STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964739	09/13/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Oak Tree Manor	**7770 128th Street N Seminole, FL 33776**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0004 - 58a-5.016 Fac - Licensure - Requirements S-S= C
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= J
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0077 - 58a-5.019(1) Fac - Staffing Standards - Administrators S-S= J
St - A - 0079 - 58a-5.019(4) Fac - Staffing Standards - Levels S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0090 - 58a-5.0191(11) Fac - Training - S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D
St - A - Z815 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses S-S= C

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

A complaint survey, CCR# 2013009685, was conducted on .

The Oak Tree Manor, assisted living facility, had deficiencies at the time of the visit.

0004-Licensure - Requirements 58A-5.016 FAC

Based on observation, interview and record review, the facility operated above their licensed capacity of 39 residents without obtaining approval from AHCA's Central Office.

Findings include:

During an investigation at the facility conducted on , the surveyor reviewed the facility's posted license. The surveyor noted that the facility was licensed for 39 residents. The surveyor also checked Floridahealthfinder.gov and verified that the facility was licensed for 39 residents.

On that same date, the surveyor reviewed the facility's admission/discharge log. Based on a review of the admission discharge log, the facility was providing bed space to 42 residents.

On that same date, when interviewed at 9:45 AM, the administrator said she believed she had 42 residents in house plus at least one resident in the hospital and confirmed she knew she was operating over her licensed capacity.

During a tour of the facility conducted that same date from approximately 1:20 PM - 2:10 PM, each resident was physically counted and 44 residents were observed in the facility.

Unclassified

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

Based on observation, interview and record review, the facility failed to provide a safe environment, free of and and respectful of the residents ' dignity and need for privacy for 7 of 9 sampled residents (Residents # 1- 6 and #9). Specifically, the facility restrained residents in wheelchairs with belts; in bed through the use of full-bed rails and in their by turning door knobs around so locked from the outside creating an unsafe environment in violation of fire codes.

Findings include:

During a complaint investigation conducted at the facility on at approximately 6:15 AM, the surveyor observed Resident #2 sitting at a table in her wheelchair while breakfast was being served. The surveyor observed that Resident #2 had what appeared to be a gait belt around her waist and around the back of the wheelchair. The belt was fastened in the back of the wheelchair and appeared to be out of Resident #2 ' s reach. (Photos taken).

On that same date at approximately 6:25 AM, the surveyor observed Resident #3 sitting at a table in her wheelchair. Resident #3 had a belt attached to the wheelchair fastened around her waist in the front. (Photo taken)

When interviewed on at approximately 2:30 PM, the administrator acknowledged that she knew that such as belts were not permitted in an assisted living facility and said that she used the belts to keep Resident #2 and Resident #3 far enough from the table so they could not reach the table and " pull on it. "

During a tour of the facility conducted on from approximately 9:45 AM - 12:10 PM, the surveyor observed full-bed rails in the under the beds belonging to Residents #2, 3, 4, 5 and 6. The surveyor also noted that the beds belonging to these residents had attachments for the rails on the beds. Throughout the tour, the surveyor noted full-bed rails under the beds belonging to approximately five additional residents outside of the sample. (Photos taken)

On that same date at approximately 9:55 AM, the surveyor interviewed Staff B outside of Resident #2 ' s When asked about the full-bed rails, Staff B said that the full-bed rails were put on the residents ' beds at night when residents went to bed and removed in the morning when staff went into the to get residents up and dressed for breakfast.

On that same date, during the tour conducted from approximately 9:45 AM-12:10 PM, the surveyor observed that the door knobs to the belonging to Residents #2, 3, 4, 5 and 9 appeared to be installed backwards. The lock under the door knob was on the outside of the . The surveyor observed this on approximately five additional outside of the resident sample throughout the tour.

On at approximately 2:00 PM, after conducting an inspection, a representative of the local fire

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department confirmed that the door knobs being installed backwards were a violation of the local fire codes; presented a threat to the safety of the residents and should be corrected immediately.

When interviewed that same date at approximately 2:35 PM, the administrator acknowledged using full-bed rails and said they were in place to keep residents from getting out of bed at night. The administrator also acknowledged that the door knobs were turned around on some of the resident and stated this was done to keep residents from locking themselves in their .

