AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968564	11/02/2015
NAME OF PROVIDER OR SUPPLIER **HIDDEN OAKS ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **945 7TH ST NW** **LARGO, FL 33770**	

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

0000 Initial Comments

Assisted Living Facility Complaint

A complaint investigation (CCR# 20150011362) was conducted on / through / at Hidden Oaks Assisted Living located at 945 7th St NW, Largo, FL. Hidden Oaks Assisted Living had deficiencies at the time of the investigation.

0025 Resident Care - Supervision

Based on interview and record review, the facility failed to be aware of the general health, safety, and physical and emotional well-being of 3 out of 5 (Residents #1, 3, and 6) sampled residents. The facility failed to contact the resident ' s primary care physician regarding a significant change, and failed to maintain a written record of any significant change that required medical attention. The facility also failed to ensure that qualified staff (Administrator and Staff B) with training in first aid and ( ) deemed eligible by the agency through Level II background screen supervised residents and failed to ensure residents received care to meet their needs including prescribed medications.

Findings include:

On at 2:40 PM an interview was conducted with Resident #3. Resident #3 stated that on / he found Resident #6 in the and called 911. Resident #3 stated paramedics and police came to the facility. Resident #6 is no longer at the facility and whereabouts are unknown.
On at 1:55 PM a record review was conducted of Resident #6's resident chart. No documentation was found regarding the incident in which Resident #6 was found in the 911 was called. No documentation was found in Resident #6 ' s chart regarding contact with his primary care physician.
On at 3:33 PM an interview was conducted with the Administrator. The Administrator stated he did not document in Resident #6 ' s chart anything about the recent incident that occurred where 911 had to be called. He stated he did not request Staff C fill out an incident report or write a statement. He stated he did not document anything in the Resident ' s chart about contacting his primary care physician. The Administrator stated Resident #6 had been through about 10 primary care doctors during his time in the facility, and the Administrator was not sure which doctor Resident #6 was currently seeing.
On at 10:45 AM a record review was conducted of the employee file for Staff B. Staff B did

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not have training in First Aid.
On at 12:15 PM a record review was conducted of the Administrator ' s employee file. The Administrator had not been trained in First Aid and .
On at 12:20 PM an interview was conducted with the Administrator. He stated he is occasionally alone with the residents. The Administrator stated he has not taken the required training for First Aid and . The Administrator was aware that an employee who was trained in First Aid and must be in the building at all times.
On at 1:10 PM an interview was conducted with Staff B. Staff B stated she works alone in the facility with the residents on a daily basis. Staff B was not aware she was required to have training in First Aid.
On at 10:45 AM a record review was conducted of the employee file for Staff A. Staff A wrote on her employment application that she had ended prior employment with an Assisted Living facility . Her application for Hidden Oaks Assisted Living facility was dated .
On at 10:45 AM a record review was conducted for the employee file for Staff C. Her Level II BGS was completed on . Her application and hire date for Hidden Oaks Assisted Living Facility was / / . Staff C had one employer listed on her application, and she ended her employment on / / . No additional employers were identified.
On at 1:15 PM an interview was conducted with Staff A. Staff A stated she had ended her employment with the previous facility at the beginning of 2014. She was not employed in a position that required a Level II background screening from the beginning of until she began in her current position on . She stated the facility did not require her to get a new Level II background screening when she started this position.
On at 3:33 PM an interview was conducted with the Administrator. He stated he thought Staff A had been employed at an Assisted Living Facility " as needed " during her time off. He spoke with her and verified she had not worked, and then said " I guess you ' re right. "
On at 3:33 PM a continued interview was conducted with the Administrator. When informed that per Staff C ' s employee file she had a break longer than 90 days in a position that required a Level II background screening, and he had failed to have her obtain a new Level II background screening, he stated " Ok. "
On at 2:40 PM an interview was conducted with Resident #3. Resident #3 stated he had been provided with one on / / when he first arrived at the facility. Resident #3 did not like the way it made him feel and he stopped taking them. Resident #3 stated he later asked Staff C for his medication and she told him she had " gotten rid of " his medication. When Resident #3 asked how they had been disposed of, she refused to answer. Resident #3 stated Staff C later told him she returned them to the pharmacy, but would not say to which pharmacy they had been returned.
On at 2:50 PM a record review was conducted of Resident #3 ' s Medication Observation Record (MOR) for the month of . The MOR documented that Resident #3 first received on at 8pm, and then on at 2pm. Both were signed by Staff C. Staff C also signed that

