STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968564	06/26/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Hidden Oaks Assisted Living	**945 7th St Nw Largo, FL 33770**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0084 - 58a-5.0191(5) Fac - Training - Assis Self-Admin Meds & Med Mgmt S-S= D
St - A - 0160 - 58a-5.024(1) Fac - Records - Facility S-S= D

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

An unannounced extended congregate care (ECC) monitoring visit was conducted on .

The Hidden Oaks Assisted Living, assisted living facility, had deficiencies at the time of the visit.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC

Based on observation, record review, and interview, the facility failed to ensure completion of all required items on the Resident Health Assessment for Assisted Living Facilities (AHCA Form 1823), by residents ' licensed health care provider and failed to ensure that required information that is not contained in the medical examination report conducted prior to the individual's admission to the facility is obtained by the administrator within 30 days after admission using AHCA Form 1823. The facility also failed to ensure completion of Section 3 of the form, Services Offered or Arranged by the Facility, by the facility Administrator or designee.

Findings include:

Two of two resident records selected for review on beginning at approximately 3:00pm contained incomplete Resident Health Assessments for Assisted Living Facilities (Form 1823). Items not provided by the health care provider bring into question the appropriateness of the residents for assisted living facility residence; however, both Assessments included a statement that on the day of the examination, in the opinion of the examining licensed health care provider, the individuals ' needs can be met in an assisted living facility.

Resident #1 was admitted into the facility on . Per Resident Health Assessment for Assisted Living Facilities (AHCA Form 1823) dated and revised Form faxed to the facility on , the medical doctor did not indicate whether Resident #1 needs 24-hour nursing or care. The Form indicates that Resident #1 Needs Assistance with all ADLs, except the resident ' s transferring needs are not specified. Whether resident needs help with taking medications is not completed-and, if assistance is needed, the type of assistance (medication administration or assistance with self- administration) is not indicated. Page 5 of the Form 1823--Services Offered or Arranged by the Facility for the Resident--is signed & dated / by the facility ' s Asst. Administrator, but none of the services offered or arranged by the facility are designated.

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Resident #2 was admitted into the facility on . Per Resident Health Assessment for Assisted Living Facilities (AHCA Form 1823) dated , Resident #2 needs medication administration. Per observation of Resident #2, interview with Staff A & Staff B, and review of Resident #2 ' s Medication Observation Record, Resident #2 is capable of, and is being provided with, assistance with self- administration of medication. Page 5 of the Form 1823--Services Offered or Arranged by the Facility for the Resident--is signed & dated by the facility ' s Asst. Administrator, but none of the services offered or arranged by the facility are designated.

Per interview conducted with Staff A on at approximately 4:00pm, Staff A acknowledged that the AHCA Form 1823s are missing information and stated that the Administrator takes care of those forms.

Class III

0054-Medication - Records 58A-5.0185(5) FAC

Based on observation, record review, and interview, the facility failed to maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications that includes the name of the resident and any known the resident may have, the name of the resident's health care provider & telephone number, and the name, strength, and directions for use of each medication per physician ' s orders. The facility also failed to ensure complete maintenance of the chart for recording each time a medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors, immediately updating each time a medication is offered.

Findings include:

Surveyor observed Staff A & Staff B providing residents assistance with self-administration of medications on beginning at approximately 2:00pm and reviewed the facility ' s Medication Observation Records. Four of 4 Medication Observation Records randomly selected for review contained errors and omissions as follows:

One (Resident #4) of four records did not indicate any known the resident may have. Two (Residents #4 & #7) of four records did not indicate the name & telephone number of the resident's health care provider.

Resident #1 was prescribed PRN Diphenoxyl/AT 2.5/.025mg-Take 2 teaspoonfuls (10ml) by mouth 3 times daily as needed for - Initialed as provided one to three times per day every day from / - ; no times or results provided on reverse page of Medication Observation Record and 8am, 2pm, & 8pm are written next to the PRN. Per interview with Staff A, a Home Health nurse wrote the times on the MOR but staff disregard them. The prescribing doctor was not contacted for a change of prescription.

Resident #3 was prescribed Ensure HP Vanilla 3x4x140z - Drink one can by mouth with breakfast and lunch 8am & 12pm - An " O " is marked for each dose from / - . At the top of the Medication Observation Record is written: " O=Out of medicine. " There is no explanation on the reverse page of the Medication Observation Record-no indication of contacting the resident ' s medical doctor and no record of attempts to provide the prescribed medication. Per interview with Staff A, that prescription should be discontinued because the resident does not need it any more. Per interview with Staff B, Resident #3 has not had any of this medication since he

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moved into the home (on).

