

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965486	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/11/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

OAKRIDGE ASSISTED LIVING FACILITY

**297 SW COUNTY ROAD 300
MAYO, FL 32066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A biennial re-licensure with Emergency Power Plan (EPP) monitoring survey was conducted at Oakridge Assisted Living Facility on _____ through _____. Deficient practice was identified at the time of the survey.	A 000		
A 008	429.26() FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (4) If possible, each resident shall have been examined by a licensed physician, a licensed physician assistant, or a licensed nurse practitioner within 60 days before admission to the facility. The signed and completed medical examination report shall be submitted to the owner or administrator of the facility who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission and continued stay in the facility. The medical examination report shall become a permanent part of the record of the resident at the facility and shall be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (5) Except as provided in s. 429.07, if a medical examination has not been completed within 60 days before the admission of the resident to the facility, a licensed physician, licensed physician assistant, or licensed nurse practitioner shall examine the resident and complete a medical examination form provided by the agency within 30 days following the admission to the facility to enable the facility owner or administrator to determine the appropriateness of the admission.	A 008		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965486	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/11/2020
NAME OF PROVIDER OR SUPPLIER OAKRIDGE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 297 SW COUNTY ROAD 300 MAYO, FL 32066		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 008	Continued From page 1 The medical examination form shall become a permanent part of the record of the resident at the facility and shall be made available to the agency during inspection by the agency or upon request. (6) Any resident accepted in a facility and placed by the department or the Department of Children and Families shall have been examined by medical personnel within 30 days before placement in the facility. The examination shall include an assessment of the appropriateness of placement in a facility. The findings of this examination shall be recorded on the examination form provided by the agency. The completed form shall accompany the resident and shall be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident providing it was completed within 90 days prior to admission to the facility. The applicable department shall provide to the facility administrator any information about the resident that would help the administrator meet his or her responsibilities under subsection (1). Further, department personnel shall explain to the facility operator any special needs of the resident and advise the	A 008			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965486	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/11/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

OAKRIDGE ASSISTED LIVING FACILITY

**297 SW COUNTY ROAD 300
MAYO, FL 32066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 008	Continued From page 2 operator whom to call should problems arise. The applicable department shall advise and assist the facility administrator where the special needs of residents who are recipients of , require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care provider as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days before the individual's admission to a facility pursuant to section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or , services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of , or any other communicable , which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care provider, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and	A 008		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965486	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/11/2020
NAME OF PROVIDER OR SUPPLIER OAKRIDGE ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 297 SW COUNTY ROAD 300 MAYO, FL 32066		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 008	Continued From page 3 license number of the examining health care provider. The medical examination may be conducted by a health care provider licensed under chapter 458, 459 or 464, F.S. (b) A medical examination completed after the resident's admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, _____, which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09170. Faxed or electronic copies of the completed form are acceptable. The form must be completed as instructed. 1. Items on the form that have been omitted by the health care provider during the examination may be obtained by the facility either orally or in writing from the health care provider. 2. Omitted information must be documented in the resident's record. Information received orally must include the name of the health care provider, the name of the facility staff recording the information, and the date the information was provided. 3. Electronic documentation may be used in place of completing the section on AHCA Form 1823 referencing Services Offered or Arranged by the Facility for the Resident. The electronic documentation must include all of the elements described in this section of AHCA Form 1823. (c) Any information required by paragraph (a), that is not contained in the medical examination report conducted before the individual's admission to the facility must be obtained by the administrator using AHCA Form 1823 within 30 days after admission. (d) Medical examinations of residents placed by the department, by the Department of Children	A 008		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965486	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/11/2020
NAME OF PROVIDER OR SUPPLIER OAKRIDGE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 297 SW COUNTY ROAD 300 MAYO, FL 32066		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 008	Continued From page 4 and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of section 429.26, F.S. and this rule. (f) Any orders issued by the health care provider conducting the medical examination for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility may be attached to the health assessment. A health care provider may attach a DH Form 1896, Florida _____ Form, for residents who do not wish _____ to be administered in the case of _____ or _____. (g) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain complete and accurate Resident Health Assessment Form (Agency for Health Care Administration Form 1823) for 1 of 3	A 008			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965486	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/11/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