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she had provided to Resident #3 on at 3pm, / at 8am, and / at 8pm. A MOR for Resident #3 for the month of could not be located.
On at 3:38 PM a follow-up interview was conducted with Resident #3. Resident #3 was shown his MOR. Resident #3 stated the MOR had been falsified. Resident #3 stated he had a prescription for that had 60 pills, and he took one. He stated there should be 59 pills remaining.
On at 3:33 PM an interview was conducted with the Administrator. The Administrator stated he had heard from Resident #3 that he did not like the way the made him feel, and he was not taking it. The Administrator stated Staff C had told him she sent the medication back to the pharmacy. The Administrator had no documentation that any had been destroyed or returned to the pharmacy. The Administrator stated he " tore apart the med cart " but could not prove any medications had been taken. The Administrator stated he did not report the missing to the police or to the Agency.
On at 3:09 PM an interview was conducted with Resident #1. Resident #1 stated the facility previously had control of his medications, but that his disappeared, so he requested control of his medications. Resident #1 stated the Administrator instructed Staff C to give him all of his medications, and Staff C returned 8 pills, not the 48 pills he should have had remaining. Staff C stated " this is the best I can do. " Resident #1 stated he reported both situations to the Administrator.
On at 1:55 PM an interview was conducted with Staff B. Staff B was not able to locate a resident file for Resident #1. Staff B stated the facility previously had possession of Resident #1 ' s medication, but the Resident now has them in his takes his own medication. She was not sure if a physician had been consulted. She could not locate an Agency form 1823 signed by a physician showing that Resident #1 was capable of administering his own medications.
On at 3:33 PM an interview was conducted with the Administrator. The Administrator did not know where the file for Resident #1 was located. The Administrator stated it was possible that Staff C took Resident #1 ' s file with her when she left. The Administrator stated he was not aware of how many pills had been returned to Resident #1 by Staff C. He stated he does not have a record of the medication because it would have been documented in the resident chart which they are unable to locate.

Class II

0030 Resident Care - Rights & Facility Procedures

Based on interview and record review, the facility failed to provide a safe and decent living environment, free from and neglect, to 4 out of 5 (Residents 1, 2, 3, and 4) sampled residents; the facility failed to treat the residents with consideration and respect. Specifically, the facility failed to protect the residents from physical and by Staff C.

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Findings include:

On at 3:09 PM an interview was conducted with Resident #1. Resident #1 stated Staff C had threatened him on multiple occasions. Resident #1 stated Staff C physically grabbed him on . Resident #1 stated Staff C also stole his medications. Resident #1 stated he informed the Administrator of these events, but nothing was done. Resident #1 stated he was afraid of Staff C, and that she was unpredictable. Resident #1 stated Staff C had locked him out of the building on at least one occasion. He stated she and Resident #6, who was reportedly her boyfriend, would leave the facility to drink, and would leave the facility without any staff at night.

On at 4:16 PM an interview was conducted with Resident #2. Resident #2 stated she was very afraid of Staff C. Resident #2 stated she had been threatened on several occasions by Staff C. Resident #2 stated " it was a nightmare. " Resident #2 stated she also heard Staff C yell and curse at other residents. Resident #2 stated she witnessed Staff C drinking while on duty. Resident #2 stated Staff C handed Resident #2 a handful of pills that Staff C had pulled out of her pocket and told her to take them, in an attempt to keep the police from finding them in Staff C ' s pocket. Resident #2 stated the pills were not prescribed to her. Resident #2 stated she spit them into the toilet and flushed them.

On at 2:40 PM an interview was conducted with Resident #3. Resident #3 stated Staff C entered his at night wearing only " tiny turquoise panties " , kicked his bed, told him to get out of the facility, threatened him, and screamed obscenities at him. Resident #3 stated he has been afraid of Staff C. Resident #3 stated Staff C has stolen his medication. Resident #3 stated Staff C continues to come into the facility because she has a key.

On at 10:03 AM an interview was conducted with Resident #4. Resident #4 stated she was afraid of Staff C. She stated Staff C is " vindictive " and she did not want to " get on her bad side " . Resident #4 stated she witnessed Staff C " completely drunk " while working. Resident #4 also witnessed Staff C yelling at other residents. Resident #4 stated she was concerned because Staff C continues to return to the facility even though she no longer works there.

On at 1:15 PM an interview was conducted with Staff A. Staff A stated the reason she left employment with the facility for two months was because of Staff C. She stated she had witnessed Staff C yell at residents. She stated she reported the occurrences to the Administrator. Staff A was concerned that Staff C had stolen the medications of several residents. Staff A stated Staff C continues to come into the building with a key.

