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 _____	R-C 05/23/2024

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 152} SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable , to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be	{A 152}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{A 152}	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide a clean and decent living environment. Additionally, the facility failed to provide an environment free from pests. Furthermore, the facility failed to maintain all existing mechanical, electrical, and structural apparatuses in good working order. Findings Included: During observations of the Memory Care Unit, conducted on . . . . . at 09:24am, it was observed that in the art/craft storage closet, there was an air conditioning air handler unit. There were games, boxes, toys, and miscellaneous items packed around the unit obstructing the air flow of the unit. The kitchen sink and backsplash were dirty. The counter behind the sink was coated with an unknown black substance. Inside the sink cabinet base the flooring was covered in a black and gray substance. There were gallons of . . sanitizer and cleaning chemicals underneath the sink. There was no locking mechanism to the cabinet. Inside the refrigerator was dirty with food substances and had broken shelves. The vent cover was missing to the refrigerator. There was red liquid on the floor in front of the refrigerator. The top of the refrigerator had a container filled with sandwiches that were not dated or properly stored. The open storage room next to the refrigerator was filled with chemicals and rags surrounding the air handler unit. The room was a storage area for resident snacks, chemicals, rags, employee lunch bags, and employee personal items. There was a sharp knife found in the top drawer of a plastic storage container. The inside of the microwave was dirty with food residue and there was an uncovered plate of sausage and muffins. In . . and	{A 152}		

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{A 152}	Continued From page 2 120, there were portable air conditioning units. The portable air conditioning unit in had a black substance in and on it. One fluorescent light in the hallway was not functioning. During observations of the dining room, conducted on at 09:47am, it was observed that in the dining room the air return vent was covered in rust. The floors, baseboard, and wall by the kitchen entrance were covered with grease, grimes, dirt, and unsightly. The door and baseboard by the activity room were covered with scuffs and scratches, dirt, and drips of unknown substance. There was one fluorescent light fixture with the light not functioning. There were eight tubular lights not functioning. There were eight ceiling tiles with brown marks that were unsightly. The ceiling wood trim had brown streak and appeared to be rotting wood. During an observation of Resident #2's bed, conducted on at 10:00am, there were live and bed bugs observed on the bed linens. During an interview with Resident #2, conducted on at 10:00am, Resident #2 stated that there were ongoing issues with bedbugs in her mattress had ongoing issues with bedbugs. Resident #2 stated that she had told the staff about the ongoing issues with the bed bugs in her room. A review of the facility's bed bug policy and procedures dated 2024 (no date noted), conducted on , revealed that upon finding evidence of bed bugs stated were to: -Resident showered, placed into brand new clothing that the facility buys them	{A 152}		

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{A 152}	Continued From page 3 -Resident immediately removed from the room to a clean temporary room -Resident clothes and belongings placed into bug heating bag for treatment -Resident room treated by exterminator . more times -Facility will also then treat resident room -All hard surfaces wiped with 90% or more -Mattress and any material furniture replaced -Revised during survey and added -Since heating until purchased room chemically treated then heat treated During observations of the hallways, conducted on at 10:06am, it was observed that the carpets were stained in various places on the second floor which included in front of the elevators, under the water fountain in the main dining room, and , , room doors were observed with scuffs and scratches. During observations, conducted on at 03:05pm, it was observed that the temperatures in the front of the 200 and 400 halls were 81 degrees according to the wall thermometers. Both thermometers temperature was set at 72 degrees. At 03:07pm, the elevator tracks were filled with dust, dirt, grime, and food particles. At 03:15pm, the temperature at the of the 200 hall was 83.6 degrees near according to the State issues Hygrometer. At 03:42am, the water fountain was observed with dust and white, yellow, and green unknown substance in the basin of the fountain. During observations, conducted on , it was observed at 02:55pm, that Resident #10 had a large tank of portable in the resident's	{A 152}		

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{A 152}	Continued From page 4 closet that was not safely stored in a rack or holder (photographic evidence obtained). During an interview with Resident #13's visiting friend, conducted on [redacted] at 01:25pm, the friend stated that Resident #13's room had the big bulky portable air conditioning unit because of ongoing issues with the main central air conditioning system not functioning. During an interview with Staff I, conducted on [redacted] at 03:45pm, Staff I stated that the facility's lights were out in the dining room because of a water leak. Staff I stated that there were a couple of rooms that had bedbugs. Staff I stated that the air conditioning was always out somewhere in the facility. During an interview with Staff T, conducted on [redacted] at 03:50pm, Staff T stated that the facility had a couple of rooms that were infested with bedbugs. Staff T stated that the air conditioning system continued to have issues with proper functioning. A review of a list of the non-functioning air conditioning systems and the rooms that were affected, conducted on [redacted], revealed that the rooms with the non-functioning central air conditioning system included [redacted], 120, 205, 207, 215, 216, 218, 307, 308, 309, 313, 323, and 421. A review of the air conditioning repair invoices, conducted on [redacted], revealed that invoice #532 dated [redacted] found no evidence that [redacted] affected by a non-functioning air conditioning system identified during the [redacted] survey were inspected or repaired. Invoice #543 dated [redacted] was for repairs to	{A 152}		

