STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911216	**02/04/2014**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Bahia Oaks Lodge	**2186 Bahia Vista Street Sarasota, FL 34239**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= A
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D

Specific Tag Findings:
These are the results of an unannounced Biennial survey conducted on _____ at Bahia Oaks Lodge an Assisted Living Facility (ALF).

The following is a description of non-compliance:

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on record review and interviews, the facility failed to assure a health assessment was completed to indicate in Section 2-B, B., the level of assistance needed in the self-administration of medications for 4 (Residents #8, #9, #13 and #15) of 15 sampled residents.

The findings include:

1. Record review on _____ revealed a Resident Health Assessment for Assisted Living Facilities (AHCA form 1823) was completed for Resident #15 on _____ Under Section 2-B, B., in regards to medications, the resident's physician did not indicate if the resident required help with taking her medications. On _____ at 1:57 p.m., the surveyor observed Resident #15 being assisted with her medications by Staff A.

On _____ at 3:10 p.m., during an interview with Staff G, she confirmed the resident is being assisted by staff with her medications. On _____ at 3:10 p.m., the surveyor discussed with the Director of Nursing (DON) that Resident #15's AHCA 1843 form Section 2-B, B., dated _____ had not been completed by the residents physician.

2. Record review on _____ revealed a Resident Health Assessment for Assisted Living Facilities (AHCA form 1823) was completed for Resident #8 on _____ Under Section 2-B, B., in regards to medications, the resident's physician indicated the resident does need help with taking her medications, but did not indicate if the resident needed assistance with self-administration of medications or needed medication administration. On _____ at 1:30 p.m., the surveyor confirmed this finding with the DON.

3. Record review on _____ revealed a Resident Health Assessment for Assisted Living Facilities (AHCA form 1823) was completed for Resident #9 on _____ Under Section 2-B, B., in regards to medications, the resident's physician indicated the resident does need help with taking his medications, but did not indicate if the resident needed assistance with self-administration of medications or needed medication administration. On _____ at 10:50 a.m., the surveyor confirmed this finding with the DON.

4. Record review on _____ documents Resident #13 was admitted to the facility on _____ Review of the

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Resident Health Assessment for Assisted Living Facilities (AHCA form 1823) documents clinical diagnoses which include, but are not limited to, severe and The assessment documents the resident requires continuously and Hospice services.

Further review of this health assessment, page 4, Section "B", failed to document whether the resident needs help with taking his or her medications and failed to document the type of assistance the resident may need (assist vs. administration).

Interview with the Resident Care Director on at 3:30 p.m., confirmed the missing documentation.

Class III

0010-Admissions - Continued Residency 58A-5.0181(4) FAC
Based on record review and interview with administrative staff, the facility failed to ensure there was a significant change health assessment form 1823 obtained for 1 (Resident #1) of 15 residents reviewed.

The findings include:

1. Observation of Resident #1 on at 10:30 a.m., revealed the resident to be in bed. The resident appeared to be very dependent and there were 2 providing care to the resident. Interview with the resident's spouse. The spouse stated the resident was very dependent and needed the staff to provide all activities of daily living. The spouse stated the resident is fed all meals.

2. Interviews with 2 of the staff (staff B and I) who care for this resident was performed on at 10:10 a.m. They both indicated during the interview the resident helps with transfers otherwise they provide total care to the resident. The staff further stated the resident has decline in the past year, but the most change has occurred in the past 3 months.

3. A focus review of Resident #1's record revealed a health exam form 1823, dated as the most current. This form stated the resident was independent in eating and required assistance with all Activities of Daily Living (ADL). When the resident showed decline, no new 1823 health assessment had been obtained.

4. Interview with the Resident Care Director (RCD) at 10:15 a.m. on stated she just started noticing the decline about a month ago. She stated she thinks the resident's decline is mental not physical. She reported she had just had a discussion about this resident with the spouse but no decisions were made at that time. She agreed she should have gotten a new health assessment for this resident.

Class III

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observation, record review and interview, the facility failed to adequately supervise the use of for 1 (Resident #13) of 19 sampled residents.

The findings include:

1. Observation during the initial tour of the facility on at 10:15 a.m., revealed Resident #13 in his

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laying on his couch in the living . . . . His eyes were closed and a nasal cannula was observed in his nose with . . running continuously at 3 liters. The cannula tubing was long and extended into the resident's . . . . . to a concentrator. A water container attached to the concentrator was empty.

