

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ARCADIA OAKS ASSISTED LIVING

**1013 EAST GIBSON STREET
ARCADIA, FL 34266**

(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 An unannounced change of ownership, health facility reporting system, emergency power plan, bed capacity increase, generator, and visitation survey was conducted on through at Arcadia Oaks Assisted Living, an assisted living facility in Arcadia, Florida. The following is a description of the deficiencies. .	A 000		
A 052 SS=D	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, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and	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: AL11965330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ARCADIA OAKS ASSISTED LIVING

**1013 EAST GIBSON STREET
ARCADIA, FL 34266**

(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 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 _____. (4) Assistance with self-administration of medication 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) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with _____, or _____ preparations. (g) Assisting with 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 the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication.	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER ARCADIA OAKS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1013 EAST GIBSON STREET ARCADIA, FL 34266		
(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 (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, orally advising the resident of the name and dosage of the medication 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	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER ARCADIA OAKS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1013 EAST GIBSON STREET ARCADIA, FL 34266		
(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 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. (g) 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. (h) 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, and interview, the facility failed to ensure staff who assist residents with self-administration of medications do so in	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ARCADIA OAKS ASSISTED LIVING

**1013 EAST GIBSON STREET
ARCADIA, FL 34266**

(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 accordance with proper procedure for 3 (Residents #9, #11, and #12) of 3 medications observations. The findings included: Supervision Of Medications: General Policies. Policy: Medication handling represents an area of great responsibility. If not managed properly, medication intended to help a resident's health condition may place the individual's health and safety at risk. 1. Only trained staff or licensed personnel are assigned responsibility of preparing supervising and recording medications or permitted access to drug storage areas in the facility. 14. Follow washing and control procedures after supervising a dose of medications to a resident and prior to administering a dose to another resident, when applicable. 1. On at 8:35 a.m., Staff A (med tech) was observed assisting Resident #11 with medications. Staff A opened the medication cart removed Resident #11's medications from the cart and compared them to the resident profile on the computer, reading the medication label to Resident #11 and checking the medications of on the Electronic Medication Administration Record (EMAR). Staff A opened 2 bottles of the medications and removed the pills from the bottles with her bare placing the pills into the cup. Staff A continued to pop the remaining medications from the cards into the souffle cup, giving the cup with the medications, and a glass of water to Resident #11, who was sitting in the chair in the medication room, and observing Resident #11 take the medications. Staff A did not perform hygiene prior to and after assisting Resident #11 with the medications. Staff A	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER ARCADIA OAKS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1013 EAST GIBSON STREET ARCADIA, FL 34266		
(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 proceeded to call Resident #12 for medications. 2. On ... at 8:45 a.m., Staff A (med tech) was observed assisting Resident #12 with medications. Staff A opened the medication room and had Resident #12 enter the medication room and had her stay seated on her motorized wheelchair. Staff A did not perform hygiene after assisting Resident #11 with medications nor did Staff A perform hygiene prior to assisting Resident #12 with her medications. Staff A donned gloves, opened the med cart and removed a needle stick pen from cart, and placed the needle pen on Resident #12's ... asking her to the button. Resident #12 pushed needle stick pen button and pricked her ... Staff A squeezed Resident #12's ... for ... and used ... machine to check ... machine read error. Staff A informed Resident #12 she needed more ... and squeezed Resident #12's ... again with no ... observed. Staff A informed Resident #12 she will have to prick a different ... Staff A placed the needle stick pen on Resident #12's pinky ... and asked her to push the button. Resident #12 pushed the button pricking her ... Staff A squeezed Resident #12's ... for ... sample and used the ... machine to take ... receiving a reading of 143. Staff A cleaned Resident #12's ... with an wipe. Staff A doffed gloves, no ... hygiene was performed. Staff A proceeded to open the med cart and removed the medication cards from the cart, reading the medications to Resident #12, checking them off on the EMARs as she read them. Staff A popped the pills into the souffle cup, and the gave cup of medications and a glass of water to the Resident #12, observing Resident #12 take the medications. No ... hygiene was performed. Staff A proceeded to call Resident #9	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ARCADIA OAKS ASSISTED LIVING