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{A 152}	Continued From page 5 a live wire that was not properly secured and posed a safety threat to the public during found during a recent fire inspection. Invoice #567 dated air conditioning units in the building were down in three separate systems that affected . . . It was noted on the invoice that the repairman was able to disassemble the fan, remove the bearing plugs, and lubricate the bearings in an attempt to free the shaft from its . However, the repairman also noted that there was no degree of certainty of how long the repairs would last and the it may last for weeks or for a day. The repairman also noted the it had been recommended to replace the condenser motor. An invoice dated noted that the there was a leak to the air conditioning system which affected the day area near the main entrance and returned during survey to find and repair the leak. The invoice noted that it was recommended that the coils should be cleaned to reduce . . . pressures on system or consider cleaning all of the coils on the rooftop. There was no evidence that the recommendation for proper maintenance was scheduled. During an interview with the Administration conducted on at 11:30am, the Administrator identified the black substance to the portable air conditioning unit in was mold. At 03:30pm, the Administrator stated that the air conditioning system continued to needs a replacement part. The Administrator stated that she was unaware that the temperature reached 83.6 degrees in the . . . of the 200 hall. The Administrator stated that the air conditioning company had been there to work on the air conditioning units for the 400 hall during the survey. The Administrator stated that there were thermostats on each hall and that the staff were	{A 152}		

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{A 152}	Continued From page 6 not taking temperatures at the . . . of the hallways to ensure that the temperatures did not exceed 81 degrees. The Administrator stated that . . needed to be stored in a rack or holder at all times. (photographic evidence obtained) Class III	{A 152}		
{A 160} SS=D	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. 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	{A 160}		

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{A 160}	Continued From page 7 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 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.	{A 160}		

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{A 160}	Continued From page 8 (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, 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) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) 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 maintain an up-to-date admission and discharge log that listed the names of all residents admitted to the facility, when they were discharged and an address of placement of the resident once discharged.	{A 160}		

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{A 160}	Continued From page 9 Findings Included: A review of the admission and discharge log, conducted on . . . . . , revealed that Resident #33 was admitted on 12/ and discharged on . . . . . . There was no place noted to where the resident was discharged to. Resident #34 was admitted on . . . . . and discharged on . There was no place noted to where the resident was discharged to. A review of the facility census, conducted on , revealed that Residents #33 and #34 were not listed as in-house residents. During an interview with the Administrator, conducted on at 02:25pm, the Administrator agreed the places where Residents #33 and #34 were discharged to were not noted in the admission and discharge log. Class III	{A 160}		
{A 000}	Initial Comments A revisit to biennial survey and complaint investigation (complaint number: 2024003233), a second revisit to complaint investigation (complaint numbers 2024000305, 2024000795, and 2024001190), and a complaint investigation (complaint number: 2024006369) were conducted at Oakview Terrace on . 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	{A 025}		

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{A 025}	Continued From page 10 429.26 (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 Resident Care Standards. 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 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.	{A 025}		

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{A 025}	Continued From page 11 (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 assess appropriately for changes in condition which caused a delay in additional services needed for two Residents (#10 and #11). Furthermore, the facility failed to assist residents with [redacted] and proper footwear for four Residents (#5, #10, #17, and #19) of five sampled residents. Findings Included: During an observation, conducted on [redacted] at 12:06pm, it was observed that Resident #17 was not wearing non-grip socks or shoes on her bare [redacted]. At 12:12pm, Residents #5 and #19 were observed sitting at dining tables and both were not wearing non-grip socks or shoes on their bare [redacted]. Staff S (Medication Technician) providing care and medications to Residents #5, #17, and #19 did not address Resident #5, #17, or #19's absence of appropriate footwear and bare [redacted]. At 02:44pm, Resident #10 had no socks or shoes on her bare [redacted] clearly visible.	{A 025}		

