the facility for residents, she deposits them in the bank. She said there is only one bank account for the facility. The manager said the bills are paid by management company.

In a phone interview on at 1:30 p.m., the director of the management company operating the facility, said all money received from residents and for residents, in the case of direct payments from Social Security, pension funds, and retirement accounts, is deposited in the facility operating account. The director said the funds are used for daily operations. He stated all capital improvements come out of his own pocket.

A review of the record for Resident #14 showed the facility is representative payee for the resident's Social Security payments. There was no evidence of separate accounting for resident funds. The facility appeared to being using the total amount received for rent payment. No portion was being used to pay pharmacy benefit co-payments. The record showed Resident #14 is covered by Medicare and Medicaid through Staywell.

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A call to the pharmacy on at 10:00 a.m., revealed they have not been paid for Resident #14's medications and are owed over $1,000.00. The financial clerk at the pharmacy stated they have suspended services to Resident #14 until payment is made.

A phone interview with the supervisor at the Medicaid office on at 10:15 a.m. revealed that Resident #14 has Medicare Part D benefits. The supervisor stated the resident is also covered by Medicaid, however, Medicaid cannot cover the co-pay for Medicare Part D. She stated the resident is responsible for the co-pay and should come out of Social Security or other retirement benefits.

There was no documentation of separate accounting of resident funds and no documentation of payments from resident fund accounts in behalf of trustee residents.

Class II

0125 Fiscal - Suretv Bonds

Based on three of three resident records reviewed and staff interview, the facility failed to obtain a surety bond for twice the amount of money handled that the facility is acting as representative payee.

The findings included:

On financial statements, including proof of a Surety Bond, were requested from the management company.

On the management company provided a year-to-date Profit & Loss statement. No other documents were provided. There was no evidence of a Surety Bond.

Class III

0152 Phvsical Plant - Safe Livina Environ/Other

Based on observation, staff interview and resident records reviewed, the facility failed to provide a safe living environment for all residents living at this facility.

The findings included:

1. A tour of the outside of the facility was conducted on at 1:00 p.m. The fences were broken and down in places. The back yard had grass grown to approximately 1 foot tall. There was a pond in the

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back yard. This pond is exposed to the facility residents. Observations throughout the course of the survey for the two days showed residents walk in and out of the building without supervision of the staff.

2. On at 1:00 p.m. observation of the facility exterior revealed the following:

a. Grass at least a foot high.

b. palm fronds on ground and hanging from trees.

c. Dirty, moldy lawn chairs. One chair has a hole in the seat.

d. Large pile of wood.

e. Broken white fence.

f. Broken brown fence that leads to an unsecured pond at rear of property.

g. Rotten door fame on rear exit door.

h. Front door sticks and is difficult to open.

j. A broken wooden bridge on north side of property.

3. On at 9:30 p.m. observation revealed discolored flooring at the facility front entrance remains.

4. On at 12:00 p.m., observation of the recliner in the front television area found the headrest to be worn through. At this time the manager stated the resident prefers sitting in the chair so a blanket is placed over the worn spot.

5. On at 10:00 a.m., the current manager stated residents are free to walk throughout the building and outside of the building. A review of Residents #3 and #16's health assessments showed they are at risk for . Since the grass is approximately one-foot-tall and is next to the pond, residents who would walk through this grass have a risk to .

6. In addition to the concerns identified above, half of the resident on the front hall were flooded from the recent heavy rain. The ceiling in the front reception area, the dining area and the kitchen were leaking water from holes in the ceiling and from ceiling mounted light fixtures. The roof over the front half of the facility is compromised. This was determined by an insurance adjuster and a contractor on

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. These two estimators stated there is major moisture incursion and mold in the front half of the building and will require a complete re-roofing. On and , Health Department inspectors stated residents cannot inhabit the six on the front hallway.

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11911992 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GULF WINDS	2745 VENICE AVENUE EAST VENICE, FL 34292

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 A0092 Reg. # 58A-5.020(1) FAC LSC	Correction Completed	ID Prefix A0093 Reg. # 58A-5.020(2) FAC LSC	Correction Completed	ID Prefix AZ815 Reg. # 408.809, 435.02(2), 435.06 LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) [initials]	DATE 9-20-16	SIGNATURE OF SURVEYOR [signature] for: Ken Smith, HFE II	DATE 9-20-16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/24/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: 6WK713

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[illegible], 2016

Administrator
Gulf Winds
2745 Venice Avenue East
Venice, FL 34292

Dear Administrator:

This letter reports the findings of a second State Licensure Revisit Survey completed on 9, 2016 by representatives of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. All deficiencies 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 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 and Revisit Report

YOSF

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