Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932515	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	7220 BAILLIE DRIVE NEW PORT RICHEY, FL 34653

(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 120 SS=D	429.17(3) .275(1); 59A-36.013(1) FAC Fiscal - Financial Stability 429.17 (3) In addition to the requirements of part II of chapter 408, each facility must report to the agency any adverse court action concerning the facility's financial viability, within 7 days after its occurrence. The agency shall have access to books, records, and any other financial documents maintained by the facility to the extent necessary to determine the facility's financial stability. 429.275 (1) The administrator or owner of a facility shall maintain accurate business records that identify, summarize, and classify funds received and expenses disbursed and shall use written accounting procedures and a recognized accounting system. 59A-36.013 Fiscal Standards. (1) FINANCIAL STABILITY. The facility must be administered on a sound financial basis in order to ensure adequate resources to meet resident needs pursuant to the requirements of chapter 408, part II, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to operate on a sound financial basis as evidenced by the failure to pay monthly bills timely. The facility was found to have outstanding balances with several vendors. Findings include: A record review of the electric bill invoice was	A 120		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932515	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	7220 BAILLIE DRIVE NEW PORT RICHEY, FL 34653

(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 120	Continued From page 1	A 120		

conducted on . The invoice was for service from through with the amount due on is $31,488.50. At the top left of the invoice next to the line "billing summary" stated "Disconnect Notice". The following statement was also on the invoice stating "Important Disconnection Information. Your account has a past due amount of $25,970.03 and electric service may be disconnected. Please pay immediately" (photographic evidence obtained).

A record review of the water and sewer bill was conducted on . The bill is for service from through and has a due date on of $61,279.55. The bill also states under the total balance due line "Past due balance is delinquent and subject to further fees and immediate disconnect" (photographic evidence obtained).

A record review of the food vendor bill was conducted on . The bill was provided by the Business Office Manager (BOM) from an internal spreadsheet that was printed on . The spreadsheet had service dates of through and total amount owed to food vendor is $24,686.85 (photographic evidence obtained).

An interview was conducted with the BOM on at 11:47am. During the interview the BOM stated $5,195.13 was paid to the electric company on and $4,488.30 was paid to the electric company on . She stated $3,426.35 was paid to the water and sewer company on and $3,546.02 was paid on . Lastly, she stated $6,169.59 was paid on to the food vendor. The BOM stated all three of the bills discussed had

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932515	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	7220 BAILLIE DRIVE NEW PORT RICHEY, FL 34653

(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 120	Continued From page 2 remaining balances and were subjected to disconnection. The BOM further stated that she does not have control of making any payments to any vendor or person and that their Corporate Finance Department does all the payments. Class III	A 120		
A 160 SS=D	59A-36.015(1) FAC Records - Facility The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932515	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	7220 BAILLIE DRIVE NEW PORT RICHEY, FL 34653

(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 160	Continued From page 3 intending to return pursuant to rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . . . . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related . . . . . , a copy of all such facility advertisements as required by section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in rule 59A-36.007, F.A.C. (j) All food service records required in rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to section 429.41, F.S., and rule chapter 69A-40,	A 160		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932515	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	7220 BAILLIE DRIVE NEW PORT RICHEY, FL 34653

(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 160	Continued From page 4 F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to section 381.031, F.S., and chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have records readily available for review by the State Agency. Additionally, the facility failed to keep an up-to-date admission and discharge log. Finding Included: Attempted record review was conducted on [redacted] and [redacted] revealed the following: [redacted], and Medication Observation Records (MORs) for Residents #1, #2, and #3 were requested and not provided.	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932515	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	7220 BAILLIE DRIVE NEW PORT RICHEY, FL 34653

(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 160	Continued From page 5 * ..... and ..... MORs for Residents ##9, #16, #17, and #22 were requested and not provided. * MORs for Residents #18, #19, and #20 were requested and not provided. A review of the admission and discharge log, conducted on .. .. and ..... , revealed there were 142 residents admitted into the facility. The facility's capacity was 135. Resident #2 continued to be listed as an in-house resident with no discharge data noted. Residents #4 and #6 had no place noted where they were admitted from. A review of Resident #2's record, conducted on , revealed that Resident #2 was admitted on ..... and expired on . During an interview with the Health and Wellness Director, conducted on at 02:30pm, the Health and Wellness Director stated that she was trying to print the missing MORs. During an interview with the Administrator, conducted on at 04:21pm, the Administrator agreed that Facility records were not readily available for review by the State Agency and that the admission and discharge log was not up to date. Class III	A 160		
A 000	Initial Comments A complaint investigation (complaint numbers: 2021003171, 2021003443, 2021005263, 2021005792, and 2021005793), a COVID-19	A 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932515	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	7220 BAILLIE DRIVE NEW PORT RICHEY, FL 34653