**1013 EAST GIBSON STREET
ARCADIA, FL 34266**

(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 for medications. 3. On at 8:55 a.m., No hygiene performed. Staff A (med tech) was observed assisting Resident #9 with medications. Staff A opened the medication cart removed Resident #9's medications from the cart and compared them to the resident profile on the computer, reading the medication label to Resident #9 and checking the medications of on the Electronic Medication Administration Record (EMAR). Staff A popped the medications from the cards into the souffle cup, giving the cup with the medications with a glass of water, to Resident #9, who was sitting in the chair in the medication room and observing Resident #9 take the medications. Staff A did not perform hygiene prior to and after assisting Resident #9 with the medications. Staff A did not perform and hygiene prior. On at 9:05 a.m., during an interview, Staff A stated she did a medication recertification training recently. She stated the class involved training regarding making sure to give only the meds listed on the EMARS, and if residents have as needed medications they are only to be given when asked for, wearing gloves when using and hygiene when assisting with medications. Staff A confirmed she did not perform hygiene when assisting Residents #11, #12 and #9 with the medications and touched the medications with her bare On at 8:00 a.m., during an interview, the Administrator stated during the assistance with medication process the med techs are required to perform hygiene. Administrator confirmed that Staff A did not follow protocol and procedures for assisting with meds when she touched the	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ARCADIA OAKS ASSISTED LIVING

**1013 EAST GIBSON STREET
ARCADIA, FL 34266**

(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 meds with her bare . . . and did not perform hygiene prior to and between assisting Residents #9, #11, and #12 with medications. Class III .	A 052		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable . . . , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER ARCADIA OAKS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1013 EAST GIBSON STREET ARCADIA, FL 34266		
(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 078	Continued From page 8 constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility that provides services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure that within 30 days of employment staff submit a written statement from a health care provider documenting the individual	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ARCADIA OAKS ASSISTED LIVING

**1013 EAST GIBSON STREET
ARCADIA, FL 34266**

(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 078	Continued From page 9 is free from signs/symptoms of communicable and evidence of freedom from () documented annually thereafter for 1 (Staff A) of 5 employee records reviewed. The findings included: Review of Staff A's file revealed a hire date of as a Medication Technician/Caregiver. Staff A's file contained evidence of documentation of a test completed on and read on, 10 months prior to hire. On at 9:40 a.m., during an interview, the Administrator stated she thought the test could be done 1 year prior and would be valid for use, she confirmed a new test should have been done and is not valid as it is past the 6 months prior to her hire. Class III	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ARCADIA OAKS ASSISTED LIVING

**1013 EAST GIBSON STREET
ARCADIA, FL 34266**

(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 An unannounced change of ownership, health facility reporting system, emergency power plan, bed capacity increase, generator, and visitation survey was conducted on through at Arcadia Oaks Assisted Living, an assisted living facility in Arcadia, Florida. The following is a description of the deficiencies. .	A 000		
A 052 SS=D	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, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and	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: AL11965330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ARCADIA OAKS ASSISTED LIVING

**1013 EAST GIBSON STREET
ARCADIA, FL 34266**

(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 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 _____. (4) Assistance with self-administration of medication 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) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with _____, or _____ preparations. (g) Assisting with 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 the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication.	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER ARCADIA OAKS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1013 EAST GIBSON STREET ARCADIA, FL 34266		
(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 (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, orally advising the resident of the name and dosage of the medication 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	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER ARCADIA OAKS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1013 EAST GIBSON STREET ARCADIA, FL 34266		
(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 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. (g) 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. (h) 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, and interview, the facility failed to ensure staff who assist residents with self-administration of medications do so in	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ARCADIA OAKS ASSISTED LIVING