2. The resident's wife was observed sitting in a recliner chair next to the couch. In an interview during this observation, she confirmed her husband is on hospice and is to wear . . at all times due to his severe . . . . and debility. When asked who manages her husband's . . . she stated, "Why, the girls on the floor do." She stated the staff on the floor change him over from the concentrator to his portable . . . They then turn the . . on and set the flow rate of . . he is to receive.

3. Record review on documents Resident #13 was admitted to the facility on . . . . . Review of the 1823 Health assessment documents clinical diagnoses which include, but are not limited to, . . , severe . . . , . . and . . The assessment documents the resident requires . . continuously and hospice services.

4. During a second interview with the resident's wife on . . . . at 2:30 p.m., in the presence of the Resident Care Director (RCD), Resident #13's wife confirmed she knew how to help her husband with his . . as staff had spoken to her about being responsible for it and she should be "better about it." She stated she didn't know the staff weren't supposed to help him with his . as she had been letting them do it. She stated, "In fact, I thought there was something wrong because just last week when my husband needed to go to the hairdresser's for a haircut and his nails trimmed, the floor girl did not know how to maneuver the . . so I had to."

5. Observation during this second interview revealed the water container on the concentrator remained empty as it was earlier in the morning during the initial tour and the resident's wife had not refilled it. Staff were unaware the resident's wife was not consistently managing her husband's . The RCD stated they would have to come up with a plan as to how to supervise and remind his wife to assist with the management of her husband's . .

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on resident interview, review of the grievance log and food chat forms, and resident council meetings, the facility failed to respond to resident complaints about food.

The findings include:

1. During the initial 2 hours in the facility, 5 sampled residents complained to the surveyors about the food quality. They reported it had no seasonings, and all they ever got to eat was chicken and fish. Review of the menu revealed both items were on the menu at least 2 times per week. The resident all reported they had complained about the food repeatedly to staff with no changes being made.

2. Review of the grievance log revealed there was no documentation of any grievances of any kind noted. The facility does have a grievance/complaint policy.

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3. Review of the resident council meeting minutes which were held monthly from through revealed there was no mention of any food complaints from any of the residents present.
An interview with the staff member who keeps the minutes was performed on at 2:15 p.m. In the interview, the staff stated sometimes the residents complained about the food in , but most of the time it was about the service, and not having enough staff to respond to them. She stated there were menu chats with the dietary supervisor about specific foods. She agreed she did not put any food complaints into the minutes.

4. A review of the weekly resident menu chat meeting minutes which were held weekly was performed. In the documentation is shown who was present (average 4 residents per meal). What follow was each residents comments about the food, and then there was a column for checks which stated "New/old, priority, and complete." On the minutes were such statements as "Don't like roasted potatoes make potatoes with parsley, polenta with cheese, more grits and pizza." It could not be determined if any of the changes suggested by the resident had been implemented and if the residents were satisfied with any changes made.

5. The Administrator stated she was unaware of any food issues during an interview on at 12:00 p.m.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observations, record review and interview, the facility failed to appropriately assist 4 (Residents #8, #15, #18 and #19) of 6 residents observed during self-administration of medications as specified in Section 429.256 (3) F.S. Staff failed to take the medications to the residents and in the presence of the resident, open the medications and identify the medications during assistance with self-administration of medications.

The findings include:

1. Observation on at 11:33 p.m. revealed Staff "A" assisting Resident #8 with self-administration of medication. The surveyor observed Staff "A" remove a tablet of 5 mg from a container and placed the tablet in a soufflé cup with a spoon while standing in the hallway at the medication cart. Staff "A" then proceeded to the resident's I said to the resident, "I have your medicine." The resident asked if it was her 11:30 a.m. pill and said Staff "A" stated "Yes." The resident took the cup from Staff "A."

Observation on at 12:34 p.m. revealed Staff "A" assisting Resident #8 with self-administration of medication. The surveyor observed Staff "A" remove a tablet of 50 mg. from a container and placed the tablet in a soufflé cup with a spoon while standing in the hallway at the medication cart. Staff "A" proceeded to the resident's I gave the cup to the resident.

2. Observation on at 1:57 p.m. revealed Staff "A" assisting Resident #15 with self-administration of medications. The surveyor observed Staff "A" remove a tablet of 50 mg. from a container and placed the tablet in a soufflé cup. Staff "A" then removed a tablet of 300 mg. from a container and place the pill in the cup while standing in the hallway at the medication cart. Staff "A" proceeded to tell Resident #15, who was coming down the hallway in her wheelchair, "I have your afternoon pills." Staff "A" poured the pills into the resident's hand and the resident took them with water.

