

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910842	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/12/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

OAKS OF CLEARWATER, THE

**420 BAY AVENUE
CLEARWATER, FL 33756**

(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 Complaint Investigation (Complaint Number: 2019019424) and a Revisit to 12/12/2019 Biennial Survey were conducted at Oaks of Clearwater on 02/12/2020. Deficiencies were identified at the time of survey.	A 000		
A 052 SS=D	429.256(3-5); 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 _____. (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.	A 052		

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: AL11910842	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/12/2020
NAME OF PROVIDER OR SUPPLIER OAKS OF CLEARWATER, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 420 BAY AVENUE CLEARWATER, FL 33756		
(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 1 (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. (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.	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910842	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/12/2020
NAME OF PROVIDER OR SUPPLIER OAKS OF CLEARWATER, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 420 BAY AVENUE CLEARWATER, FL 33756		
(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 2 (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 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	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910842	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/12/2020
NAME OF PROVIDER OR SUPPLIER OAKS OF CLEARWATER, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 420 BAY AVENUE CLEARWATER, FL 33756			
(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 3 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 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, record review, and interview, the Facility failed to ensure proper	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910842	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/12/2020
NAME OF PROVIDER OR SUPPLIER OAKS OF CLEARWATER, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 420 BAY AVENUE CLEARWATER, FL 33756		
(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 4 assistance with self-administration of medications according to the required steps in 429.256 Florida Statutes and failed to follow _____ control standards while assisting with medications for four Residents (#4, #5, #15, and #16) of five sampled residents that required assistance with self-administration of medication. Findings Included: An observation of the medication pass at 11:14am on _____, Staff D was observed popping pills out of medication packs into two small medication cups, while at the medication cart, for both residents. Neither resident was present at the medication cart and both residents were in their own room with the door closed. Staff D place each resident's medication packs into the medication cart and carried the two small medication cups with pills into the room. Resident #15's medications included _____ 5-325milligram (mg). Resident #16's medications included _____ 600mg, _____ 5mg, _____ 10-325mg, and _____ 1mg. Upon entering the room, Staff D handed Resident #15 one medication cup and stated, "here is your _____ pill". Staff handed Resident #16 the other medication cup and stated, "here are your pills including your _____ med". Staff D did not read the medication labels out loud to the residents and Staff D prepped and dispensed two residents' medications _____, which could ultimately lead to a medication error. An observation of the medication pass at 11:35am on _____, Staff B assisted Resident #4 with the prescribed medication _____ 500mg. Staff B brought the medication	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910842	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/12/2020
NAME OF PROVIDER OR SUPPLIER OAKS OF CLEARWATER, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 420 BAY AVENUE CLEARWATER, FL 33756		
(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 5 pack into the resident's room and popped the pill out on the visibly dirty wheeled walker seat. Resident #4 picked the pill up off the walker and placed it in her . Staff B did not have a medication cup to pop the pill into. Continued observation at 11:39am, Staff B assisted Resident #5 with the prescribed medication 50mg. Staff B poured two tablets into the pill bottle's lid and handed the lid to the resident. Resident #5 grabbed the lid with his left . and his thumb was touching the inside of the lid and his palm was touching the outside of the lid. Resident #5 handed the lid . to Staff B. Staff B placed the lid on the pill bottle and returned the bottle . to the central storage medication cart. A review of the Facility's required Pharmacy Consultant visit report dated conducted on, revealed that the Facility continued with ongoing medication issues. During an interview with the Administrator and Manager, conducted on at 04:20pm, both agreed that unlicensed Medication Technicians were supposed to pop pills out of medication packs in front of residents and read the medication out loud to the residents. The Administrator stated that residents have their own containers to pop medication into and "no, we do not have medication cups". The Administrator and Manager agreed that it was a risk of to place pills on a visibly dirty surface. The Administrator stated that, "they (Medication Technicians) are absolutely not to do that". Both agreed that resident should not be handling medication packs and pill bottles. Class III	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910842	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/12/2020
NAME OF PROVIDER OR SUPPLIER OAKS OF CLEARWATER, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 420 BAY AVENUE CLEARWATER, FL 33756		
(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 056	Continued From page 6	A 056		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with chapters 465 and 499, F.S., and rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for, . . . not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910842	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/12/2020