On at 9:45 AM an interview was conducted with Staff B. Staff B was not aware of the proper procedure to report suspected or neglect to the Department of Children & Families (DCF) hotline. Staff B was not aware of the term " mandatory reporter. " Staff B stated she had not been trained on the facility ' s policy and procedure on recognizing and reporting , neglect and

On at 3:33 PM an interview was conducted with the Administrator. The Administrator stated

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he had been told by Residents #1 and #3 that the residents were afraid of Staff C. Resident #2 had told the Administrator that she was afraid of Staff C. The Administrator stated he had questioned Staff C and that he " wrote her up " but failed to report any of the alleged to the Department of Children & Families (DCF) hotline. The Administrator stated he had been told by a Detective on that Staff C had hidden pills in Resident #3 ' s . The Administrator stated he never reported any of the alleged to DCF because all of the incidents appeared to occur in isolation, so he had no proof. The Administrator stated he was aware that he was a mandatory reporter and that he was required to report suspected and neglect. The Administrator stated he realized he had not handled the situation properly.
On at 5:20 PM a review was made of the facility ' s incident reports. No incident reports had been documented for any of the resident ' s reported concerns.
On at 5:20 PM a review was conducted of the facility ' s and Neglect policy. Per the facility ' s policy on recognizing and reporting , neglect, and , any employee who suspects or witnesses or neglect, must call in a report to the DCF hotline. The Administrator failed to adhere to the facility ' s written policy.
On at 5:25 PM an interview was conducted with the Administrator. The Administrator stated he realized he had not followed his own facility ' s policy on reporting suspected or neglect to the DCF hotline.

Class II

0050 Medication - Self Administered Medications

Based on interview and record review, the facility failed to obtain documentation from a healthcare provider indicating that 1 out of 1 (Resident #1) sampled residents was capable of self-administering his own medications.

Findings include:

On at 3:09 PM an interview was conducted with Resident #1. Resident #1 stated the facility previously had control of his medications, but that his disappeared, so he requested control of his medications. Resident #1 stated the Administrator instructed Staff C to give him all of his medications. Resident #1 stated he now has his medications in his his own control.
On at 1:55 PM an interview was conducted with Staff B. Staff B was not able to locate a resident file for Resident #1. Staff B stated the facility previously had possession of Resident #1 ' s medication, but the Resident now has them in his takes his own medication. She was not sure if a physician had been consulted. She could not locate an Agency form 1823 signed by a physician showing that Resident #1 was capable of administering his own medications.

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On at 12:22 PM a record review was attempted of Resident #1 ' s file. Only the Medication Observation Record (MOR) could be located for the month of . The MOR had been filled out from / through .
On at 3:33 PM an interview was conducted with the Administrator. The Administrator did not know where the file for Resident #1 was located. The Administrator stated he did not know what they had used to make the determination that Resident #1 was competent to administer his own medications. The Administrator stated it was possible that Staff C took Resident #1 ' s file with her when she left.

Class III

0054 Medication - Records

Based on interview and record review, the facility failed to ensure that 2 out of 2 staff (Staff A and B) immediately updated the medication observation record (MOR) each time the medication is offered or administered.

Findings include:

On at 12:56 PM an observation was conducted as Staff B offered medication to Resident #2.
On at 12:56 PM a record review was conducted of the MOR for Resident #2. It was documented on the MOR that Resident #2 did not receive any of her medications from / through . No explanation was documented on the back of the MOR. The MOR was not signed from through . A second MOR was located that was handwritten and signed on , , , and for . It was signed on at 8:00 AM for , , , , , , and . It was signed at 2:00 PM on , , and for . The MOR was not signed on or for any other medication besides and .
On at 12:56 PM an interview was conducted with Staff B. Staff B stated Resident #2 had been in the hospital from / through . Staff B stated Resident #2 had received her medications this morning at 8:00 AM. Staff B stated she was in the facility to witness it, but Staff A was the employee who had offered medications this morning in the facility. Staff B stated she had been in the facility the previous day and could not comment why she had not signed the MOR.
On at 1:15 PM an interview was conducted with Staff A. Staff A stated Resident #2 ' s medications come in prepackaged envelopes. Staff A pulled Resident #2 ' s medications from the cart to verify they had been provided. Staff A stated was not in the building, and the pharmacy is delivering that tonight. Staff B stated both of Resident #2 ' s , prescriptions were new and were not in the building. Staff A stated she had not signed the MOR, but that she had provided the medications at the appropriate times.

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On at 1:15 PM an interview was conducted with Staff B. Staff B stated she had signed the MOR indicating that she had provided to Resident #2 at 8:00 AM on . She stated " that is my mistake. "
On at 3:33 PM an interview was conducted with the Administrator. The Administrator stated he was aware that all of his employees needed to be retrained on assisting with self-administration of medications.

Class III

0055 Medication - Storage and Disposal

Based on interview, observation, and record review, the facility failed to appropriately store medications for 1 out of 1 sampled residents; specifically, Staff C " disposed " of medication that was not expired and should have been returned to the resident or his representative, or should have been stored in the facility for future use by the resident.

