STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932515	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakview Terrace	**7220 Baillie Drive New Port Richey, FL 34653**

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)

List of Tags Cited:

St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

An unannounced complaint survey, CCR# 2013006387, was conducted on and .

The Oakview Terrace, assisted living facility, had deficiencies at the time of the visit.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS

Based on observations, interviews, and record reviews, the facility failed to provide a safe living environment, specifically, a staff member allowed an unknown person to remain alone in a 1 (Resident #6) of 6 residents sampled for record review which placed the resident at risk of harm and caused her fear.

Findings include:

Observation of the facility's entrance on at approximately 8:25am revealed that the front door had a code that had to be entered into a keypad for entrance to and exit from the facility. If a visitor arrived before 9:00am, the entrance doors to the facility were locked and the code was not displayed near the outer door.
Observation of the entrance on at approximately 9:35am revealed that the code for the keypad was placed near the outer door to allow any visitor entrance. There was a note posted on the front entrance that stated that all visitors must sign in and out. It also stated that home health, hospice, and medical personnel must sign in the 3rd party book and state what they were doing in the facility.
Review of Resident #6's record revealed that she was admitted to the facility on . Her health assessment, Form 1823 dated indicated she was alert and oriented.
Observation of Resident #6 on at approximately 10:45am revealed that she was mobile by the use of her powered wheelchair.
In the interview with Resident #6 on at approximately 10:45am, she explained about the theft of her purse on . She stated that she went in to take a nap and thought she had locked her door. The aide (Staff G) told the resident it was time to get up. The aide was surprised to find that the resident had company. A man was crouched down behind her lounge chair. The resident told the aide that she did not know him. Then the aide left. The resident thought Staff G was going to get somebody to help. The man came and set in the chair next to the bed. He stated her family sent him over because she was not getting the care that she was supposed to be getting. She asked him to tell her the name of her family and her doctor's name. He stated he left the names in the car. She told him he was not supposed to be there. He only left after she called the front desk with her cell phone and started screaming. The facility staff had called the police and her daughter. The police came to ask questions. She knew what the man had on and what he looked like. The police never found him. The receptionist saw him. He put a false name on the sign in sheet. He looked like college kid, young guy. He was

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dressed nicely. The resident stated she was very scared afterwards. He took her purse, and her hearing aides were in her purse. He took $15 and she didn't have her hearing for 5 weeks. She stated that the staff was now more alert. It had made the resident more alert. Now, staff asks visitors who they are visiting and they have to sign in. The desk was busy the day he came. He signed in and walked slowly to the . Now staff is more careful and the resident feels more secure.

Review of copies of handwritten reports from staff revealed their accounts of what happened on in regards to the incident with Resident #6:

- The receptionist, Staff H, reported that a young man walked into the building in front of a home health aide. They were both told to sign in by the receptionist. She believed he was a new family member because he acted like he had been in the building before and knew where he was going.
- The nursing assistant (aide), Staff G, reported that she walked into Resident #6's found a man sitting in the corner of the the resident was asleep. She stated he was dressed all in black. The resident woke up and saw him and did not know who he was. Staff G asked him who he was and he stated he was a visitor. The resident was really on whom he was and he asked Staff G to give them a few minutes, so Staff G left.
- The new receptionist on duty, Staff I, reported that she received a phone call from Resident #6 at approximately 10:28am stating that a strange man had been in her a black shirt and green pants. The receptionist told her that no one came past her with that description. While she was still on the phone with the resident, the man did come by her and she asked him what his business was in the building. He stated that he was there visiting his aunt. She told him that one of the residents said that he was in her that her purse was missing. He said to the receptionist that he accidentally went into the wrong that the lady freaked out. Staff I noticed that the man was carrying a plastic tote box and inside was a black object with blue and white. Later, when she was with the resident and looked in her her purse. She was told by the resident that it was a small black purse with blue and white ribbon on it.

In the interview with the director of nursing (DON) on at approximately 10:00am, she reported that Staff G, the aide who left the unknown man alone in the Resident #6 had been terminated.

Review of Staff G's employee record revealed that she had been terminated on because she "jeopardized and compromised the resident's safety. "

In the interview with Staff J on at approximately 12:35 p.m., she stated that the facility has 2 main receptionists, but she and other staff members rotate the desk for breaks and when one of the receptionists drives the facility van (She was watching the reception desk at the time of the interview). If visitors come through the front door they have them sign in, and if 3rd party providers or vendors come, they sign in their own book. The facility started a strict "sign in" for vendors and 3rd party providers after the incident with Resident #6, but regular visitors have always had to sign in. The receptionist is on the desk until 8:30pm and then the code comes off (that was posted near the entrance door) and then there is an alarm on the doors.