NAME OF PROVIDER OR SUPPLIER OAKS OF CLEARWATER, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 420 BAY AVENUE CLEARWATER, FL 33756		
(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 056	Continued From page 7 be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to section 465.0276(5), F.S., and rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and,	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910842	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/12/2020
NAME OF PROVIDER OR SUPPLIER OAKS OF CLEARWATER, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 420 BAY AVENUE CLEARWATER, FL 33756		
(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 056	Continued From page 8 6. Expiration date. (h) Pursuant to section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to provide prescribed medications (meds) as ordered from resident's health care providers and failed to notify their health care providers when the resident did not receive their medications as ordered for five Residents (#3, #4, #5, #15, and #16) of five sampled resident that required assistance with self-administration of meds. Findings Included: A review of the Medication Time Frames printout for the medication pass, conducted on _____, revealed that Resident #3, #4, #5, #15, and #16 all had the same timeframes for their scheduled medications, which included: - AM = 08:00am through 10:00am - MID = 12:00pm through 02:00pm - PM = 04:00pm through 06:00pm - HS = 08:00pm through 10:00pm The Medication Time Frames printout did not include details of medications that required medication to be given every four hours. During an observation of the medication pass with Staff B for Resident #3, conducted on _____ at 11:30am, Staff B assisted Resident #3 with prescribed medication and gave the	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910842	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/12/2020
NAME OF PROVIDER OR SUPPLIER OAKS OF CLEARWATER, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 420 BAY AVENUE CLEARWATER, FL 33756		
(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 056	Continued From page 9 medication to the resident too early, which included 25mg. A review of Medication Observation Records (MORs) for Resident #3, conducted on , revealed that the resident's prescribed medications 81mg was scheduled at "AM"; 10mg was scheduled at "HS"; 25mg was scheduled at "AM, MID, and PM"; and, 40mg was scheduled at "AM and PM". There were no designated times to give the medications noted on the MORs. A documentation computer timestamp revealed that the was documented as given on at 07:50am and 11:35am and the was given on at 07:00am and 03:38pm and on the was given at 03:12pm. A review of MORs for Resident #4, conducted on , revealed that the resident's prescribed medications 100mg was scheduled at "AM" and 15mg was scheduled at "HS". There were no designated times to give the medications noted on the MORs. A documentation computer timestamp revealed that the and were given at 07:24am. During an observation of the medication pass with Staff B for Resident #5, conducted on at 11:39am, Staff B assisted Resident #5 with the prescribed medication and gave the medication to the resident too early, which included 50mg. A review of MORs for Resident #5, conducted on , revealed that the resident's prescribed medications 50mg was	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910842	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/12/2020
NAME OF PROVIDER OR SUPPLIER OAKS OF CLEARWATER, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 420 BAY AVENUE CLEARWATER, FL 33756		
(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 056	Continued From page 10 scheduled at "AM, MID, and HS" and 135mg was scheduled at "AM and PM". There were no designated times to give the medications noted on the MORs. A documentation computer timestamp revealed that the _____ was given on _____ at 11:45am and the _____ was given on _____ at 07:36pm. A review of MORs for Resident #15, conducted on _____, revealed that the resident's prescribed medications _____ 5-325mg take one tablet by _____ every four hours was scheduled at 02:00am, 06:00am, 10:00am, 02:00pm, 06:00pm, and 10:00pm. On _____ it was given at 03:11am, 05:32am, 11:29am, and 01:42pm. From 03:11am to 05:32am was only two hours and twenty-one minutes and not four hours as ordered. From 05:32am to 11:29am was greater than six hours and not four hours as ordered. From 11:29am to 01:42pm was only two hours and thirteen minutes and not four hours as ordered. A review of MORs for Resident #16, conducted on _____, revealed that the resident's prescribed medications _____ 10mg and _____ were scheduled at "AM, MID, and HS". There were no designated times to give the medications noted on the MORs. A documentation computer timestamp revealed that the _____ and _____ were given on _____ at 07:40am and at 11:30am. A review of the Facility's required Pharmacy Consultant visit report dated _____, conducted on _____/202, revealed that the Facility continued with ongoing medication issues.	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910842	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/12/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

OAKS OF CLEARWATER, THE

**420 BAY AVENUE
CLEARWATER, FL 33756**

(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 056	Continued From page 11 Record reviews for Residents #3, #4, #5, #15, and #16, conducted on _____, revealed that there was no evidence found that each resident's health care provider was notified that they were not receiving their prescribed medications as ordered. During an interview with the Administrator and Manager, conducted on _____ at 04:20pm, both reviewed the times that Resident #3, #4, #5, #15, and #16 received their medications and both agreed that medications were not given within the required timeframes of the Facility's policy and procedures or standards of medication practice. Class III	A 056		