Findings include:

On at 2:40 PM an interview was conducted with Resident #3. Resident #3 stated he had been provided with one on when he first arrived at the facility. Resident #3 did not like the way it made him feel and he stopped taking them. Resident #3 stated he later asked Staff C for his medication and she told him she had " gotten rid of " his medication. When Resident #3 asked how they had been disposed of, she refused to answer. Resident #3 stated Staff C later told him she returned them to the pharmacy, but would not say to which pharmacy they had been returned.
On at 2:50 PM a record review was conducted of Resident #3 ' s Medication Observation Record (MOR) for the month of . The MOR documented that Resident #3 first received on at 8pm, and then on at 2pm. Both were signed by Staff C. Staff C also signed that she had provided to Resident #3 on / at 3pm, / at 8am, and / at 8pm. A MOR for Resident #3 for the month of could not be located.
On at 3:38 PM a follow-up interview was conducted with Resident #3. Resident #3 was shown his MOR. Resident #3 stated the MOR had been falsified. Resident #3 stated he had a prescription for that had 60 pills, and he took one. He stated there should be 59 pills remaining.
On at 3:33 PM an interview was conducted with the Administrator. The Administrator stated he had heard from Resident #3 that he did not like the way the made him feel, and he was not taking it. The Administrator stated Staff C had told him she sent the medication back to the pharmacy. The Administrator had no documentation that any had been destroyed or returned to the pharmacy. The Administrator stated he " tore apart the med cart " but could not prove any medications had been taken. The Administrator stated he did not report the missing to the police or to the

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Class III

0077 Staffing Standards - Administrators

Based on interview and record review, the facility Administrator failed to provide appropriate oversight of the facility ' s employees, failed to prevent verbal and of the residents, failed to prevent the theft of medications, failed to report the theft of medications, failed to appropriately train the facility staff to perform their required duties, failed to follow the facility ' s incident reporting policy, and failed to report or neglect to the Department of Children & Families hotline.

Findings include:

On at 3:09 PM an interview was conducted with Resident #1. Resident #1 stated the facility previously had control of his medications, but that his disappeared, so he requested control of his medications.
On at 3:33 PM an interview was conducted with the Administrator. The Administrator stated he did not document in Resident #6 ' s chart anything about a recent incident that occurred where 911 had to be called. He stated he did not request Staff C fill out an incident report or write a statement. He stated he did not document anything in the Resident ' s chart about contacting his primary care physician. The Administrator stated Resident #6 had been through about 10 primary care doctors during his time in the facility, and the Administrator had not kept record of which doctor Resident #6 was currently seeing, so he was therefore unable to contact his current primary care physician.
On at 2:40 PM an interview was conducted with Resident #3. Resident #3 stated he had been provided with one on when he first arrived at the facility. Resident #3 did not like the way it made him feel and he stopped taking them. Resident #3 stated he later asked Staff C for his medication and she told him she had " gotten rid of " his medication. When Resident #3 asked how they had been disposed of, she refused to answer. Resident #3 stated Staff C later told him she returned them to the pharmacy, but would not say to which pharmacy they had been returned.
On at 2:50 PM a record review was conducted of Resident #3 ' s Medication Observation Record (MOR) for the month of . The MOR documented that Resident #3 first received on at 8pm, and then on at 2pm. Both were signed by Staff C. Staff C also signed that she had provided to Resident #3 on at 3pm, / at 8am, and / at 8pm. A MOR for Resident #3 for the month of could not be located.
On at 3:38 PM a follow-up interview was conducted with Resident #3. Resident #3 was shown his MOR. Resident #3 stated the MOR had been falsified. Resident #3 stated he had a prescription for that had 60 pills, and he took one. He stated there should be 59 pills remaining.

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On at 3:33 PM an interview was conducted with the Administrator. The Administrator stated he had heard from Resident #3 that he did not like the way the made him feel, and he was not taking it. The Administrator stated Staff C had told him she sent the medication back to the pharmacy. The Administrator had no documentation that any had been destroyed or returned to the pharmacy. The Administrator stated he " tore apart the med cart " but could not prove any medications had been taken. The Administrator stated he did not report the missing to the police or to the Agency.

On at 3:09 PM an interview was conducted with Resident #1. Resident #1 stated Staff C had threatened him on multiple occasions. Resident #1 stated Staff C physically grabbed him on . Resident #1 stated Staff C also stole his medications. Resident #1 stated he informed the Administrator of these events, but nothing was done. Resident #1 stated he was afraid of Staff C, and that she was unpredictable. Resident #1 stated Staff C had locked him out of the building on at least one occasion. He stated she and Resident #6, who was reportedly her boyfriend, would leave the facility to drink, and would leave the facility without any staff at night.