(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	Continued From page 6 focused [illegible] control visit, and a generator monitoring were conducted at Oakview Terrace on [illegible] and [illegible]. Deficiencies were identified at the time of survey.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of [illegible] or [illegible] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [illegible] or [illegible]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making [illegible] for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932515	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	7220 BAILLIE DRIVE NEW PORT RICHEY, FL 34653

(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 025	Continued From page 7 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide the level of care and services required to meet the needs of residents who were . . risks and required . . precautions for 2 (Residents #1 and #30). Additionally, the facility failed to respond to residents' requests for help in a timely fashion for six (Residents #7, #15, #25, #27, #30, and #32). Findings Included: 1. A record review conducted on . . . . . revealed the following: Resident #1's health assessment form dated	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932515	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	7220 BAILLIE DRIVE NEW PORT RICHEY, FL 34653

(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 025	Continued From page 8 . . . . . stated that the resident had . . . . , used a walker, was a risk, required precautions and required assistance with ambulation, toileting, and transfers. There was a note signed by her primary care provided dated . . . . . that stated that Resident #1 was "not able to make medical or legal decisions on her own and will need a representative". On , Resident #1 was found on the floor and sent to the hospital and returned on the same date with a diagnosis of right . The facility found placement at a rehabilitation facility for the resident. On , Resident #1 returned from the rehabilitation facility. On . . . . . , Resident #1 was found on the floor and sent to the hospital. The resident continued in a rehabilitation facility status post left , and surgery. Resident #1's health assessment form dated . . . . . stated that the resident had . . . . , had a recent right , had no physical limitations, required supervision with ambulation and transfers; and required assistance with toileting. Record review of Resident #1's incident report dated . . . . . conducted on . . . . . revealed there was no description of the outcome, no investigation into the incident that caused Resident #1's , or no inventions put in place to prevent another occurrence upon return from the rehabilitation facility. There was	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932515	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	7220 BAILLIE DRIVE NEW PORT RICHEY, FL 34653

(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 025	Continued From page 9 no notification to Resident #1 responsible party, case manager or primary care provider. Record review of Resident #1's incident report dated [redacted] conducted on [redacted] revealed there was no there was no notification to Resident #1 responsible party, case manager or primary care provider. There was no description of the outcome or investigation into the incident that caused Resident #1 to [redacted]. During an interview with Resident #1's responsible party (RP), conducted on [redacted] at 04:19pm, the RP stated that Resident #1 [redacted] and [redacted] her right [redacted] in or around [redacted]. A week after returning to the facility in [redacted] Resident #1 [redacted] and her left [redacted]. The RP stated that the facility did not discuss any type of [redacted] precautions that were put in place to prevent [redacted] re-occurrence. The RP stated that the facility never contacted her regarding each [redacted] that Resident #1 had, and it was the hospital that contacted her each time that Resident #1 [redacted] hours after arriving at the hospital. During an interview with a representative from another State Agency, conducted on [redacted] at 10:36am, the representative stated that he had difficulty investigating a complaint involving the facility via telephone because telephone calls were not answered or there would be no response from messages left. The representative had a timeline sent during his investigation of the difficulty of communication efforts with the facility. 2. During an interview with Resident #25, conducted on [redacted] at 06:23am, Resident	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932515	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	7220 BAILLIE DRIVE NEW PORT RICHEY, FL 34653

(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	Continued From page 10	A 025		

#25 stated that she had to wait up to forty minutes for someone to respond to her call light for help.

During an interview with Resident #27, conducted on at 07:17am, Resident #27 stated that staff were slow to respond to call lights.

During an interview with Resident #7, conducted on at 08:24am, Resident #7 stated that this morning she had her call light on for a long time and the resident was concerned that there was no staff available in the event of an emergency.

During an interview with Resident #15, conducted on at 11:45am, Resident #15 stated that she had to wait long times for staff to respond to the call light and that once it took twenty-five minutes.