During an interview with Resident #15 on at 2:06 p.m., when asked if she knew what medications she had just received, the resident stated, "I don't know isn't that awful." "I ask sometimes if I don't know, I should ask more often."

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3. During an interview with Staff "A" on at 10:20 a.m., she confirmed she had not identified the medications to the 2 residents that were observed receiving assistance with self-administration of their medications.

4. Observation during medication assistance on at 9:00 a.m., for Resident #18 revealed Staff B removing bottles of medications out of the medication cart and place them on top of her cart. She then compared the medications against the Medication Observation Record (MOR). She placed the bottles inside a plastic bin and carried them into the resident's The resident was observed lying in bed. She walked past the bed and over to a dining table near a window. She poured the individual medications inside a pill cup after identifying each pill to the surveyor and then walked them over to the resident who was in bed and handed the resident his medications so he could take them. Staff B failed to bring the medications to the resident, failed to open the medications in front of the resident and failed to identify which medications the resident would be taking.

After taking his medications, the surveyor asked the resident if he knew what medications he was taking and he stated, "Well no, but I know I'm in good hands."

Review of the 1823 Health Assessment for Resident #18 documents he requires assistance with self-administration of medications.

5. Observation during assistance with medications for Resident #19 on at 9:32 a.m., revealed Staff B removing medications out of the cart and comparing the medications against the MOR. After doing so, she placed a pill cup inside a plastic cup, gathered her medications and MOR and entered the resident's The resident was assisted to a seated position at his kitchen table. She walked over to the resident's futon approximately 10 feet behind the resident. She stated the name of each medication to the surveyor, placed each of them into a pill cup, walked back over to the resident and placed them on top of his placemat. She stood by the resident as he picked up each medication and self-administered. After he was finished, she exited the and signed off on the MOR. Staff B failed to bring the medications to the resident, failed to open the medications in front of the resident and failed to identify which medications the resident would be taking.

Review of the 1823 Health Assessment for Resident #19 confirmed he requires assistance with self-administration of medications.

6. A review of the facility's policy for assistance with self-administered medications by unlicensed personnel revealed: "Trained unlicensed staff can help a person to self-administer his/her medications by performing such tasks as bringing the resident's medication to the resident; reading a prescription label and removing a prescribed amount of medication from the container."

7. During an interview with the Resident Care Director on at 3:40 p.m., she stated Staff B confirmed she didn't take the medications to the resident, open them in front of the resident and failed to identify the medications he would be taking.

Class III

0054-Medication - Records 58A-5.0185(5) FAC
Based on observation, record review and interview, the facility failed to maintain an accurate and up to date Medication Observation Record (MOR) for 1 (Resident #16) of 6 residents reviewed during assistance with

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self-administration of medications based on a lack of physician order for a second dosage.

The findings include:

1. Observation during assistance with self-administration of medications for Resident #16 on at 8:26 a.m. included 20 mg. The label on this medication documented the following: 20 mg. take 1 tablet by mouth daily, take an additional tablet by mouth if weight increased 2-4 in the evening as needed."

Review of the 2014 MOR documents 2 separate entries which includes the following: 20 mg. take 1 tablet by mouth daily (8a)" and "Weigh resident daily at 5:00 p.m. & give if weight increased by 2-4 (5p)."

Record review on failed to show a physician order the resident should be weighed daily at 5:00 p.m. and should be given at 5:00 p.m. if the resident's weight increased by 2-4 lbs. A call to the pharmacy did not locate an e-order either.

Interview with the Resident Care Director (RCD) on at 4:00 p.m., confirmed there was no physician's order to support a routine dose of to be given to the resident at 5:00 p.m., based on a weight increase.

2. Further review of the MOR for Resident #16 included the following: Cream 10,000 apply sparingly to corners of the mouth 4 times daily until tube is completed" and was signed off by Staff "H" at 8:00 a.m. indicating the resident received this medication; however, this was not observed during the time Staff "H" assisted the resident with his medications.

Staff "H" was interviewed on at 9:58 a.m. and confirmed she did not give Resident #16 the medication at 8:00 a.m. despite signing off that it had been given. She stated the resident refused to take the until after he gets out of exercise which is 11:00 a.m.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on record reviews, observations and interviews, the facility failed to provide Pharmacy services to meet the needs of each resident by not clarifying medication orders for Resident #18, placing an alert sticker for a dosage change for Resident #8 and assuring a resident's medications were available from the pharmacy for Resident #9 of 6 residents sampled for medications.

