STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911682	**05/01/2017**
NAME OF PROVIDER OR SUPPLIER **OAK HAVEN**	STREET ADDRESS, CITY, STATE, ZIP CODE **9040 STAR TRAIL** **NEW PORT RICHEY, FL 34654**	

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

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on interview and record review, the facility failed to ensure that a Level II background screening was completed for all employees that had a break in service of more than 90 days from a position that required screening by a specific agency for one (Staff A) of four employees sampled.

Findings included:

A review of employee records conducted on showed that Staff A was hired on . A review of Staff A's Level II background screening showed the eligible date of . A review of Staff A's application showed that their last employer was an assisted living facility. A review of Staff A's resume showed that their employment at that assisted living facility was from , 2013 to 2015.

Staff A was observed providing assistance to the facility's residents during the survey on and their name was listed as "Aide" on the facility's weekly schedule.

An interview was conducted with the Administrator at 3:21 PM on and the concern of Staff A's lack of a required Level II background screening , due to a break in service of more than 90 days from their previous employment, was discussed. Staff A was brought in to the discussion and asked if the dates of employment were correct. Staff A stated that the dates of their last position, before accepting employment at the current facility, of , 2013 through 2015 were correct. The Administrator acknowledged that there were more than 90 days in between positions. The Administrator stated that they would send Staff A for a new Level II background screening.

Unclassified

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

Based on observation and interview the facility failed to ensure that hazardous chemicals were kept in a secure location inaccessible to 7 (#1, #2, #3, #4, #5, #6, #7) out of 7 residents living in the facility.

Findings included:

On at 9:46 AM, an unlocked closet was observed in the main sitting area. The closet door did not have a lock on it. Cleaning supplies were observed in the closet and included: Glass cleaner, abrasive powder cleanser, spray cleaner, grout remover, phosphoric cleanser, drain line cleaner, and a 1.64 gallon container of liquid cleanser. Two residents were sitting nearby in comfortable chairs as well as two additional residents sitting in an adjoining living .
At 10:43 AM an interview was conducted with caretaker (B) stated that cleaning supplies were normally kept in the closet. She confirmed that the closet door could not be locked.
At 1:19 PM, the Administrator was shown the closet with the chemicals. He said that there used to be a lock on the door and that he would have maintenance staff put a new lock on it.

Class III

0000 - Initial Comments

Assisted Living Facility

On , 2017, a change of ownership (CHOW) provisional licensure survey for the period of to in conjunction with a complaint survey, (CCR# 2017002008), was conducted at Oak Haven. Deficient practice was identified related to the CHOW provisional licensure survey.

(License # 7684)

0026 - Resident Care - Social & Leisure Activities - 58A-5.0182(2) FAC

Based on observation, interview, and record review, the facility failed to post an activities calendar with scheduled activities available at least 6 days a week for a total of not less than 12 hours per week.

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Findings included:

During the tour of the facility conducted on beginning at 9:44 AM, the facility's 2017 activities calendar was observed on a large on a table near the reception area. The page underneath was dated for 2017. There were no activities listed for the month of 2017.

An interview was conducted with Staff B at 3:10 PM on concerning the activities calendar for and they stated that they haven't done the calendar yet. There was no observation of activities during the course of the survey from 9:05 AM through exiting from the facility at 4:15 PM.

An interview was conducted with the administrator at 3:59 PM on concerning the lack of an activities calendar for and the lack of observations of activities in the facility. The administrator stated that it was a challenge and that residents tended not to participate. The administrator stated that the residents in this facility were there because it was a more quiet facility.

Class III

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

Based on observation, interview, and record review the facility failed to ensure that one (#7) out of seven residents residing in the facility administered their own medication with only the assistance of staff.