On at approximately 12:15 PM, the surveyor observed Resident #1 in her , lying on her bed. The surveyor noted that Resident #1 ' s not have a door or any means to people in the hallway from seeing into the . The surveyor then interviewed Resident #1 in her approximately 12:20 PM. Resident #1 stated that Staff C had come to her thirty minutes earlier to get Resident #1 up for lunch and change her. Resident #1 said she told Staff C she did not want to get up for lunch. Resident #1 said that approximately five minutes later, Staff D came into her I asked why she didn ' t want to get up for lunch. Resident #1 said that Staff D then said, " I 've got about ten state inspectors in this building. If you don 't get up and get changed and cleaned up, they're going to lock you up and put you away in a mental hospital. " Resident #1 said that Staff D also told her about a month ago that if she didn ' t follow the rules, she would be locked up in a mental hospital. Resident #1 also stated that the administrator had told her that if she did not do what she was asked to do at the facility, she would be sent to a mental hospital. When asked why her I no door, Resident #1 stated that Staff D had removed the door to her ..... ! months earlier " because I didn ' t comply. " Resident #1 also said she required assistance with dressing and stated that staff assisted her with dressing in the her bed in view of the doorway.

At 12:35 PM on that same date, the surveyor interviewed a representative from the Office of the Attorney General, who confirmed that at approximately 12:00 PM, while approaching Resident #1 ' s the hallway, he heard Staff D tell Resident #1 that if she needed to get up for lunch because " I've got about ten state inspectors here and if you don't get up, they're going to put you away in a mental hospital. "

On that same date at approximately 12:40 PM, the surveyor and an Adult Protective Investigator (API) from the Department of Children and Families interviewed Staff D. Staff D stated that Staff C asked him to go try to get Resident #1 up for lunch because she was "acting up " . Staff D said that he told Resident #1 that people from the state were in the building and said if she didn ' t get changed before lunch, she could be in trouble.

On that same date, when interviewed at approximately 2:25 PM, the administrator said she realized that Staff D became frustrated with Resident #1 and said that she had also advised Resident #1 in the past about the need to comply with the rules of the facility. The administrator also stated that Resident #1 ' s door had been removed approximately a year earlier because Resident #1 kept slamming it.

On , the surveyor reviewed Staff D ' s personnel file and observed documentation of a Level 1 background screen conducted on . On that same date, the surveyor checked AHCA ' s background screen website and the website stated "A new screening is required. " There was no documentation on the background screening website or in the personnel file indicating the required Level 2 background screen had

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been completed for Staff D.

During an interview conducted on at approximately 2:10 PM, the API from the Department of Children and Families (DCF) reported that she is verifying the DCF investigation for /other mental injury to Resident #1 by Staff D and for conditions hazardous on the part of the facility to the residents due to the use of the backward door locks.

Class I

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observation and interview, the facility failed to follow correct medication practices in assisting 2 of 9 sampled residents (Residents #5 and #9) with self-administration of medication. Facility staff failed to directly observe the residents take the medication, leading to unsecured medications in the facility.

Findings include:

On at approximately 7:30 AM, the surveyor observed pills on the dining next to Resident #5. No staff were present near Resident #5 providing assistance with self-administration of medication.
On that same date at approximately 7:31 AM, Resident #5 stated that when facility staff give her her pills, she saves "one pill to take at night" and brings it back to her .

On that same date at approximately 12:40 PM, Resident #5 stated that she keeps medications that she brings back to her a bottle in her drawer. The surveyor found a bottle of multiple pills in the drawer in Resident #5's . The bottle was unlabeled and the pills were different types and colors.

On that same date at approximately 1:05 PM, the surveyor interviewed Resident #9. Resident #9 stated that when the administrator brings medications to Resident #9, she sets it in front of her and walks away and does not watch her take the medication. Resident #9 said that the administrator does the same thing with other residents and said she has seen other residents wrap up the medications and put them in their pockets without taking them.

Class III

0054-Medication - Records 58A-5.0185(5) FAC
Based on interview and record review, the facility failed to ensure the Medication Observation Record (MOR) was signed at the time facility staff assisted with self-administration of the medication for 39 out of 41 residents.

Findings Include:

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1.) On when reviewing the facility's MOR, the surveyor observed that all the residents that receive scheduled morning medications on that date (39 out of 41) already had the MOR for that date signed. The morning medication pass had not yet taken place and no medication had been given.

