STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953196	**03/30/2017**
NAME OF PROVIDER OR SUPPLIER **SHADY OAKS LIVING CENTER, INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **2208 EAST 138TH AVENUE** **TAMPA, FL 33613**	

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

0000 - Initial Comments

Assisted Living Facility

An abbreviated biennial survey with limited mental health (LMH) was completed at Shady Oaks Living Center, Inc. on . Deficient practice was identified during the survey.

License# 8450

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation and interview, the facility did not ensure that residents were provided appropriate supervision to ensure resident safety for one (Resident #2) of six residents interviewed.

Findings included:

During a resident interview with Resident #2 on at 10:28 AM, the surveyor noted that there was a very strong odor of cigarette smoke in Resident #2's . The surveyor observed that there were small holes in the blanket wrapped around Resident #2's shoulders and small holes in the fitted sheet on Resident #2's bed. The surveyor observed that on the table next to Resident #2's bed, there was a lighter and a clear container filled with a clear liquid. In the clear container of liquid, the surveyor observed several cigarette butts in the liquid in the container.

In an interview on at 10:28 AM, Resident #2 confirmed that he/she does smoke in his/her . Resident #2 stated that he/she does sometimes smoke in his/her , but that he/she was a controlled individual. Resident #2 stated that he/she had last smoked in the an hour ago. Resident #2 stated that he/she had not had any incidents and that he/she was not sure where the holes in the sheet and the blanket had come from.

On at 1:50 PM, the Assistant Administrator was interviewed regarding Resident #2 smoking in the resident's . The Assistant Administrator confirmed that Resident #2 was not allowed to smoke in his/her , but still did it anyway. The Assistant Administrator stated that the staff monitor Resident #2 for smoking in his/her if they see him/her smoking in the , they tell him/her to go outside. The Assistant Administrator indicated that no other interventions to prevent Resident #2 from smoking in his/her been put in place. The Assistant Administrator stated that they could not hold his/her smoking materials or lighters because the resident doesn't trust anyone and wont' let anyone touch his/her belongings. The Assistant Administrator stated that the facility does store and distribute the smoking materials of some residents, but not for Resident #2.

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Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation, interview, and record review, the facility did not ensure that residents were provided assistance with the self-administration of with a pre-filled syringe according to the manufacturer's directions. This occurred for one (Resident #9) of three residents observed.

Findings included:

During a medication pass observation on at 12:33 PM, Staff E, a medication technician, assisted Resident #9 with the self-administration of using a ˘ KwikPen, a pre-filled syringe. During this observation, Staff E retrieved the ˘ KwikPen for the resident, attached the disposable needle to the pen, dialed the dose of on the pen, handed the ˘ KwikPen to Resident #9 and watched Resident #9 inject the . At no point during this observation did the surveyor observe Staff E prime the ˘ KwikPen or instruct the resident to prime the ˘ KwikPen.

On at 12:36 PM, Staff E confirmed that he/she never had the resident prime the pen. Staff E stated that was not required for that type of injection.

On , a review of the manufacturer's instructions for the ˘ KwikPen showed that priming the pen was a required step in the use of the device for administration. The instructions stated, "Prime before each injection. Priming ensures that the Pen is ready to dose and removes air that may collect in the cartridge during normal use. If you do not prime before each injection, you may get too much or too little ."

Class III

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

Based on observation and interview, the facility did not ensure that the medication observation record (MOR) was updated after the medication was offered or administered to the resident for one (Resident #4) of three residents observed.

Findings included:

During the medication pass observation on at 12:12 PM, Staff E, a medication technician,

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assisted Resident #4 with the self-administration of medication. Staff E assisted Resident #4 with the self-administration of two medications. Staff E reviewed the MOR with the surveyor and observed that there was a third medication Resident #4 was supposed to take at that time as well. This medication had already been marked off as given to Resident #4 by Staff E, but it was not one of the two previous medications Staff E had assisted Resident #4 with. Staff E removed this medication from the cart and assisted Resident #4 with the self-administration of this medication after the MOR had already been signed.

In an interview on at 12:12 PM, Staff E stated that the medication technicians were supposed to update the resident's MOR after the resident had taken the medication.

On at 12:57 PM, the Assistant Administrator stated that the medication technicians were supposed to update the MOR after the resident had taken the medication. The Assistant Administrator confirmed that the MORs were not to be signed prior to the resident being assisted with the medication.

Class III

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

Based on observation and interview, the facility did not ensure that only a licensed nurse took a medication order by telephone. This occurred for one (Resident #9) of three residents observed during the medication pass observation.

