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 _____	03/02/2022

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	Initial Comments A complaint investigation (complaint numbers: 2022001529, 2022001673, and 2022002992), a generator monitoring visit, and a second revisit to [redacted] complaint investigation (complaint numbers: 2021015724 and 2021015358) were conducted at Oakview Terrace on [redacted]. Deficiencies were identified at the time of survey.	A 000		
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 [redacted] 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 [redacted], the facility must, pursuant to Section	A 054		

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A 054	Continued From page 1 429.41, 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 immediately update Medication Observation Records (MORs) each time a medication was offered to two Residents (#4 and #5) of three sampled residents that required assistance with self-administration of medications. Findings Included: A MORs review for Resident #4, conducted on , revealed that Resident #4's MORs had medications not documented as offered or given to the resident which included the resident's prescribed 10mg on and at 02:00pm; Cream 100,000 on at 02:00pm; and Cream 0.1% on at 02:00pm. A record review for Resident #4, conducted on , revealed that Resident #4 was admitted on . Resident #4's health assessment dated stated that the resident required assistance with self-administration of medications. A MORS review for Resident #5, conducted on , revealed that Resident #5's MORs had medications not documented as offered or given to the resident which included the resident's prescribed Prevalite Powder on and at 02:00pm. A record review for Resident #5, conducted on	A 054		

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A 054	Continued From page 2 . . . . . , revealed that Resident #5 was admitted on . Resident #5's health assessment dated . . . . . stated that the resident required assistance with self-administration of medications. During an interview with the Director of Nursing, conducted on at 04:00pm, the Director of Nursing agreed that Resident #4 and #5's MORs had medications that were not documented as offered or given to the residents. Class III	A 054		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. . . , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance . . , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, ... , or	A 162		

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A 162	Continued From page 3 other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A [illegible] record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their [illegible] recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an [illegible] recipient, a copy of	A 162		

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A 162	Continued From page 4 the Department of Children and Families form Alternate Care Certification for , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident	A 162		

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A 162	Continued From page 5 participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided 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 maintain resident records for hospice residents with the required interdisciplinary care plan ( ) and failed to document changes in condition in resident record for two Residents (#5 and #7) of two sampled residents. Findings Included: A record review for Resident #5, conducted on . . . . . , revealed that Resident #5 did not have any documentation in the resident's record regarding changes in condition or incidents that occurred on . Resident #5 was admitted on . . . . . An employee record review, conducted on , revealed that former Staff G had a disciplinary writeup/action in his employee record for an incident that occurred on and that the employee violated that company policies and had a physical altercation with Resident #5	A 162		

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A 162	Continued From page 6 who resided in the memory care unit. Staff G had hit Resident #5 in the and Staff G was suspended pending an investigation of the incident. A record review for Resident #7, conducted on , revealed that Resident #7 was admitted to the facility on and into hospice services on . There was no that described the care and services that hospice provided and those that the facility provided in the resident's record. During an interview with the Director or Nursing, conducted on at 03:26pm, the Director of Nursing stated that the facility was behind in their documentation in resident records and needed to make late entries. At 04:00pm, the Director of Nursing agreed that there was no documentation in Resident #5's record regarding the incident in which Staff G hit her in the . The in-house incident report for the incident was not provided. The Director of Nursing agreed that Resident #7 did not have an that described the care and services that hospice provided and those that the facility provided in the resident's record. Class III	A 162		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to	A 165		

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A 165	Continued From page 7 assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. [illegible]; 2. [illegible] or [illegible] damage; 3. Permanent [illegible]; 4. [illegible] or [illegible] of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15	A 165		

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A 165	Continued From page 8 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) [illegible], neglect, or [illegible] must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate	A 165		

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A 165	Continued From page 9 regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to submit an adverse incident report (AIR) within fifteen days of an adverse incident for one Resident (#5) of one sampled resident that had an adverse incident. Findings Included: During an interview with a State Agent, conducted on at 10:17am, the State Agent stated that she verified allegations of , , of former Staff G toward Resident #5 and that Staff G was and terminated for his job. During an interview with Staff C, conducted on at 02:10pm, Staff C stated that she notified the Assistant Director of Nursing who in turn notified the Director of Nursing immediately when Staff G was witnessed hitting Resident #5 by Staff B. An employee record review, conducted on , revealed that former Staff G had a disciplinary writeup/action in his employee record for an incident that occurred on and that the employee violated that company policies and had a physical altercation with Resident #5 who resided in the memory care unit. Staff G had hit Resident #5 in the and Staff G was suspended pending an investigation of the incident. After Law enforcemnt conducted an investigation, Staff G was and charged by law enforcement on and was terminated from employment.	A 165		

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A 165	Continued From page 10 A review of an AIR for Resident #5, conducted on . . . . . , revealed that the facility submitted an initial or one-day AIRs report on . The AIR was not a full report and did not include the Analysis of the Incident or the Corrective Action Summary. The AIR stated that a full report was required to be submitted within fifteen days of the incident. There was no fifteen-day AIR to review for Resident #5. During an interview with the Director of Nursing, conducted on . . . . . at 04:00pm, the Director of Nursing agreed that the facility had not submitted a full AIR report within 15-days of the incident by Staff G toward Resident #5. Class III	A 165		