STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963950	**06/26/2018**
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 relicensure survey was conducted . . . . through . . . . at Beneva Lakes, an assisted living facility (license # 9563) in Sarasota, Florida.

The following is description of the deficiencies.

0009 - Admissions - Admission Package - 58A-5.0181(3) FAC; 400.0078(2)

Based on record review and interview, the facility failed to ensure residents received a copy of the resident contract or facility brochure containing all the required information on admission for 2 (Resident #1 and Resident #10) of 2 resident records reviewed.

The findings included:

Review of Resident #1's contract provided by the facility on revealed a contract the resident had signed in 2015 with the previous owner. There was no contract with Consulate who had assumed ownership in 2016.

Review of Resident #10's contract provided by the facility on had been signed the day prior on . . . . . Resident #10's admission date was listed on the face sheet as . . . . .

On . . . . at 9:49 a.m., the director of nursing said when the facility changed ownership from Lamplight to Consulate in 2016, some of the contracts didn't get switched over.

On at 10:15 a.m., the administrator said he didn't know why contracts weren't changed over. He said this just came to light during the survey and they will look into it.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on record review and interview, the facility failed to have proper documentation for 1 (Resident #3) of 5 residents reviewed for assistance with self-administration and a complete medication observation record (MOR) for 3 (Resident #1, #14 and #17) of 5 residents reviewed for orders.

The findings included:

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1. Review of Resident #3's record on ... at 1:00 p.m., showed a ... inventory count sheet for , IR 15mg. On card #1 of #2 on at 6 a.m., it showed one tablet was signed out. On Card #2 of #2 on ... at 6 a.m., it showed one tablet was signed out.

During an interview on ... at 2:00 p.m., the nursing supervisor said she does not know what happened.

During an interview on at 12:10 p.m., the ALF administrator said that employee is no longer here and she doesn't know what happened.

2. Review of Resident #14's record on ... at 10:00 a.m., showed the resident was admitted on at 12:00 p.m. She has not received , 5mg take one tab by mouth twice daily for 6 doses, ..., ..., ..., ..., ..., ... 20mg take one capsule by mouth every morning ..., ..., ..., . The order for , was transcribed as , 5mg take one tab by mouth twice daily, but written on MOR for 9 a.m., only. ... Solution 15mcg/2ml 1 dose inhale orally two times a day for did not get transcribed to the MOR.

During an interview on at 11:06 a.m., thenursing supervisor had no response for surveyor. Medications were ordered ... and some were delivered ... at 6:52 p.m. Resident #14 has not received , or since move-in on .

Review of resident record showed a note written at 7:30 a.m., stating "complain of not being able to breathe this AM due to not having breathing treatment for 2 days since move-in." There was no documentation in the record to indicate the physician was notified of the delay in the medication.

3. Resident #1's MOR revealed Resident #1 had not received his ordered dose of , 300 mg (a medication for nerve pain) by mouth at bedtime on ..., ..., ... and ... . The back of the MOR was documented , on order on and , not on cart on .

4. Resident #17's MOR revealed a blank space on for , 3 mg tablet, take one tablet by mouth at bedtime for ..., ... and a blank space for ... 100 mg tablet by mouth at bedtime for , . MOR also revealed , 1 mg tablet take 1 tablet by mouth every morning for ..., ..., was documented as not given on ..., ... and ... . The back of the MOR was documented that , 1 mg not available on , and . There was no documentation why the space was blank on ... for the , ... 3 mg or the ... 100 mg tablet on .

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5. On [redacted] at 12:39 p.m., the nursing supervisor said the process for refilling medications is when they are down to 9 or 10 pills, the med techs are instructed to order it. When it goes empty that's when they find out it's an insurance authorization issue or a need for a new prescription from the doctor.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview, the facility failed to obtain a written statement from a health care provider documenting that the newly hired staff does not have any signs or symptoms of communicable [redacted] within 30 days of beginning employment for 3 (Staff D, E and F) of 4 staff reviewed.

The findings included:

Staff D's employee file revealed a hire date of [redacted] as a resident aide/med tech. Staff D's file contained no written statement from a health care provider documenting that Staff D does not have any signs or symptoms of communicable [redacted].

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

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

On [redacted] at 12:30 p.m., the administrator agreed this documentation was missing and would correct this.

Class III

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

Based on record review and interview, the facility failed to ensure required training's are documented in staff personnel files and include the dates of participation and the training program agenda for 3 (Staff D, E, and F) of 3 employee files reviewed.

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The findings included:

Staff D's file contained 12 training certificates all dated . The hours indicated on these training certificates indicated 13 plus hours of training on . The certificates also contained no agenda for the specified trainings.

Staff E's file contained 12 training certificates all dated . The hours indicated on these training certificates indicated 13 plus hours of training on . The certificates also contained no agenda for the specified trainings.

Staff F's file contained 12 training certificates. All the certificates had originally been dated . On 6 of these certificates white out had been placed over the 1 and then re-written as 2. The certificates also contained no agendas for the specified training.

On at 12:06 p.m., The assisted living facility (ALF) administrator admitted she does not do orientation over a hour day, or all in one day. The ALF administrator said it is usually over a 2-3 day period. The ALF administrator admitted the certificates reflect trainings that were all done on one day and there should not be white out on the certificates.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview the facility failed to keep a clean living environment for 1 (Resident #15) of 5 resident's . The resident's of cat .

The findings included:

Observation of Resident #15's showed a cat in the a litter box. Under the bed was a rug with a puddle running off of it.

During an interview on the contracted housekeeping company supervisor said he was told the resident has a . The resident has a cat and it urinates all over the place. The cleaned daily and her linens are changed twice a day. Her cleaned once weekly.

During an interview on at 10:15 a.m., the administrator said the resident is responsible for the cleaning of the litter box.

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During an interview [redacted] at 10:45 a.m., the resident on said she is responsible for cleaning the kitty litter.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview, the facility failed to ensure residents were provided with information including written informed consent that unlicensed staff will be assisting the resident with the self-administration of medications for 2 (Resident #1 and Resident #10) of 2 resident records reviewed.

The findings included:

Review of Resident #1's contract provided by the facility on [redacted] revealed a contract the resident had signed in 2015 with the previous owner. This also included a previous informed consent that unlicensed staff will be assisting the resident with the self-administration of medications signed [redacted]. There was no contract with the current owner, Consulate, who had assumed ownership in 2016 or informed consent that Consulate would be providing assistance with self-administration of medications by unlicensed staff.

Review of Resident #10's file revealed an admission date of [redacted]. The contract provided by the facility on [redacted] had been signed the day prior on [redacted]. From [redacted] there was no documentation that resident's had been informed that Consulate would be providing assistance with self-administration of medications by unlicensed staff.

On [redacted] at 9:49 a.m., the director of nursing said when the facility changed ownership from Lamplight to Consulate in 2016, some of the contracts didn't get switched over.

On [redacted] at 10:15 a.m., the administrator said he didn't know why contracts and associated paperwork weren't changed over. He said this just came to light during the survey and they will look into it.

Class III