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	AL11932515	**02/21/2018**
NAME OF PROVIDER OR SUPPLIER **OAKVIEW TERRACE**	STREET ADDRESS, CITY, STATE, ZIP CODE **7220 BAILLIE DRIVE** **NEW PORT RICHEY, FL 34653**	

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

0000 - Initial Comments

Assisted Living Facility

On , 2018, an abbreviated biennial re-licensure survey with extended congregate care (ECC) and limited nursing services (LNS) was conducted at Oakview Terrace. Deficient practice was identified during the survey.

(License #7689)

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on observation, record review, and interview the facility failed to ensure that one Resident (#14) of one sampled resident met admission criteria.

Findings Included:

During a medication observation conducted on at 01:37pm, it was revealed that Resident #14 required medication administration via tube feeding (G-Tube).

A focused record review of Resident #14's Agency for Health Care Administration Health Assessment Form 1823 dated conducted on , revealed that Resident #14 was admitted to the facility needing "total care for feeding" and "medication administration via G-Tube due to muscle spasms and twitching" upon admission in , 2018.

During a staff interview with the Director of Nursing (DON) conducted on at 02:35pm, the DON acknowledged and confirmed that Resident #14 was unable to self-care for their G-Tube at admission. The Director of Nursing stated that, "we admitted her with our ECC license and she is on hospice."

Class III

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

Based on observation, record review, and interview, the facility failed to determine the continued appropriateness of residency and, failed to obtain an interdisciplinary care plan specifying services being provided by hospice and those being provided by the facility and agreeable to all parties for one

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Resident (#14) of one sampled hospice resident.

Findings Included:

During a med pass observation for Resident #14 conducted on at 01:37pm, Staff D, a Licensed Practical Nurse, administered Resident #14's ordered and Jevity formula via a feeding tube without properly checking for placement of the tube. Staff D placed the stethoscope underneath Resident #14's gown and listened to their abdomen. Staff D did not administer air through a syringe to listen for placement. Staff D did not pull Resident #14's gown back to check the feeding tube site for irregularities. After the procedure, Staff D removed her gloves and walked out of Resident #14's washing her hands.

During a focused record review on of Resident #14's Agency for Health Care Administration Health Assessment Form 1823 dated , it was revealed that Resident #14 was admitted to the facility needing "total care for feeding" and "medication administration via G-Tube due to muscle spasms and twitching" upon admission in , 2018. Resident #14's record did not contain an Interdisciplinary Care Plan specifying care and services provided by hospice and those being provided by the facility and agreeable to all parties (hospice, the facility, and Resident #14).

During an interview with the Director of Nursing (DON) conducted on at 02:15pm, the DON stated that the expectation for checking for placement of the feeding tube is to "listen with a stethoscope as air is placed in the tube." The DON stated that, "they (referring to nurses) should also visually inspect" the feeding tube site before administration.

During a staff interview with the Director of Nursing conducted on at 02:35pm, the DON acknowledged and confirmed that Resident #14 was unable to self-care for G-Tube at admission. The Director of Nursing stated that, "we admitted her with our ECC license and she is on hospice." The DON did not provide an interdisciplinary plan of care between hospice and the facility, specifying care and services provided to the resident.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation and interview the facility failed to provide medication (med) administration for two Residents (#12 and #14) of two sampled residents as ordered.

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Findings Included:

During a med pass observation for Resident #12 conducted on at 11:40am, Staff D improperly, administered Resident #12 ordered HFA inhaler by administering two quick puffs with only two seconds lapsing between puffs. Staff D then placed the HFA inhaler back in to the central storage med cart without cleaning the mouthpiece.

During a med pass observation for Resident #14 conducted on at 01:37pm, Staff D administered Resident #14 ordered , and Jevity formula via a feeding tube without properly checking for placement of the tube. Staff D placed the stethoscope underneath Resident #14 gown and listened to abdomen. Staff D did not administer air through a syringe to listen for placement. Staff D did not pull Resident #14 gown back to check the feeding tube site for irregularities. After the procedure, Staff D removed her gloves and walked out of Resident #14 washing her hands.

During an interview with the Director of Nursing (DON) conducted on at 02:00pm, the DON stated that the expectation for checking for placement of the feeding tube is to "listen with a stethoscope as air is placed in the tube." The DON stated that, "they (referring to nurses) should also visually inspect" the feeding tube site before administration.

Class III

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

Based on observation, record review, and interview the facility failed update Medication Observation Records (MORs) immediately each time a medication (med) was offered or administered for three residents (#13, #15, and #16) of five sampled residents who need assistance with self-administration of medication or medication administration.

Findings Included:

During a med observation for Resident #13 conducted on at 11:50am, it was revealed that the MORs were not signed for ordered , 0.25mg on at 11:00am; on 11:00am; on at 11:00am; and, on at 11:00am. No documented explanation on back of MOR as to the reason med not given.

During a MOR audit for Resident #15 conducted on , revealed that ordered med

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25mg was not signed as given on at 06:00am. No documented explanation on back of MOR to the reason med not given.

During a MOR audit for Resident #16 conducted on , revealed that ordered med , 0.5mg not signed as given on at 06:00am and on at 06:00am. No documented explanation on back of MOR as to the reason med not given.

During a staff interview with the Director of Nursing (DON) conducted on at 02:15pm, the DON stated that it is the facility's expectation that meds are signed for immediately after the med is given. The Director of Nursing acknowledged and confirmed meds not signed for Residents #13, #5, and #16 and stated that, "they (referring to staff) probably missed signing for the meds."

Class III

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

Based on observation and interview, the facility failed to keep centrally stored medication (meds) in a locked cart at all times.