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{A 025}	Continued From page 12 Resident #10's left was (photographic evidence obtained). Resident #10 was in a hospital style gown. Resident #10 was sitting in her lounge chair placed in the center of the room. Resident #10 did not have access to her call light. During an interview with Staff S (Medication Technician), conducted on at 12:20pm, Staff S stated that staff do not assist Memory Care Residents #5, #17, and #19 with socks and shoes and that the resident's do not wear socks and shoes. A record review for Resident #5, conducted on , revealed that Resident #5 was admitted on . According to Resident #5's health assessment form dated , the resident had a diagnosis of of the and was . Resident #5 was under the care of hospice and required precautions. Resident #5 required assistance with bathing, , grooming, toileting, and transferring. During an interview with Resident #10, conducted on at 02:44pm, Resident #10 stated that at approximately 01:44pm, a staff member pushed the resident's rolling walker down the hallway while Resident #10 was sitting on the seat. Resident #10 stated that she was unaware that her were dragging on the carpeted floor. Resident #10 stated that staff frequently pushed the resident on the rolling walker while the resident sat on the seat. Resident #10 stated that she was a lot weaker since her recent hospital stay. Resident #10 stated that she did not have a wheelchair. Resident #10 stated that she had wanted to put on the call light to call for assistance for the but could not get	{A 025}		

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(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 13 up on her own and the call light was across the room. Resident #10 stated that since the recent hospital stay, the resident was not able to fit into any of her clothing. At 03:15pm, Resident #10 stated that she had forgotten to ask the two staff for help with the ˬ left . A record review for Resident #10, conducted on . . . . . , Resident #10's health assessment form dated did not note the resident's physical and sensory limitation and noted that the resident was independent with all activities of daily living and transferring. There was no extra care noted for Resident's need for assistance with transferring and ambulation documented in the resident's record. During an interview with Staff I (Medication Technician), conducted on . . . . . at 03:45pm, Staff I stated that there was a list of residents that required every two hours checks. A review of the list of residents that required every two hours checks, conducted on , revealed that Resident #10 was not listed as a resident to be checked on every two hours. During an interview with Resident #11, conducted on at 02:56pm, Resident #11 stated that it took ten or twelve days to get the ˬ for her left . Resident #11 stated that on . . . . . she got up from her chair while wearing new shoes and her left ankle turned and she down. Resident #11 stated that once she received the ˬ the results showed two . . . . . Resident #11 stated that the facility seemed to be short-staffed, and it took long wait times for staff to answer call lights.	{A 025}		

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{A 025}	Continued From page 14 A record review for Resident #11, conducted on , revealed that Resident #11 was admitted on . . . . . According to Resident #11's undated health assessment, the resident required . precautions and assistance with transfers. There were no interventions for prevention documented in resident #11's record. There was no documentation in Resident #11's record regarding the incident in which the resident sustained two to the left . . During a telephone interview with the Advance Registered Nurse Practitioner (ARNP) for Resident #11, conducted n at 03:33pm, the ARNP stated that it took two weeks to obtain an , for Resident #11's ankle that was probably due to the facility's fax machine that breaks down often and randomly goes offline but was not sure of the reason. During an interview with Staff T, (Resident Care Aide), conducted . . . . . at 03:50pm, Staff T stated that Residents have to put on their call lights when they want something. During an interview with the Wellness Director, conducted on at 09:28pm, the Wellness Director stated that the facility sometimes needs more staff on duty. The Wellness Director stated that when Resident #11 complained of , to the left ankle, the facility obtained an , from the resident's doctor. The Wellness Director stated that the order was sent to the mobile , company. The Wellness Director was unable to provide the dates of notification to Resident #11's primary care provider or follow up with the , mobile company. The Wellness Director stated that the whole delay took about a week. At 03:35pm, the	{A 025}		

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{A 025}	Continued From page 15 Wellness Director stated that there was no documentation for care and services that were provided to residents. The Wellness Director stated that Resident #10 preferred to be in a hospital gown over clothes since her return from the hospital. The Wellness Director stated that staff were supposed to provide supervision and/or assistance with and grooming for residents in the Memory Care Unit. The Wellness Director agreed that bare could potentially place residents at risk for . The Wellness Director was unable to provide documentation in Resident #11's record of the resident's . At 04:25pm, the Wellness Director stated that there was no incident report for Resident #10's . The Wellness Director was unable to provide evidence that Resident #10's primary care provider was notified of the scraped left . Class III	{A 025}		
{A 032} SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children	{A 032}		

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{A 032}	Continued From page 16 and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and,	{A 032}		

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{A 032}	Continued From page 17 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that all staff had required Elopement drill for 6 of 17 (Staff L, Staff M, Staff N, Staff O, Staff P, and Staff Q) sampled employees. Findings Included: A review of the Staff Elopement Drills, conducted on , revealed that Staff L, Staff M, Staff N, Staff O, Staff P and Staff had not participated in Elopement Drills. During the interview with the Administrator on at 11:14am, she he agreed that all staff had not particiapted in an Elopement Drill. Class III	{A 032}		
{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	{A 052}		