Resident #3 was also prescribed PRN Acetamin ER 650mg tab - Take one tablet by mouth every 6 hours as needed for pain - Initialed as provided once per day on 24 of 26 days from 6/1/14- ; no times or results provided on reverse page of Medication Observation Record.

Resident #4 was prescribed 100mg Cap - Take one capsule 3x day 8am, 1pm, & 8pm-- An " A " is marked for 8pm dose through 1pm dose. Ten additional medications are similarly marked with an " A " during the same time period. At the top of the Medication Observation Record is written: " A=Away. " There is no explanation on the reverse page of the Medication Observation Record-no indication of whether resident took medications while " away. " Per interviews with Staff A & B, Resident #4 ' s family took his medications and a copy of the Medication Observation Record to assist Resident #4 with taking medications as prescribed while away from the facility. Staff A & B acknowledged that no record was kept of these medications being provided.

Resident #7 was prescribed 1mg tablet tab - Take one tablet by mouth twice daily 8am & 5pm -- Initialed as provided at 8am & 5pm on through (9 days) - An " O " is marked for each dose from through time of Surveyor visit. At the top of the Medication Observation Record is written: " O=Out of medicine. " There is no explanation on the reverse page of the Medication Observation Record-no indication of contacting the resident ' s medical doctor and no record of attempts to provide the prescribed medication.

Resident #7 was also prescribed Diludid 2mg Tab - No directions for use, purpose, or time specified -- Initialed as provided three to five times per day from through -no times specified; initials for having provided the medication originally placed 6/1 through whited out-cannot discern when or how often the medication was provided. Per Pharmacy Label: 2mg tablets - substituted for Diludid 2mg tab - Take 2 tablets by mouth every 4 hours as needed for pain. Per interview with Staff A, the resident is usually given one pill, sometimes 2, as they are trying to wean her off the med. There was no indication of contacting the resident ' s medical doctor for a revised order.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC

Based on observation, record review, and interview, the facility failed to ensure that any change in directions for use of a medication for which the facility is providing assistance with self-administration is accompanied by a written medication order issued and signed by the resident ' s health care provider and promptly recorded in the resident's medication observation record. The facility also failed 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.

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Findings include:

Surveyor observed Staff A & Staff B providing residents assistance with self-administration of medication on beginning at approximately 2:00pm and reviewed the facility ' s Medication Observation Records. Four of 4 Medication Observation Records randomly selected for review contained errors and omissions as follows:

Resident #1 was prescribed PRN Diphenoxyl/AT 2.5/.025mg Take 2 teaspoonfuls (10ml) by mouth 3 times daily as needed for - Initialed as provided one to three times per day every day from 6/1/14- ; no times or results provided on reverse page of Medication Observation Record and 8am, 2pm, & 8pm are written next to the PRN. Per interview with Staff A, a Home Health nurse wrote the times on the MOR but staff disregard them. The prescribing doctor was not contacted for a change of prescription.

Resident #3 was prescribed Ensure HP Vanilla 3x4x140z - Drink one can by mouth with breakfast and lunch 8am & 12pm - An " O " is marked for each dose from / - . At the top of the Medication Observation Record is written: " O=Out of medicine. " There is no explanation on the reverse page of the Medication Observation Record-no indication of contacting the resident ' s medical doctor and no record of attempts to provide the prescribed medication. Per interview with Staff A, that prescription should be discontinued because the resident does not need it any more. Per interview with Staff B, Resident #3 has not had any of this medication since he moved into the home (on).

Resident #3 was also prescribed PRN Acetamin ER 650mg tab - Take one tablet by mouth every 6 hours as needed for pain - Initialed as provided once per day on 24 of 26 days from / - ; no times or results provided on reverse page of Medication Observation Record.

Resident #4 was prescribed , 100mg Cap - Take one capsule 3x day 8am, 1pm, & 8pm-- An " A " is marked for 8pm dose through 1pm dose. Ten additional medications are similarly marked with an " A " during the same time period. At the top of the Medication Observation Record is written: " A=Away. " There is no explanation on the reverse page of the Medication Observation Record-no indication of whether resident took medications while " away. " Per interviews with Staff A & B, Resident #4 ' s family took his medications and a copy of the Medication Observation Record to assist Resident #4 with taking medications as prescribed while away from the facility. Staff A & B acknowledged that no record was kept of these medications being provided.