Findings included:

On at approximately 10:00 AM during a tour of the facility, five cylinders of were observed in resident #7's .
An interview was conducted with Caretaker/Medication Tech (B) at 10:53 AM. She said that resident #7 was ordered as needed. The Medication Observation Record (MOR) was then reviewed with the Caretaker, staff (B). The was not present on the MOR. Staff (B) stated that all medications and treatments were listed on the MOR. She stated that the resident had lived at the facility for about 6 months. She said that staff would assist the resident with putting the on. The resident was sitting in the living a chair with an machine and tank next to her. The aid said that she would direct the resident on how to put it on. She said the resident received 3 liters of .

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SUMMARY STATEMENT OF DEFICIENCIES
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At 12:25 PM, an interview was conducted with the Administrator. A copy of the physician order was requested for the use of the for resident #7. He provided form 1823, the Resident Health Assessment for Assisted Living Facilities signed on 11/ . The resident was admitted to the facility on . Included on form 1823 under the section Nursing/treatment/ service requirements was: ( ) at 3 L (liters) continuous via n/c. (nasal cannula). Diagnoses listed on form 1823 included, Acute , Distress and ( ). Additionally, the Administrator provided a form from the supply company dated titled Conserving Device Orientation Checklist. The checklist included: Note and explain physician's prescription. Liters per minute 3 hours per day 24. No adjustment should be made to the flow rate unless prescribed by the physician. Staff (B) signed the form. He stated that he did not have a physician order for the as needed . He said that the resident did not want to use it and had not. He stated that he did not think that they contacted the physician.

At 12:39 PM the Administrator stated that he had called the nurse practitioner and that she was going to try to contact the physician and have an order sent over to change it to prn (as needed).

The administrator provided a copy of the new order for the . The top of the page had the date and time stamp of at 12:48 PM. The order included: Clarification of order for .

( ) 2 L (liters) via NC (nasal cannula) at HS (hour of sleep) and prn while awake.

At 3:00 PM, an interview was again conducted with staff (B). She stated that the resident would let staff know when she was short of breath. Staff (B) stated that she would turn on the machine and make sure it was set for 3 liters. Sitting next to the resident who was sitting in the living a concentrator machine and an tank. The staff member said that she would take the tubing and assist the resident with placement, helping to put it over her ears and proper placement in the nostrils. With the aid present, the resident was asked if she knew how to turn on the machine herself. She stated no. The aid was asked when the last time the resident used the . She said about a week after she had been admitted to the facility. She said she was sure that was the last time because they write shift reports. She said that at the time of the interview she had not been made aware that there was a new order received changing the order from 3 liters to 2 liters.

Class III

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

Based on observation, interview, and record review the facility failed to follow physician orders for one (#7) out of seven residents for the continuous use of .

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SUMMARY STATEMENT OF DEFICIENCIES
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Findings included:

On at approximately 10:00 AM during a tour of the facility, five cylinders of were observed in resident #7's .
An interview was conducted with Caretaker/Medication Tech (B) at 10:53 AM. She said that resident #7 was ordered as needed. The Medication Observation Record (MOR) was then reviewed with the Caretaker, staff (B). The was not present on the MOR. Staff (B) stated that all medications and treatments were listed on the MOR. She stated that the resident had lived at the facility for about 6 months. She said that staff would assist the resident with putting the on. The resident was sitting in the living a chair with an machine and tank next to her. The aid said that she would direct the resident on how to put it on. She said the resident received 3 liters of .

