

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964649	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/22/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER OAKBRIDGE TERRACE AT AZALEA TRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 10100 HILLVIEW ROAD PENSACOLA, FL 32514
--	---

(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 On -22, 2020 an unannounced biennial re-licensure and Limited Nursing Services survey was conducted at Oakbridge Terrace at Azalea Trace in Pensacola, FL. Deficiencies were identified at the time of survey.	A 000		
AN277 SS=D	59A-36.022(2) FAC LNS - Resident Care Standards (2) RESIDENT CARE STANDARDS. (a) A resident receiving limited nursing services in a facility holding only a standard and limited nursing services license must meet the admission and continued residency criteria specified in rule 59A-36.006, F.A.C. (b) In accordance with rule 59A-36.010, F.A.C., the facility must employ sufficient and qualified staff to meet the needs of residents requiring limited nursing services based on the number of such residents and the type of nursing service to be provided. (c) Limited nursing services may only be provided as authorized by a health care provider's order, a copy of which must be maintained in the resident's file. (d) Facilities licensed to provide limited nursing services must employ or contract with a nurse(s) who must be available to provide such services as needed by residents. The facility's employed or _____ nurse must coordinate with third party nursing services providers to ensure resident care is provided in a safe and consistent manner. The facility must maintain documentation of the qualifications of nurses providing limited nursing services in the facility's personnel files. (e) The facility must ensure that nursing services are conducted and supervised in accordance with chapter 464, F.S., and the prevailing standard of	AN277		

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: AL11964649	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/22/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

OAKBRIDGE TERRACE AT AZALEA TRACE

**10100 HILLVIEW ROAD
PENSACOLA, FL 32514**

(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
AN277	Continued From page 1 practice in the nursing community. This Statute or Rule is not met as evidenced by: Based on staff interview, clinical record review, and policy review the facility failed to ensure that monthly nursing assessments for Limited Nursing Services (LNS) were conducted and supervised by a Registered Nurse (RN) for 3 of 3 records reviewed (#2, #7, and #9) The findings include: On _____ a record review was conducted for resident #2, which revealed that the monthly assessments for _____ and _____ were performed by practical nursing staff and not registered nursing staff. On _____ a record review was conducted for resident #7, which revealed that the monthly assessments for _____ _____ were performed by practical nursing staff and not registered nursing staff. On _____ a record review was conducted for resident #9, which revealed that the monthly assessments for _____ and _____ _____ were performed by practical nursing staff and not registered nursing staff. On _____ at approximately 2:15 PM, an interview was conducted with the Administrator who stated that his staff nurse, Employee D, manages the LNS program and kept the book up to date. On _____ at approximately 8:50 AM, a	AN277		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964649	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/22/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

OAKBRIDGE TERRACE AT AZALEA TRACE

**10100 HILLVIEW ROAD
PENSACOLA, FL 32514**

(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
AN277	Continued From page 2 follow up interview was conducted with the Administrator who confirmed that Employee D was designated to manage the LNS program. He further stated that he was not aware the the LNS program required oversight by a RN. He also validated that all the signatures on the LNS resident monthly assessments were performed by licensed practical nurses and not a RN. A review of the facilities Policy and Procedure titled: "Limited Nursing Services L-O2AL" with an issue date of stated for item #6 on page 2 "LNS are conducted and supervised per nursing licensure and prevailing standard of practice in the nursing community". Class III	AN277		