Resident #7 was prescribed , 1mg tablet tab - Take one tablet by mouth twice daily 8am & 5pm -- Initialed as provided at 8am & 5pm on through / (9 days) - An " O " is marked for each dose from through time of Surveyor visit. At the top of the Medication Observation Record is written: " O=Out of medicine. " There is no explanation on the reverse page of the Medication Observation Record-no indication of contacting the resident ' s medical doctor and no record of attempts to provide the prescribed medication.

Resident #7 was also prescribed Diludid 2mg Tab - No directions for use, purpose, or time specified -- Initialed as provided three to five times per day from through -no times specified; initials for having provided the medication originally placed 6/1 through whited out-cannot discern when or how often the medication was

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provided. Per Pharmacy Label: 2mg tablets - substituted for Diludid 2mg tab - Take 2 tablets by mouth every 4 hours as needed for pain. Per interview with Staff A, the resident is usually given one pill, sometimes 2, as they are trying to wean her off the med. There was no indication of contacting the resident ' s medical doctor for a revised order.

Class III

0078-Staffing Standards - Staff 58A-5.019(2) FAC

Based on record review and interview, the facility failed to ensure that newly hired staff submitted a statement from a health care provider, based on an examination conducted within the previous six months, that the person does not have any signs or symptoms of a communicable including . Failure to ensure that all staff are free from communicable (s) including places residents, employees, and facility visitors at risk of adverse medical consequences.

Findings include:

One of three employee records selected for review on at approximately 2:30pm contained no evidence of newly hired staff having submitted within 30 days of hire a statement from a health care provider, based on an examination conducted within the previous six months, that the person does not have any signs or symptoms of a communicable including .

Staff A was hired as a Live-in Caregiver/Medication Technician on / -employee ' s records contained a statement of freedom from communicable dated based on testing -There was no evidence of testing or statement of freedom from communicable within the previous six months of hire date.

Per interview conducted with Staff A on at approximately 4:00pm, she was unaware of the need for current testing.

Class III

0084-Training - Assis Self-Admin Meds & Med Mgmt 58A-5.0191(5) FAC

Based on observation, record review, and interview, the facility failed to ensure that 1 of 3 staff who provides residents assistance with self-administration of medications has successfully completed annual 2-hour updates on providing assistance with self-administration of medications and safe medication practices in an assisted living facility. Providing assistance with self-administration of medications without completing the required trainings puts residents at risk of adverse medical consequences.

Findings include:

Per review of the facility's employee records conducted on beginning at approximately 1:30 p.m., Staff A was hired as a Live-in Caregiver/Medication Technician on / .

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Surveyor observed Staff A providing residents assistance with self-administration of medications on . Per review of the facility ' s Medication Observation Records, Staff A has provided residents assistance with self-administration of medications throughout the current month of , 2014. Per interview with Staff A, she has provided residents assistance with medications since becoming employed by the facility on / and previously took the required 4-hour training in providing assistance with self-administration of medications.

Surveyor review of the personnel record for staff A revealed that staff A completed 4 hours of initial medication training on / . As of record review, there was no evidence of any medication training beyond / -- there was no evidence of completion of annual 2-hour training updates on providing assistance with self-administration of medications and safe medication practices in an assisted living facility.

Per interview conducted with Staff A on at approximately 2:00pm, Staff A pointed out a posted list of free trainings provided by the facility ' s pharmacist and acknowledged that she should attend one of the classes.

Class III

0160-Records - Facility 58A-5.024(1) FAC

Based on observation, record review, and interview, the facility failed to maintain an up-to-date admission and discharge log listing the names of all residents, each resident's date of admission, and the place from which the resident was admitted.

Findings include:

Per interview conducted with Staff A on at approximately 1:00pm, the facility ' s current census is 9 residents.

Per review of the facility ' s Admission and Discharge Log conducted on beginning at approximately 1:30pm, only 8 current residents are listed on the Log. There is no entry for Resident #7 in the Admission and Discharge Log. Surveyor observed Resident #7 in the facility on the day of visit and selected Resident #7 ' s medication record for review. Resident #7 requested medications from Staff A while Surveyor was reviewing facility records with Staff A.

Per further review of the facility ' s Admission and Discharge Log, there is no indication on the Admission and Discharge Log of the place from which Residents #2, #5, and #9 were admitted.

Per interview conducted with Staff A on at approximately 4:00pm, Staff A confirmed that Resident #7 is a resident of the facility and is not listed on the facility ' s Admission and Discharge Log.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Hidden Oaks Assisted Living
945 7th St Nw
Largo, FL 33770

Dear Administrator:

This letter reports the findings of an extended congregate care (ECC) monitoring visit that was conducted on , 2014, by representative(s) 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 after 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(s). 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

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