2.) In an Interview with the Administrator on the same day at approximately 6:35 AM, the Administrator verbally admitted to pre-marking the MOR prior to giving the medications to the residents. The administrator also stated she completes the morning medication pass without assistance from any other staff.

Class III

0077-Staffing Standards - Administrators 58A-5.019(1) FAC

Based on observation, interview and record review, the facility's administrator failed to insure that 9 of 9 sampled residents (Residents #1-9) were provided adequate care, free of and the use of . The facility administrator also failed to provide appropriate oversight and knowingly operated the facility above it's licensed capacity of 39 residents.

Findings include:

During an investigation at the facility conducted on , the surveyor reviewed the facility's posted license. The surveyor noted that the facility was licensed for 39 residents. The surveyor also checked Floridahealthfinder.gov and verified that the facility was licensed for 39 residents.

On that same date, the surveyor reviewed the facility's admission/discharge log. Based on a review of the admission discharge log, the facility was providing bed space to 42 residents.

On that same date, when interviewed at 9:45 AM, the administrator said she believed she had 42 residents in house plus at least one resident in the hospital and confirmed she knew she was operating over her licensed capacity. The administrator stated that she planned to ask for an increase in bed space from Central Office and understood that she was over capacity but in the meantime, "I just can't say no."

During a tour of the facility conducted that same date from approximately 1:20 PM - 2:10 PM, each resident was physicalily counted and 44 residents were observed in the facility.

On that same date at approximately 6:15 AM, the surveyor observed Resident #2 sitting at a table in her wheelchair while breakfast was being served. The surveyor observed that Resident #2 had what appeared to be a gait belt around her waist and around the back of the wheelchair. The belt was fastened in the back of the wheelchair and appeared to be out of Resident #2 ' s reach. (Photos taken).
On that same date at approximately 6:25 AM, the surveyor observed Resident #3 sitting at a table in her wheelchair. Resident #3 had a belt attached to the wheelchair fastened around her waist in the front. (Photo

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taken)

When interviewed on at approximately 2:30 PM, the administrator acknowledged that she knew that such as belts were not permitted in an assisted living facility and said that she used the belts to keep Resident #2 and Resident #3 far enough from the table so they could not reach the table and " pull on it. "

During a tour of the facility conducted on from approximately 9:45 AM - 12:10 PM, the surveyor observed full-bed rails in the under the beds belonging to Residents #2, 3, 4, 5 and 6. The surveyor also noted that the beds belonging to these residents had attachments for the rails on the beds. Throughout the tour, the surveyor noted full-bed rails under the beds belonging to approximately five additional residents outside of the sample. (Photos taken)

On that same date at approximately 9:55 AM, the surveyor interviewed Staff B outside of Resident #2 ' s . When asked about the full-bed rails, Staff B said that the full-bed rails were put on the residents ' beds at night when residents went to bed and removed in the morning when staff went into the to get residents up and dressed for breakfast.

On that same date, during the tour conducted from approximately 9:45 AM-12:10 PM, the surveyor observed that the door knobs to the belonging to Residents #2, 3, 4, 5 and 9 appeared to be installed backwards. The lock under the door knob was on the outside of the . The surveyor observed this on approximately five additional outside of the resident sample throughout the tour.

On at approximately 2:00 PM, after conducting an inspection, a representative of the local fire department confirmed that the door knobs being installed backwards were a violation of the local fire codes; presented a threat to the safety of the residents and should be corrected immediately.

When interviewed that same date at approximately 2:35 PM, the administrator acknowledged using full-bed rails and said they were in place to keep residents from getting out of bed at night. The administrator also acknowledged that the door knobs were turned around on some of the resident and stated this was done to keep residents from locking themselves in their .

Class I

0079-Staffing Standards - Levels 58A-5.019(4) FAC
Based on interview and record review, the facility failed to maintain an accurate written work schedule for 6 of 6 sampled staff (Staff A-F), indicating which staff were scheduled to be in the facility at designated times providing care to residents.

Findings include:

During an investigation at the facility conducted on , the surveyor requested and reviewed the current

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staff schedule. The surveyor noted that according to the written schedule, Employees B and F were scheduled to work 7:00 AM - 7:00 PM with the administrator.
At 7:30 AM, the surveyor noted that Employee F was not present and Employees A, C and D were present in the facility.

