STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963878	**07/27/2017**
NAME OF PROVIDER OR SUPPLIER **BRADENTON OAKS COURTYARD**	STREET ADDRESS, CITY, STATE, ZIP CODE **1015 7TH AVENUE EAST** **BRADENTON, FL 34208**	

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

0000 - Initial Comments

Assisted Living Facility

On , a biennial re-licensure survey was conducted at Bradenton Oaks Courtyard, Assisted Living Facility. Deficient practice was identified during the survey.

(License # 6662)

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

Based on observation, interview, and record review the facility failed to ensure for 1 resident (#13) of 3 sampled residents that medication is stored in a secure place within the resident's apartment or in some other secure place that is out of sight of other residents.

Findings included:

On at 11:30 AM during a review of resident records it was revealed that resident #13 had a statement on the health assessment that he could self-administer his own medication. A tour of the resident's he has a private shares a common area including a kitchen with another resident. The resident stores the sharps container on the kitchen countertop and stores his -filled pens in the refrigerator. The resident does not have locked secured container to store his medication. The has access to the kitchen, refrigerator, and countertop.

During interview with the facility's Resident Care Director on , at 2:30pm the director who is an LPN stated that he conducts an assessment every couple of months of the resident. The LPN stated that the resident is alert and has a good understanding of his medication. The resident conducts his accu-checks and reports the findings to him. The Director agreed to meet with me at the resident's . The Director was surprised to find the sharps container on the kitchen countertop and the -filled pens in the refrigerator. The -filled pens were in an open container in the refrigerator that is shared with another resident. The LPN stated he did not know that the was being stored in this manner.

The facility failed to provide the resident with a method to store his in a safe manner, which would may pose a safety hazard to other residents.

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Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record review and interview the facility failed to ensure that three employees (Staff: A, D, and E) of three sampled employees (who provide direct resident care) received required in-service trainings within 30-days of employment.

Findings included:

A record review conducted on for Staff A, with a hire date of revealed that the employee's record did not contain the required hours of training for ADL's and Behavioral Needs, Elopement Response, Nutritional & Safe Food Handling, and Recognizing and Reporting , Neglect, and , within 30-days of hire.

A record review conducted on for staff E, with a hire date of . Staff E's record did not include documentation of Control, ADL's and Behavioral Needs, Elopement Response, Emergency Preparedness & Evacuation, Incident Reporting, Resident Rights, Recognizing & Reporting , Neglect, and , , and Nutritional & Safe Food Handling training's within 30-days of hire as required.

A record review conducted on for staff D, with a hire date of . Staff D's record did not include documentation of nutritional and safe food handling training within 30-days of hire as required.

An interview conducted with the executive director on at 2:56 pm who stated, "This is what we have."

Class III

0082 - Training - / - 58A-5.0191(3) FAC

Based on record review and interview the facility failed to ensure that 1 of 3 employee (who provide direct resident care) records reviewed completed a one-time education course on and within

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SUMMARY STATEMENT OF DEFICIENCIES
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30 days of employment.

Findings included:

A record review was conducted for staff E, with a hire date of . Staff E's record did not include documentation of a one-time education course on and within 30 days of employment as required.

An interview was conducted with the executive director on at 2:56 pm. They stated "this is what we have."

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on record review and interview, the facility failed to ensure that one employee (Staff A) of three sampled employees (who provide direct resident care) received the required ( ) training within 30-days of employment.

Findings included:

A record review conducted on for Staff A, with a hire date of revealed that the employee's record did contained a training certificate for training. However, no contact hours were documented on the training certificate.

An interview conducted with the Executive Director on at 02:56pm who stated, "This is what we have."

Class III

0167 - Resident Contracts - 58A-5.025 FAC

Based on interview and record review, the facility failed to follow resident contracts and ensure that a

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SUMMARY STATEMENT OF DEFICIENCIES
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30-day written notice be given before any rate increase for one resident (#1) of four sampled residents.

Findings included:

A record review conducted on revealed that Resident #1's Power of Attorney (POA) received less than a 30-day notice for a services rate increase. The letter of 'increase in rate' was dated on and the increased amount of $200.00 was to be effective on . Resident #1's contract on page 5 stated that for "Adjustments to Fees of Services: We may adjust your Monthly Fee and the other fees under this Agreement upon thirty (30) days' advance written notice to you and Responsible Party."

An interview conducted on at 03:28pm with Resident #1's POA confirmed that the facility gave less than a 30-day notice of a rate increase due to additional services needed for resident #1's decline in condition as the POA stated that I received the letter of an increased rate a week ago.

During a Staff Interview conducted on at 05:04pm confirmed the facility did not provide a 30-day notice for a rate increase as the Executive Director stated that we thought if there was a change in condition, we could increase the rate for the increased level of care needed. We don't wait 30-days to charge for higher level of care. We charge right away and inform the resident right away that they are going to be charged the higher rate.

Class III