Findings included:

On at 12:25 PM, Staff E, a medication technician, assisted Resident #9 in checking his/her own glucose level. The resident showed the glucometer to Staff E, the glucometer had a reading of 498. Staff E reviewed the sliding scale orders for the KwikPen. Staff E stated that for a reading above 400 the Advanced Registered Nurse Practitioner (ARNP) would have to be contacted. Staff E then called the ARNP and left a message notifying the ARNP of Resident #9's glucose level.

On at 12:33 PM, Staff E received a call back from the ARNP. Staff E stated that the ARNP told him/her to give Resident #9 14 units of . This order had been received by Staff E, a medication technician, as a telephone order from the ARNP. Staff E then proceeded to assist Resident #9 with the self-administration of the .

On at 12:36 PM, Staff E confirmed that he/she had received a verbal order over the phone to

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assist Resident #9 with taking 14 units of . Staff E stated that he/she only does that for the . Staff E confirmed that he/she was a medication technician and was not able to take verbal orders over the phone.

On at 12:59 PM, the Assistant Administrator stated that the facility did not employ any licensed nurses. The Assistant Administrator confirmed that medication technicians could not take telephone orders.

Class III

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on record review and interview, the facility did not ensure that the Administrator completed core training requirements for one (Administrator) of three employees reviewed.

Findings included:

On , a review of the Administrator's employee file revealed that there was no documentation that the Administrator had completed the required core training.

In an interview with Staff A on at 6:11 PM, Staff A stated that he/she was sure the Administrator completed the core training. Staff A confirmed that he/she could not find documentation of core training completion for the Administrator.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the facility did not ensure that residents were provided with an environment free of hazards for one of one unattended housekeeping cleaning carts. Additionally, the facility did not ensure that residents were provided with a clean and structurally maintained environment for one (the male) of two observed .

Findings included:

On at 9:53 AM, the surveyor observed Staff F, a housekeeper, leave the housekeeping cleaning cart unattended in a resident hallway off of a main dining area. There were multiple bottles of cleaners on top of the cart that were not secured in any way.

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On at 11:05 AM, the surveyor observed Staff F leave the housekeeping cleaning cart unattended in front of the door of a resident's . There was no staff member watching the cart. There were multiple bottles of cleaners on top of the cart that were not secured in any way. The surveyor observed that, in the cart had been left in front of, there was a resident in bed in that their eyes closed. During the time period that the cart was unattended, one resident walked past the cart.

On at 2:27 PM, the Assistant Administrator stated that staff were not allowed to leave any chemicals unattended. The Assistant Administrator stated that if the housekeepers had to leave the carts, there was a bucket they could use to carry the chemicals with them.

On at 11:27 AM, the men's observed with Staff D. The surveyor observed that there was a cup of trash on a shower chair in one of the shower stalls. There were black, flying insects inside the cup, on the outside of the cup, on the walls of the shower stall, and on the curtain of the shower stall. There were also black, flying insects observed flying around inside the shower stall. There was water on the floor of the shower stalls and on the floor outside of the shower stalls. There was a section of missing tile on the lower portion of a wall near a toilet stall. There were sections of broken tiles observed on the wall in a toilet stall. There was a handrail, which was not attached to the wall, sitting on the floor propped up against the wall behind a sink.

On at 11:31 AM, Staff D stated that the facility's maintenance workers were aware of the issues in the men's would be fixing them. Staff D stated that the handrail had been torn off the wall of one of the toilet stalls and may have been off the wall for about a day. Staff D confirmed that there were flying insects in the shower stall in the men's . Staff D stated that they try to spray for the flying insects, but that they got worse when there was water on the floor of the a leak in the .

In an interview at 2:27 PM on , the Assistant Administrator stated that the facility's maintenance workers were working at another facility that day.

On at 2:34 PM, the Assistant Administrator confirmed the surveyor's findings in the men's . The Assistant Administrator stated that the facility's maintenance workers had a list of things to fix in the men's .

In an interview with Resident #8 on at 3:30 PM, the resident stated that the men's a, "total disaster." Resident #8 stated that the dirty and had bugs in it. Resident #8 stated that the been in that condition for the past 21 months. Resident #8 stated that the

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facility staff did not listen to his concerns.

Class III

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(8) FAC

Based on record review and interview, the facility did not ensure that staff received a minimum of three hours of continuing limited mental health (LMH) training biennially for one (Staff B) of three employees reviewed.

Findings included:

On , a review of Staff B's employee file revealed that Staff B was hired in the direct care position of, "Medication Aid," on . Staff B had last completed LMH training 11/ . There was no documentation that three hours of continuing LMH education had been completed biennially.

On at 5:38 PM, the Assistant Administrator confirmed that there was no additional LMH training for Staff B. The Assistant Administrator stated that the facility had videos for that training and that Staff B would receive that training tomorrow.

Class III