During one call light test, conducted on revealed the following:

At 12:09pm, found Resident # 30 sitting on the floor next to the bed. Resident #32 was present and stated that she had just sat down on the floor. Obtained permission to perform a call light test and ensured Resident #30 was not injured. Resident #30 and #32 both laughed and said that staff would not come to answer the call light. Call light activated at 12:10pm. Resident #30 assured that she was okay, and she wanted to show that staff would not come to answer the call light and that staff do not listen or respond to resident's needs anymore.

At 12:27pm, there was still no response for the call light. The call light was observed to be lit just outside the door and there were no staff in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932515	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	7220 BAILLIE DRIVE NEW PORT RICHEY, FL 34653

(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 025	Continued From page 11	A 025		

hallway. Staff F responded at 12:29pm. Upon finding Resident #30 on the floor, Staff F stated that she needed to get the nurse and left the room. It took one minute for Staff F to return with the Health and Wellness Director. Both employees assisted Resident #30 into a standing position without performing any type of assessment. Upon standing, both employees left the room. Resident #30 stated that "I told you they wouldn't come".

Resident #30 was followed to her own room and found that she had a walker one corner of her room. Resident #30 stated that she did not use the walker because she did not like it.

The Health and Wellness Director and Staff F did not remind Resident #30 to use her walker or obtain the walker for her.

A record review for Resident #30, conducted on , revealed that Resident #30's health assessment form dated stated that she had and general and required supervision with ambulation and transfers and daily oversight for wellbeing and whereabouts. Resident #30's care plan dated stated that the resident required one person assistance with ambulation and transfers. There were no other care plans found in the resident's record.

During an interview with the Health and Wellness Director, conducted on at 04:00pm, the Health and Wellness Direct stated that it was expected that call lights were answered within five minutes. Health and Wellness Director stated that here was a lack of communication in the building for staff to be able to respond quickly to residents' needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932515	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	7220 BAILLIE DRIVE NEW PORT RICHEY, FL 34653

(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 025	Continued From page 12 During an interview with the Administrator, conducted on ..... at 04:21pm, the Administrator denied having communication difficulties with responsible parties, CMs or other state agencies. Class III	A 025		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known ... the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical	A 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932515	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	7220 BAILLIE DRIVE NEW PORT RICHEY, FL 34653

(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 054	Continued From page 13 , the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to update Medication Observation Records (MORs) immediately each time medications (meds) were offered to four Residents (#16, #17, #18, and #21) of four sampled residents. Findings Included: A MORs review for Resident #16, #17, #18, and #21, conducted on , revealed that the resident had meds that were not documented as given or offered to the residents. Resident #16 had the prescribed med , ( ) 5mg was not documented as given or offered to the resident on , , and at 08:00pm; Inhaler was not documented as given or offered to the resident on , , , at 05:00pm; ( ) 50mcg spray was not documented as given or offered to the resident on , , and at 05:00pm; ( ) 40mg was not documented or offered to the resident on , , , , , and at 05:00pm; and Pregabalin (,) 150mg was not documented as given or offered to the residents on , , , , , and , and at 08:00pm. Resident #17 had the prescribed med , 25mcg was not documented as	A 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932515	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	7220 BAILLIE DRIVE NEW PORT RICHEY, FL 34653

(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 054	Continued From page 14 given or offered to the resident on [redacted] through at 06:00am. Resident #18 had the prescribed med Iatropium/[redacted] Solution 0.5-2gram/3ml was not documented as given or offered to the resident on [redacted], and [redacted] at 05:00pm and 10:00pm. Resident #21 had the prescribed med [redacted] 10mg was not documented as given or offered to the resident on [redacted] and [redacted] at 06:00pm. During an interview with the Health and Wellness Director, conducted on 5/[redacted] at 01:00pm through 01:30pm, Residents #16, #17, #18, and #21's MORs were reviewed, and the Health and Wellness agreed that the residents' MORs had meds that were not signed as given or offered to the residents. Class III	A 054		
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	A 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932515	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	7220 BAILLIE DRIVE NEW PORT RICHEY, FL 34653

(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 15 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 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	A 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932515	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	7220 BAILLIE DRIVE NEW PORT RICHEY, FL 34653

(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 16	A 056		

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,
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 observation, record review, and interview, the facility failed to provide prescribed medications (meds) as ordered from residents' health care providers for six Residents (#3, #16,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932515	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	7220 BAILLIE DRIVE NEW PORT RICHEY, FL 34653