The surveyor interviewed the administrator at 7:45 AM. The administrator stated, "The schedule really isn't accurate. We all just work the same shifts all the time."

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC
Based on interview and record review, the facility failed to ensure 1 of 4 staff (Staff C) had documentation of completing the required staff in-service training within 30 days from the date of hire. Specifically, there was no evidence that Staff C completed the following in-service trainings: emergency preparedness and evacuation, incident reporting, resident rights and recognizing and reporting resident , neglect and .

Findings Include:

On , a record review was completed on Staff C ' s personnel file. Staff C ' s hire date was .
No evidence was found that any of the above trainings were completed by Staff C.

On that same date at approximately 2:30 PM, an interview was completed with the facility administrator. The administrator acknowledged the findings and was asked about the missing documentation. The administrator was unable to produce verification that the required trainings were completed.

Class III

0090-Training - 58A-5.0191(11) FAC
Based on interview and record review, the facility failed to ensure 1 of 4 sampled staff (Staff C) had completed the required training on the facility ' s policy on . ( ) within 30 days from the date of hire.

Findings Include:

On , a record review was completed on Staff C (date of hire -) personnel file. No evidence was found that the required Training was completed.

On that same date at approximately 2:30 PM, an interview was completed with the facility administrator. The administrator acknowledged the finding and was asked about the missing documentation. The administrator was

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unable to produce verification that the required training was completed.

Class III

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC
Based on observation, interview and record review, the facility failed to maintain a safe living environment, free of hazards and in compliance with local health and fire codes for all residents (Residents #1-9).

Findings include:

The surveyor conducted a tour of the facility on , from approximately 10:00 AM - 11:20 AM. During the tour, the surveyor noted that one of the facility's labeled exits on the north side of the building was not accessible due to wheelchairs, walkers and other miscellaneous equipment piled in front of the door. The outside of the door had sand bags stacked in front of it.
The surveyor also observed the door knobs to the belonging to Residents #2, 3, 4, 5 and 9 appeared to be installed backwards. The lock under the door knob was on the outside of the .

On that same date at approximately 2:00 PM, after conducting an inspection, a representative of the local fire department confirmed that the blocked exit and the door knobs being installed backwards were a violation of the local fire codes; presented a threat to the safety of the residents and should be corrected immediately.

On that same date, an inspector from the local county health department's environmental division conducted an inspection of the facility's kitchen. When interviewed at approximately 2:40 PM, the health department inspector confirmed that the inspection was unsatisfactory and had multiple violations related to food storage, sanitation and hand washing practices.
On , the surveyor reviewed the inspection report from the health department's kitchen inspection conducted . The report noted unlabeled, uncooked food stored in the refrigerator, food stored covered only with paper towel, concerns about residents walking in and out of the kitchen and unclean kitchen equipment.

Class III

Z815-Background Screening; Prohibited Offenses 408.809, 435.02(2), 435.06

Based on interview and record review, the facility failed to conduct the required Level 2 background screening on 2 of 4 staff (Staff C and D) providing personal care and services to residents and having access to resident personal property and living areas.

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Findings Include:

On , a review of Staff C employee personnel file was conducted. A date of hire could not be determined with the contents of staff C personnel file. Eligible background screen verification was observed dated .

On that same date at approximately 9:10 am the facility administrator was asked about Staff C ' s hire date. The administrator left the returned with a partially completed application with the date written on the application. The administrator stated that Staff C was hired in 2012 but failed to give a specific date.

On , a review of Staff D employee personnel file was conducted. The surveyor observed documentation of a Level 1 background screen completed on .

On that same date, a search on the agency background screening website was conducted, which revealed a determination that a new background screen was required.

On that same date at approximately 2:30 PM, an interview was completed with the facility administrator who acknowledged the findings and stated that she did not know that a new background screening was required for Staff D.

Unclassified

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Oak Tree Manor
7770 128th Street N
Seminole, FL 33776

Dear Administrator:

Re: **CCR# 2013009685**

This letter reports the findings of a complaint survey that was conducted on , 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 Caufman
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone (727) 552-2000; Fax (727) 552-1161

RICK SCOTT
GOVERNOR

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Oak Tree Manor
DBA Oak Tree Manor, INC.
7770 128th Street North
Seminole, FL 33776
Attn: Christine Gibree, Administrator

Dear . Gibree:

This letter reports finding of a complaint investigation conducted on , 2013 by representatives of the Agency for Health Care Administration. **Within 10 business days from receipt of this letter, you are directed to comply with the tangible step outlined below in order to correct the deficient practice.** Attached are the deficiencies noted in the investigation.