At 12:25 PM, an interview was conducted with the Administrator. A copy of the physician order was requested for the use of the for resident #7. He provided form 1823, the Resident Health Assessment for Assisted Living Facilities signed on 11/ . The resident was admitted to the facility on . Included on form 1823 under the section Nursing/treatment/ service requirements was: ( ) at 3 L (liters) continuous via n/c. (nasal cannula). Diagnoses listed on form 1823 included, Acute Distress and ( ). Additionally, the Administrator provided a form from the supply company dated titled Conserving Device Orientation Checklist. The checklist included: Note and explain physician's prescription. Liters per minute 3 hours per day 24. No adjustment should be made to the flow rate unless prescribed by the physician. Staff (B) signed the form. He stated that he did not have a physician order for the as needed . He said that the resident did not want to use it and had not. He stated that he did not think that they contacted the physician.
At 12:39 PM the Administrator stated that he had called the nurse practitioner and that she was going to try to contact the physician and have an order sent over to change it to prn (as needed).
The administrator provided a copy of the new order for the . The top of the page had the date and time stamp of at 12:48 PM. The order included: Clarification of order for ( ) 2 L (liters) via NC (nasal cannula) at HS (hour of sleep) and prn while awake.
At 3:00 PM, an interview was again conducted with staff (B). She stated that the resident would let staff know when she was short of breath. Staff (B) stated that she would turn on the machine and make sure it was set for 3 liters. Sitting next to the resident who was sitting in the living a concentrator machine and an tank. The aid was asked when the last time the resident used the . She said about a week after she had been admitted to the facility. She said she was sure that was the last time because they write shift reports. She said that at the time of the interview she had not

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been made aware that there was a new order received changing the order from 3 liters to 2 liters.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation, interview, and medication review the facility failed to ensure that medications for 4 (#2, #5, #8, #9) out of 9 residents in which the facility had responsibility of securing were placed in a locked secured area out of reach of individuals.

Findings included:

On at 10:18 AM, two plastic bins were observed sitting on top of the refrigerator in the main dining . Upon inspection of the contents of the two containers, many medication punch cards containing pills were observed in the containers. A State Surveyor then took pictures with the Administrator present.
Review of the medications revealed four different residents. Two current residents (#2, #5), one discharged resident (#9), and one hospitalized resident (#8). The medications included the following:
Resident #2:
, 10 mg: , 5 mg; , 40 mg; 20 mg; ;
25 mg; , Sod 88 mcg; 500 mg; 4 mg.
Resident #5:
Poly-iron 150 mg cap, 6 punch cards and 500 mg, 2 punch cards
Resident #9: Discharged
10mg (milligram); 40mg; , 10mg; 30mg; ,
10mg; , 15 mg; 10mg; , 15mg; , 300mg;
, - , 25 mg - 100 mg.
Resident #8: Hospitalized
, Tart 25 mg; 40 mg; , 15 mg; , 10 mg; , 2.5 mg;
20 mg.

At 10:26 AM, an interview was conducted with caretaker/medication tech (B). She stated that all of the medications were going back to the pharmacy. She said that resident #2's medication had just arrived from another facility because she was a new resident who had arrived on Saturday.

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She stated that she did not realize the medications were up on the refrigerator. She said that staff would usually put them in the corner and then place something over top of it. She motioned to the corner being referenced, which was next to the refrigerator where the medications were found.
An interview was then conducted with the Administrator. He stated that probably Staff (B) was doing the end of month change out of medications, but that they still should not be unsecured sitting on top of refrigerator. The Administrator then removed the medications from the area.

Class III

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

Based on interview and record review, the facility failed to provide evidence of a negative examination documented on an annual basis (Exam) for two (Administrator and Staff A) of four employee records reviewed.

Findings included:

A review of employee records conducted on showed that the Administrator was hired on and Staff A was hired . A review of the Administrator's and Staff A's record showed no proof of a Exam.

The Administrator was interviewed at 3:19 PM on concerning the lack of proof of a Exam in their own employee record as well as Staff A's record. The Administrator reviewed the 2 records and acknowledged that there was no proof of Exams.

Class III

0083 - Training - First Aid and - 58A-5.0191(4) FAC

Based on interview and record review, the facility failed to provide proof of training in first aid (First Aid Training) for one (Staff C) of four employee records reviewed.

Findings included:

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A review of employee records conducted on ..... showed that Staff C's record lacked proof of First Aid Training. A review of the facility's staffing schedule showed that Staff C worked alone on the 11:00 PM-7:00 AM shifts on Saturdays and Sundays.

The Administrator was interviewed at 3:26 PM on .. concerning the lack of proof of First Aid Training for Staff C. The Administrator reviewed Staff C's employee record and acknowledged that there was no proof of First Aid Training.

Class III