(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	Continued From page 17 #17, #18, #19, and #20) of six sampled residents. Findings Included: During an observation of Resident #16's med, conducted on at 11:30am, there were five pills remaining in the med pack and should have had one pill remaining in the med pack for the dose due at at 08:00pm. On at 04:05pm, there continued to be five pills remaining in the med pack. A record review for Resident #3, conducted on and , revealed the following: Resident #3's health assessment dated stated that the resident required assistance with self-administration of meds and had a history of , Bacteremia, ( ), , and Enterobacterales which are a large order of different types of that commonly cause . Resident #3 did not receive prescribed meds in , , and . On , Resident #3 was prescribed the 100mg take one tablet every twelve hours for seven days for signs and symptoms of a . The med was not on Resident #3's Medication Observation Records (MORs) and did not appear that it was filled or given to the resident. On , Resident #3 was prescribed the 500mg take one tablet three times every day for seven days for signs and symptoms of a . The med was not	A 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932515	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	7220 BAILLIE DRIVE NEW PORT RICHEY, FL 34653

(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 18 documented as given on . . . . . at 08:00pm through at 02:00pm and through . . . . . and . . . . . and . . . . . at 08:00pm; and at 02:00pm; and . . . . . at 08:00am. The med was reordered to continue through at 02:00pm. On . . . . . , Resident #3 was prescribed the . . . . . , 800-160mg take one table every twelve hours for five days. The med was not documented as give on . . . . . , ... , ... , and at 08:00pm and on at 08:00am. On . . . . . Resident #3 was prescribed the . . . . . , , 100mg take one capsule every twelve hours for ten days for signs and symptoms of a . . and the med was not documented as given on . . . . . through at 08:00pm and on at 08:00am. A MORs and med review with Staff F and Staff N for Residents #16, #17, #18, #19, and #20, conducted on . . . . . revealed the following: On . . . . . , Resident #16 was prescribed the . . . . . , , 100mg take one capsule by . . . every twelve hours for seven days. The med was not documented as given on at 08:00am and . . /201 and . . . . . at 08:00pm. There were five pills remaining and should have been one pill remaining. Resident #16 missed four doses of his prescribed	A 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932515	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	7220 BAILLIE DRIVE NEW PORT RICHEY, FL 34653

(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 19 On . . . . . , Resident #17 was prescribed the . , 800-150mg take one tablet every twelve hours for ten days. The med was not documented as given on . . . . . , ... , & . . . . . at 08:00pm and on . . . . . at 08:00am. There were eight pills remaining in the med pack and should have been six pills remaining. Resident #17 missed two doses of her prescribed . . . . . . On . . . . . , Resident #18 was prescribed the , 500mg take one tablet twice every day for seven days. The med was not documented as given on . . . . . and . . . . . at 08:00pm. All doses should have been taken and there were five pills remaining in the med pack. Resident #18 missed five doses of her prescribed . On . . . . . , Resident #19 was prescribed the . . . . . 500mg take one capsule every eight hours for seven days. The med was not documented as given on . . . . . through . . . . . at 11:00pm and . . . . . through . . . . . at 01:00pm. There were thirteen pills remaining in the med pack and should have been ten pills remaining. Resident #19 missed three doses of her prescribed . . On . . . . . , Resident #20 was prescribed . . . . . and . . . . . 875-125mg take one tablet every twelve hours for fourteen days. There were four doses dispensed and should have been two doses dispensed. There was no accounting of what happened to the two missing doses of the . . There was documentation on . . . . . at 08:00pm and . . . . . at 08:00am that Resident #20 refused these two doses. There was no documented evidence that Resident #20's primary care	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932515	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW TERRACE	7220 BAILLIE DRIVE NEW PORT RICHEY, FL 34653

(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 20 provider was notified that he was not taking his prescribed . During an interview with Staff F and Staff N conducted on beginning at 11:30am, Staff F agreed Resident #16, #17, #18 and #19 had missed the prescribed . Staff N agreed Resident #20 had missed the prescribed . During an interview with the Health and Wellness Director, conducted on at 04:05pm, the Health and Wellness Director reviewed Resident #16, #17, #18, #19, and #20's prescribed and agreed that the residents were not receiving their prescribed medications. The Health and Wellness Director verified that Resident #16 continued with five pills in his med pack and that he did not receive his last dose on at 08:00pm. Photographic evidence obtained Class III	A 056		