

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932515	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 05/23/2024
NAME OF PROVIDER OR SUPPLIER OAKVIEW TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 7220 BAILLIE DRIVE NEW PORT RICHEY, FL 34653			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{A 000}	Initial Comments A second revisit to complaint investigation (complaint numbers (2024000305, 2024000795, and 2024001190), a revisit to biennial survey and complaint investigation (complaint number: 2024003233), and a complaint investigation (complaint number: 2024006369) were conducted at Oakview Terrace on Deficiencies were identified at the time of survey.	{A 000}			
{A 054} SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors.	{A 054}			

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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{A 054}	Continued From page 1 (c) For medications that serve as chemical _____, the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have medication doses noted on medication observation records (MORs) for one Resident (#9). Furthermore, the facility failed to immediately update (MORs) each time medications were offered or given to one Resident (#13) of nine sampled residents. Findings Included: A MORs review for Resident #9, conducted on _____, revealed that there was no dose noted for Resident #9's prescribed medications _____ and _____ / _____, DS (double strength). A MORs review for Resident #13, conducted on _____, revealed that Resident 13's prescribed _____ 50mcg was not documented as given on _____ at 08:00am. During an interview with the Wellness Director, conducted on _____ at 01:25pm, the Wellness Director agreed that there was no dose noted for Resident #9's prescribed medications _____ and _____ / _____, DS (double strength). The Wellness Director agreed that Resident #13's prescribed _____ 50mcg was not documented as given on _____ at 08:00am.	{A 054}			

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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 054}	Continued From page 2 Class III	{A 054}		