OAKRIDGE ASSISTED LIVING FACILITY

**297 SW COUNTY ROAD 300
MAYO, FL 32066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 008	Continued From page 5 residents reviewed (Resident #6). Findings: A record review for Resident #6 revealed admission date of . The resident's health assessment revealed no answer provided to the question "In your professional opinion, can this individual's needs be met in an assisted living facility, which is not a medical, nursing, or facility (Yes or No)?" in Section 1.D. on Page 2. On at 11:10 AM, during an interview, the Administrator confirmed that Resident #6's health assessment had mission information. Class III	A 008		
A 052	429.256(); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, including an syringe that is prefilled with the proper dosage by a pharmacist and an that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident. (b) In the presence of the resident, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her .	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965486	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/11/2020
NAME OF PROVIDER OR SUPPLIER OAKRIDGE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 297 SW COUNTY ROAD 300 MAYO, FL 32066		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 052	Continued From page 6 (d) Applying _____ medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a _____, including removing the cap of a _____, opening the unit dose of _____ solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the _____. (h) Using a _____ to perform _____ level checks. (i) Assisting with putting on and taking off _____ stockings. (j) Assisting with applying and removing an _____ but not with titrating the prescribed _____ settings. (k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device. (l) Assisting with measuring vital signs. (m) Assisting with _____ bags. (4) Assistance with self-administration does not include: (a) Mixing, _____, converting, or _____ medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a _____ of the body. (d) Administration of _____ preparations. (e) Irrigations or debriding agents used in the treatment of a skin condition.	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965486	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/11/2020
NAME OF PROVIDER OR SUPPLIER OAKRIDGE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 297 SW COUNTY ROAD 300 MAYO, FL 32066		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 052	Continued From page 7 (f) _____, or _____ preparations. (g) Medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be _____ or older, trained to assist with self-administered medication pursuant to the training requirements of rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in section 429.256, F.S. and this rule. (b) In addition to the specifications of section 429.256(3), F.S., assistance with self-administration of medication includes, in the presence of the resident, reading the medication label aloud and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965486	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/11/2020
NAME OF PROVIDER OR SUPPLIER OAKRIDGE ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 297 SW COUNTY ROAD 300 MAYO, FL 32066			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 052	Continued From page 8 make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in section 429.256(4), F.S. 1. As used in section 429.256(4)(g), F.S., the term "competent resident" means that the resident is cognizant of when a medication is required and understands the purpose for taking	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965486	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/11/2020
NAME OF PROVIDER OR SUPPLIER OAKRIDGE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 297 SW COUNTY ROAD 300 MAYO, FL 32066		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 052	Continued From page 9 the medication. 2. As used in section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (g) All trained staff must adhere to the facility's _____ control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure trained staff (Staff A, Medication Technician) adhered to the facility's _____ control policy and procedures when assisting with the self-administration of medication for 4 of 4 reviewed residents (Residents #2, #3, #5, and #11). Findings: On _____ from 11:32 AM to 1:28 PM, Staff A, Medication Technician, was observed providing assistance to Resident #5 with self-administration of _____ Tablet, Resident #2 with self-administration of _____ Tablet, Resident #3 with self-administration of _____ Tablet, and Resident #11 with self-administration of _____ and _____ Tablets. Staff A was observed not wearing gloves and not washing her _____ before or after providing assistance with self-administration of medication to Residents #5, #2, #3 and #11. On _____ at 1:36 PM, during an interview, Staff A stated she forgot to sanitize her _____ when assisting with self-administration of medication.	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965486	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/11/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

OAKRIDGE ASSISTED LIVING FACILITY

**297 SW COUNTY ROAD 300
MAYO, FL 32066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 052	Continued From page 10 On ... at 10:21 AM, during an interview, the Administrator confirmed medication technicians were expected to wear gloves or wash their ... before providing assistance with self-administration of medication. A review of the facility's ... control policy reviewed on ... revealed, "Universal Precautions a. All staff will utilize universal precautions in any interactions involving care of resident. This will include washing ... before and after resident contact." Class III	A 052		