The findings include:

1. During an interview with Resident #9 on at 10:10 a.m., he stated "Yes", he had run out of medication before and has happened about four times. Resident #9 stated he takes the medication Requip before he goes to bed for his restless leg and a few times has had to go without it. Resident #9 stated this happened as recently as last month.

Resident #9's medication record for the month of 2014 revealed on the resident had not received his Requip 0.5 mg at bedtime as the medication was "on order." The medication record also indicated

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the resident had not received the evening dose of Pradaxa 150 mg., as the medication was "on order."

Resident #9's medication record for 2013 revealed on and the resident had not received his Requip .5 mg., at bedtime and reason noted on was the medication was not in the cart and "on order." The medication also indicated the resident had not received 0.125 mg., in the evening from through , a total of 10 missed doses. The reason was documented as being "on order."

Resident #9's medication record for 2013 revealed the resident had not received 0.125 mg., in the evening from through , a total of 7 missed doses. The reason was documented as being "on order."

During an interview with Resident #9 on at 10:30 a.m., he confirmed he does not order his own medications and did not recall being informed of any other medications not being available, just the Requip. The resident stated the nurse is in here "all the time" to take his and check his rate.

During an interview with the Resident Care Director on at 10:50 a.m., she reviewed the resident's medication records and confirmed the resident received his medications from the facility's pharmacy. The surveyor discussed the missing doses of Requip, Pradaxa, and . The Resident Care Director (RCD) stated she did not know the resident had gone 17 days without his and would have expected to be notified by staff right away when the medications did not come in. She stated she herself or the other nurse does check the resident's pulse and daily and she had not noted any issues.

2. Observation on at 12:34 p.m., revealed Staff "A" assisting Resident #8 with self-administration of medications. The surveyor observed Staff "A" remove a tablet from a bottle labeled 50 mg. take one tablet every 6 hours as needed (for pain). Staff "A" stated the resident takes one 4 times a day and will ask for them for her lower back pain. Staff "A" stated the resident had one earlier at 7:00 a.m. The resident's medication record for 2014 indicated the 50 mg was to be given every 4 hours as needed for pain. During reconciliation of medications, a physician's order dated documented the frequency of the had been changed from every 6 hours to every 4 hours as needed.

During an interview with Staff "A" on at 10:20 a.m., she confirmed she was aware the order had been changed and should have put an alert label on the bottle. The surveyor discussed this finding with the Resident Care Director on at 2:00 p.m., and she confirmed the facility procedure would have been to place an alert sticker on the bottle.

3. Observation on at 9:00 a.m. revealed Staff "B" assisting Resident #18 with self-administration of medications. Included in the medications she handed the resident was 20 mg., one half tablet.

During reconciliation of medications, a fax to the physician dated documented the following: "Residents daughter states he has been upset and tearful. Could we restart Daughter has asked. Thank you." The physician responded on and documented, "Yes, you can restart at previous dose."

Review of the "Previous dose" ordered by this physician was dated and documented the following: "Decrease to 10 mg. every other day for 7 days then discontinue..."

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Review of the "Patient Discharge Medication Instructions (Medication Reconciliation)" dated includes 10 mg. oral table-tab(s) oral once a day," however, this is signed by a Registered Nurse (RN) and not a physician.

The facility failed to clarify the physician's orders for . They failed to call the physician and clarify whether he/she wanted the resident to receive the "Every other day" or 10 mg. daily as they were providing the resident.

During an interview with the Resident Care Director on at 2:30 p.m., she confirmed the documentation was confusing and staff should have called the physician and clarified the orders for the .

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC
Based on a review of 3 personal files and interview with administrative staff, the facility failed to ensure the required training was performed for 3 (Staff A, B and C) of the 6 staff reviewed

The findings include:

1. Review of personal files revealed Staff A was hired on , Staff B was hired on , and Staff C was hired on . In none of the files reviewed was there evidence the employee received Activities of Daily Living (ADL) and behavioral needs training.

2. Employee A did not have evidence of emergency preparedness & evacuation training present in the record.

3. Employees A and C did not have evidence of incident report training present in the record.

4. Employee B did not have evidence of any resident rights training having been provided.

5. Interview with the Administrator on at 12:00 p.m., indicated agreement the facility does not have documentation of this training being provided to the employees.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Bahia Oaks Lodge
2186 Bahia Vista Street
Sarasota, FL 34239

Dear Administrator:

This letter reports the findings of a Biennial survey that was conducted on , 2014 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. Staff from this office will conduct a review after , 2014 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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,

Harold D. Williams
Field Office Manager

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Enclosure: State Form

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