STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965667	**01/31/2017**
NAME OF PROVIDER OR SUPPLIER **ARBOR OAKS AT GREENACRES**	STREET ADDRESS, CITY, STATE, ZIP CODE **3400 JOG RD** **GREENACRES, FL 33467**	

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

0000 - Initial Comments

A Relicensure survey was conducted on and at Arbor Oaks at Greenacres (License #9996). The facility had no deficiencies at the time of the visit.

A revisit to complaint #201601156 was conducted in conjuction with this relicensure survey.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on resident record review and staff interview, the facility failed to accurately document Hospice services on Health Assessments (AHCA Form 1823) for 2 of 6 residents whose records were reviewed (Resident #1 and Resident #3).

The finding include:

The current Health Assessments for Resident #1 and Resident #2 were reviewed; each of these residents are presently receiving Hospice Care. Resident #1 was admitted to Hospice in of 2015. The current health assessment is dated . Resident #2 was admitted to Hospice in 2016. The current health assessment is dated . Neither resident's current Health Assessment (AHCA Form 1823) documents the resident is receiving Hospice Care.

During interview with the Administrator on at 1:15 PM, she acknowledged the need for residents receiving Hospice care to have a new health assessment completed, and for Hospice Services to be documented on any of the resident's health assessments for as long as the resident is receiving Hospice services.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation and interview it was determined the facility failed to provide a safe and decent living environment, specifically related to staff's failure to appropriately wash/sanitize hands when providing medication administration for 5 of 5 residents (Residents #11, #12, #13, #14, and #15) by 1 of 2 Licensed Practical Nurses observed (Staff A). In addition, based on observation and interview it was determined the facility failed to post the advocacy numbers on the memory care unit and not all of the required advocacy numbers in assisted living.

The Findings included:

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ARBOR OAKS AT GREENACRES	**3400 JOG RD GREENACRES, FL 33467**

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

1) During medication observation conducted with Staff A (a Licensed Practical Nurse), on beginning at approximately 8:58 AM through 9:30 AM, she provided medication administration to the following residents without washing/sanitizing her hands at any time:

a. Resident #11: Staff A provided four oral medications; she handled the 200 mg tablet (obtained from an over the counter bottle) with her bare unwashed/unsanitized hands.

b. Resident #12: Staff A provided 2 oral medications; she handled the Valsartin 320 mg & the 25 mg pills (obtained from prescription bottles) with her bare unwashed/unsanitized hands.

c. Resident #13: Staff A provided 6 oral medications.

d. Resident #14: Staff A provided 5 oral medications; she handled the , -Dipyridam ER 200TEV (obtained from prescription bottle) with her bare unwashed/unsanitized hands.

e. Resident #15: Staff A provided 7 oral medications; she handled the *Florajen 3 capsule AME & the Q- , 325 mg 2 tablets every 4-6 hours as needed for pain with her bare unwashed /unsanitized hands.

During interview conducted with the ED (Executive Director) and RCC (Resident Care Coordinator), on at 10:05 AM, they were informed that Staff A failed to wash or sanitize her hands at any time during the medication observation conducted on beginning at approximately 8:58 AM for a total of 5 residents. They both acknowledged that the expectation is for staff providing medications are to wash or sanitize their hands between residents.

In addition, the ED and the RCC were informed that Staff A handled oral (pill form) medications that were obtained from medication bottles with her bare unwashed/unsanitized hands for 4 of these residents. They were also informed that Staff A failed to wash or sanitize her hands prior to donning gloves and administering eye drops for Resident #13. The ED acknowledged that the facility's policy for Administering Eye Drops noted to wash hands prior to the provision of eye drops.

Class III

0057 - Medication - Over The Counter (OTC) Products - 58A-5.0185(8) FAC

Based on observation, interview and record review, it was determined the facility failed to ensure that an OTC (Over the Counter) medication stored by the facility was labeled with the resident's name for 1 of 6 residents observed (Resident #11).

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ARBOR OAKS AT GREENACRES	**3400 JOG RD GREENACRES, FL 33467**

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

The Findings included:

During medication observation, interview and record review conducted with Staff A (a Licensed Practical Nurse), on beginning at approximately 8:57 AM; she was observed to obtain a bottle of 200 mg tablets from the medication cart. Staff A acknowledged this bottle of was not labeled with any resident's name (there was no box for this medication). She stated it belonged to Resident # 11. Resident #11's MAR (Medication Administration Record) noted she is to receive (,) 200 mg every 6 hours as needed.

During subsequent interview conducted with the ED (Executive Director) and the RCC (Resident Care Coordinator), on beginning at approximately 10:05 AM, they were informed that Resident #11's was not labeled with her name. The ED stated it is the expectation that all OTCs have the resident's name on the bottle or box.

Class III

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

Based on interview and record review, it was determined the facility failed to ensure that each staff member had evidence of a negative examination on an annual basis, for 1 of 3 direct care staff reviewed (Staff A).

The Findings included:

During interview and personnel record review conducted with the Business Office Manager , on beginning at approximately 11:25 AM, she was provided the opportunity to locate the annual statement for 2016 for Staff A (with a date of hire noted as). The Business Office Manager was not able to locate this documentation at the time of this review. The last annual statement for Staff A was dated .

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation and interview, it was determined the facility failed to conspicuously post the weekly menu of have them easily available to residents in this assisted living facility or in the memory care unit; and provide meals to residents who require pureed diets, in an attractive, appetizing manner.

The Findings included:

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

1) During observation, interview and record review conducted with the ED (Executive Director), on beginning at approximately 10:40 AM; she was asked to locate the weekly menu on the Memory Care Unit. She stated they are not posted on the Memory Care Unit as she was not aware this was required. The ED was asked to locate the weekly menu on the Assisted Living Unit. She went to the bulletin board and stated the weekly menus for the 6-week cycle should be posted here, but she acknowledged that none were present at this time.

2) On and , during observation of lunch meal in the Memory Care Unit, two residents who were prescribed a pureed diet were each served a large bowl of pureed food. The food contained in the bowl was undistinguishable as to what food items had been pureed and was being provided to the residents (photo evidence available).

On at 1:00 PM, the Food Service Director (FSD) was interviewed regarding her procedure for pureeing food for residents requiring a pureed diet. The FSD stated, "Whatever is on the menu for that day is pureed together...the individual menu items are not pureed separately."

On at 1:20 PM, the Administrator stated that the food was pureed together to assist the resident care aides in feeding the residents more efficiently, because if it took too long, the residents would often refuse to eat more of the meal. The Administrator and Food Service Director acknowledged the need to puree the food items separately and present the meal in a more appetizing and dignified manner.

Class III