On at 4:16 PM an interview was conducted with Resident #2. Resident #2 stated she was very afraid of Staff C. Resident #2 stated she had been threatened on several occasions by Staff C. Resident #2 stated " it was a nightmare. " Resident #2 stated she also heard Staff C yell and curse at other residents. Resident #2 stated she witnessed Staff C drinking while on duty. Resident #2 stated Staff C handed Resident #2 a handful of pills that Staff C had pulled out of her pocket and told her to take them, in an attempt to keep the police from finding them in Staff C ' s pocket. Resident #2 stated the pills were not prescribed to her. Resident #2 stated she spit them into the toilet and flushed them.

On at 2:40 PM an interview was conducted with Resident #3. Resident #3 stated Staff C entered his at night wearing only " tiny turquoise panties " , kicked his bed, told him to get out of the facility, threatened him, and screamed obscenities at him. Resident #3 stated he has been afraid of Staff C. Resident #3 stated Staff C has stolen his medication. Resident #3 stated Staff C continues to come into the facility because she has a key.

On at 10:03 AM an interview was conducted with Resident #4. Resident #4 stated she was afraid of Staff C. She stated Staff C is " vindictive " and she did not want to " get on her bad side " . Resident #4 stated she witnessed Staff C " completely drunk " while working. Resident #4 also witnessed Staff C yelling at other residents. Resident #4 stated she was concerned because Staff C continues to return to the facility even though she no longer works there.

On at 1:15 PM an interview was conducted with Staff A. Staff A stated the reason she left employment with the facility for two months was because of Staff C. She stated she had witnessed Staff C yell at residents. She stated she reported the occurrences to the Administrator. Staff A was concerned that Staff C had stolen the medications of several residents. Staff A stated Staff C continues to come into the building with a key.

On at 9:45 AM an interview was conducted with Staff B. Staff B was not aware of the proper procedure to report suspected ' or neglect to the Department of Children & Families (DCF)

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hotline. Staff B was not aware of the term " mandatory reporter. " Staff B stated she had not been trained on the facility ' s policy and procedure on recognizing and reporting , neglect and

On at 3:33 PM an interview was conducted with the Administrator. The Administrator stated he had been told by Residents #1 and #3 that the residents were afraid of Staff C. Resident #2 had told the Administrator that she was afraid of Staff C. The Administrator stated he had questioned Staff C and that he " wrote her up " but failed to report any of the alleged to the Department of Children & Families (DCF) hotline. The Administrator stated he had been told by a Detective on / that Staff C had hidden pills in Resident #3 ' s . The Administrator stated he never reported any of the alleged to DCF because all of the incidents appeared to occur in isolation, so he had no proof. The Administrator stated he was aware that he was a mandatory reporter and that he was required to report suspected and neglect. The Administrator stated he realized he had not handled the situation properly.

On at 5:20 PM a review was made of the facility ' s incident reports. No incident reports had been documented for any of the resident ' s reported concerns.

On at 5:20 PM a review was conducted of the facility ' s and Neglect policy. Per the facility ' s policy on recognizing and reporting , neglect, and , any employee who suspects or witnesses or neglect, must call in a report to the DCF hotline. The Administrator failed to adhere to the facility ' s written policy.

On at 5:25 PM an interview was conducted with the Administrator. The Administrator stated he realized he had not followed his own facility ' s policy on reporting suspected or neglect to the DCF hotline.

Class II

0078 Staffing Standards - Staff

Based on interview and record review, the facility failed to ensure that 3 out of 3 (Staff A, Staff B, and Staff C) employees had annual documentation that the employee is free from ( ); the facility failed to ensure that staff was trained and qualified to perform their assigned duties.

Findings include:

On at 10:45 AM a record review was conducted of the employee file for Staff A. The most recent documentation that Staff A was free from was dated / .

On at 10:45 AM a record review was conducted of the employee file for Staff B. The most recent documentation that Staff B was free from was dated .

On at 10:45 AM a record review was conducted of the employee file for Staff C. The most