**1013 EAST GIBSON STREET
ARCADIA, FL 34266**

(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 accordance with proper procedure for 3 (Residents #9, #11, and #12) of 3 medications observations. The findings included: Supervision Of Medications: General Policies. Policy: Medication handling represents an area of great responsibility. If not managed properly, medication intended to help a resident's health condition may place the individual's health and safety at risk. 1. Only trained staff or licensed personnel are assigned responsibility of preparing supervising and recording medications or permitted access to drug storage areas in the facility. 14. Follow washing and control procedures after supervising a dose of medications to a resident and prior to administering a dose to another resident, when applicable. 1. On at 8:35 a.m., Staff A (med tech) was observed assisting Resident #11 with medications. Staff A opened the medication cart removed Resident #11's medications from the cart and compared them to the resident profile on the computer, reading the medication label to Resident #11 and checking the medications of on the Electronic Medication Administration Record (EMAR). Staff A opened 2 bottles of the medications and removed the pills from the bottles with her bare placing the pills into the cup. Staff A continued to pop the remaining medications from the cards into the souffle cup, giving the cup with the medications, and a glass of water to Resident #11, who was sitting in the chair in the medication room, and observing Resident #11 take the medications. Staff A did not perform hygiene prior to and after assisting Resident #11 with the medications. Staff A	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER ARCADIA OAKS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1013 EAST GIBSON STREET ARCADIA, FL 34266		
(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 proceeded to call Resident #12 for medications. 2. On ... at 8:45 a.m., Staff A (med tech) was observed assisting Resident #12 with medications. Staff A opened the medication room and had Resident #12 enter the medication room and had her stay seated on her motorized wheelchair. Staff A did not perform hygiene after assisting Resident #11 with medications nor did Staff A perform hygiene prior to assisting Resident #12 with her medications. Staff A donned gloves, opened the med cart and removed a needle stick pen from cart, and placed the needle pen on Resident #12's ... asking her to the button. Resident #12 pushed needle stick pen button and pricked her ... Staff A squeezed Resident #12's ... for ... and used ... machine to check ... machine read error. Staff A informed Resident #12 she needed more ... and squeezed Resident #12's ... again with no ... observed. Staff A informed Resident #12 she will have to prick a different ... Staff A placed the needle stick pen on Resident #12's pinky ... and asked her to push the button. Resident #12 pushed the button pricking her ... Staff A squeezed Resident #12's ... for ... sample and used the ... machine to take ... receiving a reading of 143. Staff A cleaned Resident #12's ... with an wipe. Staff A doffed gloves, no ... hygiene was performed. Staff A proceeded to open the med cart and removed the medication cards from the cart, reading the medications to Resident #12, checking them off on the EMARs as she read them. Staff A popped the pills into the souffle cup, and the gave cup of medications and a glass of water to the Resident #12, observing Resident #12 take the medications. No ... hygiene was performed. Staff A proceeded to call Resident #9	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ARCADIA OAKS ASSISTED LIVING

**1013 EAST GIBSON STREET
ARCADIA, FL 34266**

(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 for medications. 3. On at 8:55 a.m., No hygiene performed. Staff A (med tech) was observed assisting Resident #9 with medications. Staff A opened the medication cart removed Resident #9's medications from the cart and compared them to the resident profile on the computer, reading the medication label to Resident #9 and checking the medications of on the Electronic Medication Administration Record (EMAR). Staff A popped the medications from the cards into the souffle cup, giving the cup with the medications with a glass of water, to Resident #9, who was sitting in the chair in the medication room and observing Resident #9 take the medications. Staff A did not perform hygiene prior to and after assisting Resident #9 with the medications. Staff A did not perform and hygiene prior. On at 9:05 a.m., during an interview, Staff A stated she did a medication recertification training recently. She stated the class involved training regarding making sure to give only the meds listed on the EMARS, and if residents have as needed medications they are only to be given when asked for, wearing gloves when using and hygiene when assisting with medications. Staff A confirmed she did not perform hygiene when assisting Residents #11, #12 and #9 with the medications and touched the medications with her bare On at 8:00 a.m., during an interview, the Administrator stated during the assistance with medication process the med techs are required to perform hygiene. Administrator confirmed that Staff A did not follow protocol and procedures for assisting with meds when she touched the	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER ARCADIA OAKS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1013 EAST GIBSON STREET ARCADIA, FL 34266		
(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 meds with her bare . . . and did not perform hygiene prior to and between assisting Residents #9, #11, and #12 with medications. Class III .	A 052			
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable . . . , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER ARCADIA OAKS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1013 EAST GIBSON STREET ARCADIA, FL 34266		
(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 078	Continued From page 8 constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility that provides services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure that within 30 days of employment staff submit a written statement from a health care provider documenting the individual	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ARCADIA OAKS ASSISTED LIVING

**1013 EAST GIBSON STREET
ARCADIA, FL 34266**

(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 078	Continued From page 9 is free from signs/symptoms of communicable and evidence of freedom from () documented annually thereafter for 1 (Staff A) of 5 employee records reviewed. The findings included: Review of Staff A's file revealed a hire date of as a Medication Technician/Caregiver. Staff A's file contained evidence of documentation of a test completed on and read on, 10 months prior to hire. On at 9:40 a.m., during an interview, the Administrator stated she thought the test could be done 1 year prior and would be valid for use, she confirmed a new test should have been done and is not valid as it is past the 6 months prior to her hire. Class III	A 078		