Findings Included:

During an observation of the medication on at 11:30am, upon entering the medication , Staff E was observed standing at the 400 hall med cart and Staff D was standing in front of the 100 hall med cart preparing for a med pass. Staff E walked out of the med the 400 hall med cart unlocked with the med cart keys in the key lock. Staff D left out of the med five seconds after Staff E. The med was open. The cart with resident prescription creams was unlocked. Both Staff D and Staff E returned to the med at 11:34am.

During an interview with the Director of Nursing (DON) conducted on at 02:00pm the DON stated that, "the door should be closed and locked if no one is in the med ." and expects the med carts and treatment carts to be locked if the door is open.

Class III

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

Based on interview and employee record review the facility failed to ensure that three (A, B, C) out of four employees had completed the and Acquired Deficiency

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training as required within 30 days of hire.

Findings included:

On , employee files were reviewed for four current employees of the facility. It was revealed that three of the employees did not have documentation that they had completed training for and . The following employees did not have the required training:
Employee A, a resident care aid had a hire date of per employee file review.
Employee B, a resident care aid had a hire date of per employee file review.
Employee C, a resident care aid had a hire date of per employee file review.
The Administrator was given the employee files and informed that the training could not be located for the sampled employees. She was asked to review the files and provide the trainings when located.
At 2:03, during an interview with the Administrator she stated that employees A, B, and C had not completed the required training.

Class III

0086 - Training - ADRD - 58A-5.0191(9) FAC

Based on interview and employee record review the facility failed to provide initial training for 's and Related to two (A, B) out of four employees who worked in the facility for longer than three months and whereas the facility included a secured unit.

Findings included:

On , four employee records were reviewed for compliance with training in the area of and Related (ADRD). It was discovered that two of the employees did not have the initial 4 hours of training required within three months of employment.
Employee A, a resident care aid had a hire date of and had not completed the training.
Employee B, a resident care aid had a hire date of and had not completed the training.
The Administrator was given the employee files and informed that the training could not be located for the sampled employees. She was asked to review the files and provide the trainings when located.
At 2:03, during an interview with the Administrator she stated that employees A and B had not completed the required training.

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Class III

0090 - Training - [redacted] - 58A-5.0191(11) FAC

Based on interview and employee record review the facility failed to ensure that one (Administrator) out of four employee records reviewed had received at least one hour of training of the [redacted].

Findings included:

On [redacted], four employee files were reviewed for compliance with required trainings for working in an assisted living facility. It was revealed that the Administrator's employee file did not contain documentation that she had received at least one hour of training on [redacted].
At 2:03 p.m., an interview was conducted with the Administrator who stated that she had not taken the training.

Class III

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

Based on record review and interview, the facility failed to maintain a six-month file of menu substitutions.

Findings included:

A dining and food service review was conducted on [redacted]. A request was made to review the facility's six-month file of menu substitutions. The Administrator presented a file that only contained menu substitutions for [redacted], 2018 and [redacted], 2018.

An interview was conducted with the Administrator at 11:00 AM on [redacted] concerning only two months of menu substitutions being recorded. The Administrator acknowledged that the facility only noted two months of their menu substitutions.

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0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on record review and interview, the facility failed to submit their comprehensive emergency management plan (CEMP) for review and approval to the local emergency management agency.

Findings included:

A request was made on to review the approval letter from the local emergency management agency for the facility's CEMP.

An interview was conducted with the Administrator on 10:02 AM concerning the status of the facility's CEMP. The Administrator stated that they did not yet have an approved CEMP. The Administrator stated that they had to change the "hurricane zone" for zone B to zone C and then it would be approved.

Class III

E207 - ECC - Services - 58A-5.030(8) FAC

Based on observation and interview the facility failed to provide extended congregate care (ECC) services that respects resident privacy, dignity, and safety in accordance with standards of practice for one Resident (#11) of one sampled resident admitted to the facility's ECC program.

Findings Included:

During an observation of Resident #11's care and services, specifically a transfer from wheelchair to bed conducted on at 12:10pm, Staff C and the Director of Nursing Trainee (DONT) performed a two-person transfer. Staff C grabbed Resident #11 under left arm/shoulder and DONT grabbed resident under right arm/shoulder lifting Resident #11 out of the wheelchair by her shoulders. Resident #11 had their knees bent and did not appear to be placing much if any weight on their own legs. Staff C stated that Resident #11 "puts some of her weight on her legs but doesn't help too much."

During an observation of Resident #11's care and services, specifically an brief change conducted on at 12:15pm, Staff C proceeded to turn Resident #11 on her right side (facing toward the) and remove the resident's brief. The window blinds remained open during brief change. Staff C wiped Resident from front to back (to butt) three times using the same wipey cloth. Staff C obtained another wipey cloth and proceeded to wipe from front to back (to butt) three times with this wipey cloth. Staff C was stooped over Resident #11 during brief change. Staff C did not raise

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Resident #11's bed to a safe working height. After procedure, Staff C removed her gloves, retrieved the garbage bag, and sealed it closed. Staff C retrieved the used , that was not in a bag and proceeded to leave Resident #11's . Staff C carried the used , down the hall.

Class III

E210 - ECC - Training - 58A-5.0191(7) FAC

Based on record review and interview the facility failed to ensure that all employees providing direct care to residents in an Extended Congregate Care (ECC) program completed two-hours of in-service training within six months of beginning employment for one employee (Staff A) of five sampled employees.

Findings Included:

During a personnel record review for Staff A conducted on revealed that there was no ECC in-service training certificate in Staff A's personnel file. Staff A's hire date is .

During a staff interview with the Administrator conducted on at 02:03pm the Administrator acknowledged and confirmed that Staff A's personnel file did not contain an ECC in-service training certificate. The Administrator stated that " did not have the in-service training certificate."

Class III