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recent documentation that Staff C was free from was dated / . Staff C remained employed in the facility until / / .
On at 1:15 PM an interview was conducted with Staff A. Staff A stated she had just gone to obtain a test because she was out of compliance for her annual rescreening.
On at 3:33 PM an interview was conducted with the Administrator. The Administrator stated he was aware that Staff A, Staff B, and Staff C were all out of compliance for their annual testing.
On at 9:45 AM an interview was conducted with Staff B. Staff B was unaware of who had provided her training, and stated all of her training took about 3 hours to complete. Staff B denied receiving training on Elopement Response, emergency preparedness and evacuation, incident reports, recognizing and reporting , neglect and Policy & Procedures (P&P), and Extended Congregate Care (ECC). Staff B did not know what the word " elopement " meant, and she was not able to provide the appropriate facility response to an elopement. Staff B did not know what control was or how to put it into effect while working in the facility. Staff B was not aware of what to do in an emergency or how to assist with evacuating the residents. She stated that type of training would be helpful. Staff B had not heard of the term Extended Congregate Care (ECC) and was unaware of what the initials stood for.
On at 10:45 AM a record review was conducted of the employee file for Staff B. The employee file showed that Staff B received 15 hours of training by the Administrator on / .
On at 3:33 PM an interview was conducted with the Administrator. The Administrator stated he could not say on which days the training was provided. He stated he could not remember if the trainings were all conducted on one day or not. He stated he printed out the certificate and signed it on the day that all of the trainings were complete. He was not aware that Staff B was unaware of the facility ' s policy on elopement, reporting and neglect, or emergency preparedness and evacuation.

Class III

0083 Training - First Aid and

Based on interview and record review, the facility failed to ensure that 2 out of 4 employees sampled (Administrator and Staff B) who are left alone with the residents holds a currently valid card documenting completion of training in First Aid and ( ).

Findings include:

On at 10:45 AM a record review was conducted of the employee file for Staff B. Staff B did not have training in First Aid.
On at 12:15 PM a record review was conducted of the Administrator ' s employee file. The Administrator had not been trained in First Aid and .

AGENCY FOR HEALTH CARE ADMINISTRATION

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	AL11968564	11/02/2015
NAME OF PROVIDER OR SUPPLIER **HIDDEN OAKS ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **945 7TH ST NW** **LARGO, FL 33770**	

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

On at 12:20 PM an interview was conducted with the Administrator. He stated he is occasionally alone with the residents. The Administrator stated he has not taken the required training for First Aid and . The Administrator was aware that an employee who was trained in First Aid and must be in the building at all times.
On at 1:10 PM an interview was conducted with Staff B. Staff B stated she works alone in the facility with the residents on a daily basis. Staff B was not aware she was required to have training in First Aid.

Class III

0084 Training - Assis Self-Admin Meds & Med Mgmt

Based on interview and record review, the facility failed to ensure that 1 out of 3 (Staff A) employees had completed the 4 hour initial training in assistance with self-administration of medication, and 3 out of 3 (Staff A, Staff B, and Staff C) obtained the 2 hour training update for assistance with self-administration of medication.

Findings include:

On at 10:45 AM a record review was conducted of the employee file for Staff A. No documentation could be located that Staff A had received her initial 4-hour training in Assistance with Self-Administration of Medications. No documentation was located in the employee file for Staff A for the annual 2 hour update for assistance with self-administration of medication.
On at 10:45 AM a record review was conducted of the employee file for Staff B. Staff B had last received 4 hours of training on . No documentation could be located in the employee file for Staff B for the annual 2 hour update for assistance with self-administration of medication.
On at 10:45 AM a record review was conducted of the employee file for Staff C. Staff C had last received 4 hours of training on / . No documentation could be located in the employee file for Staff C for the annual 2 hour update for assistance with self-administration of medication.
On at 12:56 PM an observation was conducted as Staff B completed a medication pass for Resident #2.
On at 1:15 PM an interview was conducted with Staff A. Staff A stated she had obtained the initial 4 hours of training several years ago while at a different facility. She had no documentation of that training. Staff A stated she had obtained the required 2-hours of updated training on RN.org. She was able to pull up verification of the training that had been completed on and . She stated she had not yet printed the certificates to be placed in her employee file. Staff A was aware that the training she had completed today was out of compliance.
On at 2:15 PM an observation was conducted as Staff A completed a medication pass for

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Resident #4
On at 3:33 PM an interview was conducted with the Administrator. He stated he was aware that Staff A, Staff B, and Staff C were out of compliance " for the 2 hour med tech refresher course " .

Class III

0091 Training - Documentation & Monitoring

Based on interview and record review, the facility failed to provide the required training documentation for 1 of 3 (Staff B) sampled staff.