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{A 052}	Continued From page 18 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 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	{A 052}		

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{A 052}	Continued From page 19 route. (c) Administration of medications by way of a tube inserted in a [illegible], of the body. (d) Administration of [illegible] preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with [illegible], or [illegible] 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. (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 [illegible] 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.	{A 052}		

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{A 052}	Continued From page 20 (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 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	{A 052}		

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{A 052}	Continued From page 21 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 proper assistance with self-administration of medication by not comparing medication labels to the medication observation records for three (Residents #13, #17, and #20) of three sampled residents. Findings Included: During a medication pass observation with Staff S (an unlicensed Medication Technician) for Residents #13, #17, and #20, conducted on from 12:06pm through 12:17pm, Staff S did not compare Residents #13, #17, #20's medications to their medication observation records before giving the residents their medications. Staff S assisted Resident #13 with 25mg and 0.5mg. Staff S assisted Resident #17 with 100mg. Staff S assisted Resident #20 with 325mg. During an interview with the Wellness Director, conducted on at 01:25pm, the	{A 052}		

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{A 052}	Continued From page 22 Wellness Director agreed that unlicensed Medication Technician's were supposed to compare resident medication labels to their medication observation records before giving the residents their medications. Class III	{A 052}		
{A 056} SS=G	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions,	{A 056}		

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{A 056}	Continued From page 23 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 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	{A 056}		

Agency for Health Care Administration

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{A 056}	Continued From page 24	{A 056}		

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 notify health care providers when residents did not receive their prescribed medications as ordered for three (Residents #9, #11, and #17) of three sampled residents. Furthermore, the facility failed to follow directions of use for one (Resident #11) prescribed medication which place the resident at risk for signs and symptoms of an , overdose which can include trouble breathing, , severe drowsiness, , , , , , or .

Findings Included:

A MORs review for Resident #9, conducted on , revealed that Resident #9's MORs had prescribed medications that were documented as not given to the resident due to the resident's refusals which included , 12% lotion, 10mg,

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{A 056}	Continued From page 25 (no dose noted), and / , double strength (no dose noted). There was no evidence that Resident #9's primary care provider was notified that the resident was not receiving medications as prescribed. A MORs review for Resident #11, conducted on , revealed that Resident #11's MORs had prescribed medications that were documented as not given to the resident due to the resident was "out of the facility" for a family outing which included 10mg, / , double strength (no dose noted), 0.1% Cream, Sevelamer 0.8grams, and 12% lotion. There was no evidence that Resident #11's primary care provider was notified that the resident was not receiving medications as prescribed. Resident #11's prescribed 50mg was noted to take one tablet twice every day and scheduled at 08:00am and 04:00pm. Resident #11 had an as needed 50mg which was noted to take one tablet every day as needed for , and to "*separate from routine doses by four hours*". The as needed was scheduled to be given every day at 08:00am with the scheduled 50mg routinely scheduled dose (photographic evidence obtained). The doses were not separated by four hours. Resident #11 received 100mg of every day from through at 08:00am. A MORs review for Resident #17, conducted on , revealed that Resident #17 MORs had a prescribed dietary supplement for loss documented as not given to the resident due to "not available", "waiting on delivery", "out of them", and "don't have any" from	{A 056}		

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{A 056}	Continued From page 26 through . . . . There was no evidence that Resident #17's primary care provider and responsible party were notified that the resident was not receiving the dietary supplement as prescribed. During an interview with the Wellness Director, conducted on at 01:25pm, the Wellness Director agreed that Residents #9, #11, and #17 had prescribed medications or dietary supplements that were documented as not given to the residents. The Wellness Director stated that there was no evidence that Resident #9, #11, and #17's primary care provider and/or responsible parties were notified that the residents were not taking their medications or dietary supplements as prescribed. The Wellness Director agreed that the facility was not following the directions of use for Resident #11's prescribed medication. Class II	{A 056}		
{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	{A 078}		

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 _____	R-C 05/23/2024

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

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{A 078}	Continued From page 27 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 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 to provide 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.	{A 078}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{A 078}	Continued From page 28 (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 one (Staff D) of nine employees whose records was reviewed included written documentation from a health care provider stating that they are free from communicable . . . . . within 6 months prior to hire or within 30 days of hire Findings included: A review of employee records conducted on revealed Staff D was hired on . . . . . There was no statement from a health care provider indicating Staff D was free from communicable . . . . . in the record. An interview was conducted with the Administrative Assistant on at 11:14am, she agreed there was no written signed statement from a health care provider stating Staff D was free from communicable . . . . . in record. Class III	{A 078}		