In the interview with the administrator on at approximately 12:50 p.m., she confirmed that there was now a strict policy for all 3rd party providers to show identification and list the reason for the visit. She stated that the policy was strict because the unknown man who came into Resident #6's carrying a tote box that was believed to be from a home health agency.

Class III

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0055-Medication - Storage and Disposal 58A-5.0185(6) FAC

Based on observations, interviews, and record reviews, the facility failed to properly secure medications for residents that received and/or medications. The facility also failed to remove expired medications from currently used medications.

Findings include:

Observation of a medication to a first floor common area on at approximately 10:35am revealed that the door to the medication open and the cabinets and refrigerator which held residents' medications were unlocked. The cabinets contained boxes of medications for use with a and the refrigerator held vials of different types of .
Some examples of the medications (treats conditions) for residents include: Resident #10 - 0.63mg; Resident #11 - (Iprat) 0.5mg/ (Alb) 3mg ( ); and Resident #12 - Iprat 0.5/Alb 3mg ( ). Some examples of residents' (treats) in the unlocked refrigerator include: Resident #13 - Lantus 100 units/ml, R 100units/ml; Resident #14 - 100units/ml, Lantus 100 units/ml; and Resident #15 - 100 units/ml, 100units/ml.
There was a box of 0.083% observed for Resident #16 that had expired in .
Observation of the same medication at approximately 6:10pm revealed that the door to the , the cabinets, and the refrigerator were still unlocked.
Interview with the director of nursing (DON) on at approximately 10:45am revealed that she had left the door to the medication .
In the interview with the DON on at 6:10pm, she acknowledged that the door was left unlocked again.
Interview with the administrator on at approximately 12:50pm revealed that the medication was found unsecured on held all the medications for residents that received medications and .

Class III

0165-Risk Mgmt & QA; Adverse Incident Report 429.23 FS; 58A-5.0241 FAC
Based on interviews and record reviews, the facility failed to report an adverse incident for 1 (Resident #6) of 6 residents sampled for record review.

Findings include:

In the interview with Resident #6 on at approximately 10:45 a.m., she explained about the theft **of her** purse on . She stated that she went in to take a nap and thought she had locked her door. The aide (Staff G) told the resident it was time to get up. The aide was surprised to find that the resident had company. A man was crouched down behind her lounge chair. The resident told the aide that she did not know him. Then the aide left. The resident thought Staff G was going to get somebody to help. The man came and set in the chair next to the bed. He stated her family sent him over because she was not getting the care that she was supposed to be getting. She asked him to tell her the name of her family and her doctor's name. He stated he left the

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names in the car. She told him he was not supposed to be here. He only left after she called the front desk with her cell phone and started screaming. The facility staff had called the police and her daughter.
Review of copies of handwritten reports from staff revealed their accounts of what happened on in regards to the incident with Resident #6:

- The receptionist, Staff H, reported that a young man walked into the building in front of a home health aide. They were both told to sign in by the receptionist. She believed he was a new family member because he acted like he had been in the building before and knew where he was going.
- The nursing assistant (aide), Staff G, reported that she walked into Resident #6's found a man sitting in the corner of the the resident was asleep. She stated he was dressed all in black. The resident woke up and saw him and did not know who he was. Staff G asked him who he was and he stated he was a visitor. The resident was really on whom he was and he asked Staff G to give them a few minutes, so Staff G left.
- The new receptionist on duty, Staff I, reported that she received a phone call from Resident #6 at approximately 10:28am stating that a strange man had been in her a black shirt and green pants. The receptionist told her that no one came past her with that description. While she was still on the phone with the resident, the man did come by her and she asked him what his business was in the building. He stated that he was there visiting his aunt. She told him that one of the residents said that he was in her that her purse was missing. He said to the receptionist that he accidentally went into the wrong that the lady freaked out. Staff I noticed that the man was carrying a plastic tote box and inside was a black object with blue and white. Later, when she was with the resident and looked in her her purse. She was told by the resident that it was a small black purse with blue and white ribbon on it.

Interview with the director of nursing on at approximately 7:00 p.m. revealed that she was not aware that the facility needed to call in an adverse incident when a man came in and stole a resident's purse.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Oakview Terrace
7220 Baillie Drive
New Port Richey, FL 34653

Dear Administrator:

Re: **CCR# 2013006387**

This letter reports the findings of a complaint survey that was conducted on , 2013, and , 2013, by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

for Patricia Reid Cauffman
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

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