Findings include:

On at 10:45 AM a record review was conducted of the employee file for Staff B. The training documentation for Staff B was one sheet of paper, listing all of the trainings she had received, totaling 15 hours. It was dated and signed by the Administrator. The certificate failed to include the training program agenda; the dates of participation and the location of the training program.
On at an interview was conducted with Staff B. Staff B was unaware of who had provided her training, and stated all of her training took about 3 hours to complete. Staff B denied receiving training on Elopement Response, emergency preparedness and evacuation, incident reports, recognizing and reporting , neglect and , Policy & Procedures (P&P), and Extended Congregate Care (ECC). Staff B did not know what the word " elopement " meant, and she was not able to provide the appropriate facility response to an elopement. Staff B did not know what control was or how to put it into effect while working in the facility. Staff B was not aware of what to do in an emergency or how to assist with evacuating the residents. She stated that type of training would be helpful. Staff B had not heard of the term ECC and was unaware of what the initials stood for.
On at 3:33 PM an interview was conducted with the Administrator. The Administrator stated he could not say on which days the training was provided. He stated he could not remember if the trainings were all conducted on one day or not. He stated he printed out the certificate and signed it on the day that all of the trainings were complete. The Administrator did not have an agenda for the trainings. He was not aware that Staff B was unaware of the facility ' s policy on elopement, reporting and neglect, or emergency preparedness and evacuation.

Class III

0160 Records - Facility

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SUMMARY STATEMENT OF DEFICIENCIES
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Based on observation, interview, and record review, the facility failed to maintain an accurate and up-to-date admission and discharge log with a listing of all of the residents ' names, date of discharge, reason for discharge, and the identification of the facility or home address to which the resident was discharged; the facility failed to maintain a resident file on the premises for 1 out of 4 (Resident #1) sampled residents.

Findings include:

On at 9:45 AM a review was made of the facility ' s current resident census. Resident #2 was listed as a current resident. Resident #8 was not listed as a current resident.
On at 9:55 AM a record review was conducted of the facility ' s Admission Discharge log. Resident #2 was listed as discharged on . Resident #2 was not listed as readmitted on the Admission/Discharge log.
On at 9:55 AM a record review was conducted of the facility's Admission Discharge log. Resident #8 was listed as being a current resident. Resident #8 had not been listed as discharged from the facility.
On at 10:00 AM Resident #2 was observed in the facility.
On at 9:57 AM an interview was conducted with Staff B. Staff B confirmed Resident #2 remained a resident in the facility. Staff B stated Resident #8 had been discharged several months ago. She did not know the date of discharge or the discharge location. Staff B stated either the Administrator or Staff C updated the Admission discharge log.
On at 3:33 PM an interview was conducted with the Administrator. In regards to Resident #2, the Administrator stated he was not aware Resident #2 had not been readmitted on the Admission Discharge log. In regards to Resident #8, the Administrator stated " I forgot to sign her out. "

Class III

0162 Records - Resident

Based on interview and record review, the facility failed to ensure that the resident records for 1 out of 4 (Resident #1) sampled residents was maintained on the premises.

Findings Include:

On at 3:20 PM an interview was conducted with the Agency surveyor who had been at the facility on . The Surveyor stated the employees had been unable to locate the resident chart for Resident #1 at the time of her survey.
On at 10:45 AM a request was made for the resident chart for Resident #1. Staff B was

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unable to locate the chart for Resident #1.
On at 12:22 PM a request was made for the resident chart for Resident #1. The Administrator was unable to locate the chart for Resident #1.
On at 12:22 PM an interview was conducted with the Administrator. The Administrator did not know where the chart was for Resident #1. The Administrator stated he was not sure what they had been using for the past two weeks. The Administrator stated that he thought Staff C may have taken the chart for Resident #1 with her when she quit.

Class III

Z816 Background Screening-Compliance Attestation

Based on interview and record review, the facility failed to ensure that 2 out of 4 sampled employees (Staff A and Staff C) had a Level II background screening (BGS) after a 90 break in service from a position that requires a Level II screening.

Findings include:

On at 10:45 AM a record review was conducted of the employee file for Staff A. Staff A wrote on her employment application that she had ended prior employment with an Assisted Living facility . Her application for Hidden Oaks Assisted Living facility was dated .
On at 10:45 AM a record review was conducted for the employee file for Staff C. Her Level II BGS was completed on . Her application and hire date for Hidden Oaks Assisted Living Facility was / . Staff C had one employer listed on her application, and she ended her employment on / . No additional employers were identified.
On at 1:15 PM an interview was conducted with Staff A. Staff A stated she had ended her employment with the previous facility at the beginning of 2014. She was not employed in a position that required a Level II background screening from the beginning of until she began in her current position on . She stated the facility did not require her to get a new Level II background screening when she started this position.
On at 3:33 PM an interview was conducted with the Administrator. He stated he thought Staff A had been employed at an Assisted Living Facility " as needed " during her time off. He spoke with her and verified she had not worked, and then said " I guess you ' re right. "
On at 3:33 PM a continued interview was conducted with the Administrator. When informed that per Staff C ' s employee file she had a break longer than 90 days in a position that required a Level II background screening, and he had failed to have her obtain a new Level II background screening, he stated " Ok. "