The investigation resulted in findings of noncompliance with the following area:

1) A 030 – Resident Care – Rights and Facility Procedures – Class I – Your Assisted Living Facility failed to provide a safe environment, free of and . The facility failed to ensure resident's rights to privacy were respected.

2) A 077 – Staffing Standards – Administrator – Class I – Your facility failed to have an administrator providing appropriate supervision and oversight to insure that residents were receiving adequate care in an environment free of . The administrator knowingly permitted the facility to use unauthorized and to operate over their licensed capacity of 39 residents.

3) A 081 – Staff – In-Service Training – Class III – Your facility failed to insure that all staff received required trainings, including training in resident rights, recognizing , neglect and , incident reporting and emergency procedures.

4) A 090 – Staff – Training – Class III - Your facility failed to insure that all staff received training on your facility's policy for ( ).

5) A 004 – Licensure – Unclassified - Your facility knowingly admitted more than its licensed capacity of 39 residents.

6) Z 815 – Background Screens/Prohibited Offenses – Unclassified – Your facility failed to insure that all staff having contact with and providing care to residents had a current Level 2 background screen.

7) A 052 – Medication – Assistance with Self-Administration of Medication – Class III - Your facility failed to insure staff correctly assisted residents with self-administration of medications, including observing residents take the medications and insuring residents did not have access to unsecured medications.

8) A 054 _ Medication Records – Class III - Your facility failed to insure that Medication Observation Records (MORs) accurately reflected whether residents were taking medications as prescribed due to staff signing the MORs prior to assisting with self-administration of medications.

9) A 152 – Physical Plant – Safe Living Environment – Your facility failed to insure that the physical plant was a safe environment for the residents, in compliance with health and safety codes, including providing the residents with access to fire exits and allowing the residents the ability to leave their

Your facility must comply with the following:

1) All facility staff having contact with and providing direct care to residents must be re-trained on resident rights and recognizing , neglect and of adults. This training must be provided by a representative of the Department of Elder Affairs or the Department of Children and Families or an approved provider of one of these agencies. **This shall be completed within 10 days from the date of this letter.**

   Employee John Poole shall not have contact with residents of the facility prior to completing this training and having a current Level 2 background screen indicating he is eligible.

2) Your facility will insure that all employee files contain documentation of completing required staff trainings, including training on emergency procedures, incident reporting and evacuation procedures. All trainings must be completed according to required time frames and any staff that are not up to date on trainings shall not be scheduled to provide care to residents. **This shall be completed within 10 days from the date of this letter.**

3) Your facility will insure that all employee files, including any newly hired staff, contain documentation of a current Level 2 background screen indicating the employee is eligible. **This shall be completed within 10 days from the date of this letter.**

4) All facility staff providing assistance with self-administration to residents must be re-trained on correct medication practices by a licensed pharmacist or registered nurse using the 2012 Assistance with Self-Administration Medication Guide released by the Department of Elder Affairs and available on their website at: http://elderaffairs.state.fl.us/doea/publications.php. **This shall be completed within 10 days from the date of this letter.**

5) Your facility will insure that no are being used on residents, other than half-bed rails with permission from the resident or their representative and documentation from the resident's current medical provider. This documentation must be updated bi-annually. **This shall be completed within 10 days from the date of this letter.**

Half-bed rails are the ONLY allowed in an assisted living facility. No full-bed rails or wheelchair are permitted.

6) Your facility will correct the violations noted in the reports from the Pinellas County Health Department and City of Seminole Fire Department dated to insure that the residents' living environment is compliant with all health and fire codes. Your facility will install all door knobs on resident with the locks on the inside of the doors. Your facility will clear all marked emergency exits. Your facility must submit updated health and fire inspection reports to the St. Petersburg Field Office, indicating that the violations are corrected. **This shall be completed within 21 days from the date of this letter.**

7) Your facility will continue to follow the plan submitted to the St. Petersburg Field Office on to bring your census down to your licensed capacity.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact **Paul Brown**, ALF Supervisor, at 727-552-2000.

Sincerely,

Paul S Brown

Health Facility Evaluator Supervisor