AGENCY FOR HEALTH CARE ADMINISTRATION

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

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Steve Lomonico
Administrator
Invicta Health Care Management dba Hidden Oaks Assisted Living
945-7th Street NW
Largo, FL 33770

Dear Mr. Lomonico:

This letter reports the findings of a complaint survey conducted , 2015 – , 2015 by representatives of the Agency for Health Care Administration. Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's request as directives below:

The inspection resulted in findings of non-compliance in the following areas:

A 0025 – Resident Care – Supervision - The facility failed to be aware of the general health, safety, and physical and emotional well-being of 1 out of 5 sampled residents. The facility failed to contact the resident's primary care physician regarding a significant change, and failed to maintain a written record of any significant change that required medical attention. The facility also failed to ensure that qualified staff with training in first aid and ( ) deemed eligible by the agency through Level II background screen supervised residents and failed to ensure residents received care to meet their needs including prescribed medications.

A 0030 – Resident Rights – Rights and Facility Procedures - The facility failed to provide a safe and decent living environment, free from and neglect, to 4 out of 5 residents; the facility failed to treat the residents with consideration and respect. Specifically, the facility failed to protect the residents from physical and by staff.

A 0077 – Staffing Standards – Administrator - The facility Administrator failed to provide appropriate oversight of the facility's employees, failed to prevent verbal and of the residents, failed to prevent the theft of medications, failed to report the theft of medications, failed to appropriately train the facility staff to perform their required duties, failed to follow the facility's incident reporting policy, and failed to report or neglect to the Department of Children & Families hotline.

You are directed to comply with the following:

1) Your facility must develop a written policy on steps to take in emergency situations, including sudden illness or injury of a resident. Your facility is directed to review and revise any current policies regarding emergency procedures.

   This policy must include:

   A) Directions on calling emergency personnel;
   B) Directions on notifying the resident's primary care physician;
   C) Directions on which staff person in charge should be notified, and which staff person is responsible for follow-up;
   D) Specific instructions on how residents will be assessed post-injury;
   E) Directions on where the documentation regarding each occurrence will be maintained.
   F) All current and future staff must be trained on this policy and these steps, and be able to demonstrate knowledge of this policy. Documentation of this training must be maintained at the facility and available for Agency staff to review upon request. This must be completed no later than **, 2015.**

2) The facility must be administered by an individual who is CORE trained and have a passing score on the exam. Documentation of registration for CORE training must be provided by **, 2015.** The CORE training and exam must be completed by **, 2016,** unless approval is received by the St. Petersburg field office.

3) The Administrator and all facility employees must complete the 4-hour training on Assistance with Self-Administration of Medication from a licensed pharmacist or Registered Nurse. The documentation of completion of this training should include the name of the trainer, credentials, location of training, and number of hours of training provided, and must be maintained in each employee's employee file, and be available for Agency staff to review upon request. This must be completed no later than **, 2015.**

4) The Administrator and all facility employees must be trained in and First Aid and the documentation must be maintained in each employee's employee file and available for Agency staff to review upon request. This must be completed no later than **, 2015.**

5) The facility must establish a medication policy that will address the following:
   A) Medication Security;
   B) Who has access to medications;
   C) What to do in the event that medication is reported missing by residents or staff, to whom it should be reported, and where it should be documented;

D) A daily audit.

E) All current and future staff must be trained on this policy and these steps and be able to demonstrate knowledge of this policy. Documentation of this training must be maintained at the facility and available for Agency staff to review upon request. This must be completed no later than **, 2015.**

6) The facility shall have a resident file for each resident available at all times in the facility. All resident files must be maintained for 2 years following the departure of a resident from the facility. This must be completed no later than **, 2015.**

7) The Administrator and all facility employees must be trained in Resident Rights and recognizing and reporting and neglect by a representative of the Long-Term Care Ombudsman Program, Department of Children & Families, or a trainer approved by one of these agencies. This must be completed no later than **, 2015.**

8) The facility must establish an Policy that will address the following:

A) The actions staff should take if they witness , including if/when they are to write a written statement;

B) If a resident reports , who is to call the hotline;

C) Where documentation of reported is maintained.

D) All current and future staff must be trained on this policy and these steps, and must be able to demonstrate knowledge of this policy. Documentation of this training must be maintained at the facility and must be available for Agency staff review upon request. This must be completed no later than **, 2015.**

9) The staff identified as being and verbally and physically toward residents is not to have access to the facility or to the residents. **This must be enacted immediately.**

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 **. Laura Manville**, ALF Enforcement Team Manager, Survey and Certification Support Branch, at (727) 552-1955 or **Paul Brown**, St. Petersburg Field Office, (727) 552-2000.

Sincerely,

Paul Y Brown

FOR Paul Brown
Health Facility Evaluator Supervisor

PFB