STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953196	**04/16/2018**
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 unannounced complaint survey (CCR#2018005303), was conducted on at Shady Oaks Living Center (License #8450), an assisted living facility located in Tampa, Florida. There were deficiencies identified during the survey.

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

Based on observation, interview and record review, the facility failed to clarify isolation orders from a healthcare provider for residents with a condition ( ), which contributed to a failure to contain a and/or bed bug infestation for six (#1, #3, #8, #9, #13 and #14) of 13 residents; and failed to ensure privacy for two (#7 and #12) of 14 residents interviewed and observed.

Findings included:

While conducting a facility tour on at 10:15 a.m., Resident #7 and Resident #12 were observed lying in bed with no window curtains. The window of the positioned immediately near the common residents' smoking area.

During interview with Resident #7 on at 10:48 a.m., Resident #7 stated that a staff (identified as a nurse) took down the window shutters on .

A record review for Resident #1 and Resident #13 revealed isolation orders, dated for " / infestation per CDC Guidelines."

During interview with direct care staff on , Staff A and Staff C were not aware of multiday isolation orders for Resident #1 and Resident #13 during treatment related to a infestation.

During interview with the Nurse Practitioner, on , at 03:49 p.m., he clarified that Resident #1 and Resident #13 had an active order for isolation from first treatment on to the second treatment scheduled for .

During interview with the Assistant Administrator on at 04:01 p.m., she stated that the Facility Resident #1 and Resident #13 on while the cream/treatment was on, because the facility understood that the isolation orders was only for the day that the cream was on the resident. The

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Assistant Administrator confirmed that she did not get clarification for the isolation orders and just went by the date it was written.

During interview with the Clinical Director and the Nurse Practitioner, on at 04:44 p.m., the Clinical Director stated that based on clinical suspicion, pending results, the Facility and the Facility's ARNP (identified as the Facility's Medical Director) were advised to treat the facility for . The Clinical Director clarified that contact isolation was not for one day, the resident has to be treated. The two treatment dosages had to be given before contact isolation was lifted.

During interview with Resident #13 on at 12:03 p.m., the resident complained of ongoing possible bed bug infestation that resulted in bites at night and scarring in the resident's area, possibly from scratching.

During interview with Resident #9 on at 12:19 p.m., the resident complained of ongoing bed bug infestation in the caused skin irritation in arms, legs and area with itching that interrupted sleep.

On at 05:21 p.m., Resident #8 complained of uncontrollable itching. Resident #8 had red bumps on abdomen area with visible irritation from scratching. Resident #8 stated that the itching was also on the back of both legs.

During interview with Resident #3 on at 05:55 p.m., the resident had no waste basket in their the resident was not sure why there was no waste basket in the . Resident #3 stated that the waste basket in the community used. Resident #3 indicated there was an ongoing bed bug infestation in their resulted in bites at night.

During interview with Resident #14 on at 06:35 p.m., the resident was observed with red bumps and irritation from scratching on right side of abdomen and both legs. Resident #14 did not know the cause of the itching but stated that the bumps and itching were all over the body especially the legs and back.

Record review of pest control company visits revealed that on #1 and #2 were treated for bed bugs. There was no record that indicated whether the (#3, #5, #8 and #9) belonging to the residents that complained of bites and infestation were inspected or treated by a pest control company as a follow up to residents' complaint of bites and itches.

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On , at approximately 07:00 p.m., the owner and Assistant Administrator confirmed that the window in the to Resident #7 and Resident #12 did not have any form of cover that provided visual privacy from common smoking area.

Class III

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

Based on observation, interview and record review, the facility failed to provide closet or wardrobe space for hanging clothes for one (#6) resident; failed to provide a dresser, chest or other furniture designed for storage of personal effects for two (#7 and #13) residents; and failed to provide a waste basket in for nine (#3, #4, #5, #6, #7, #9, #10, #11, and #13) of fourteen residents observed and interviewed. The facility also failed to maintain a safe and sanitary living environment, free of pest infestation in compliance with local health department requirements.

Findings included:

Facility tour conducted on at 10:15 a.m. revealed that toured did not have waste baskets. Residents were observed using grocery bags, and storing trash on the floor or on top of dressers.

During interview with Resident #6, on at 10:22 a.m., resident expressed desire to have a closet to hang clothing. The two residents did not have a waste basket. Resident #6 stated that he placed trash on the dresser until it is picked up by housekeeping or until the resident goes outside of the facility to the main dumpster.

During interview with Resident #7, on at 10:48 a.m., the resident stated that the facility took her night stand and dresser and she was not provided with a reason. Resident #6 pointed out that she kept her clothes that were stored in a dresser in a basket positioned on the floor. The observed with discarded paper and used cigarettes. Resident #4 stated that there was no waste basket in the ; so trash was placed on the floor.

During interview with Resident #4, on at 11:00 a.m., the resident stated that a grocery bag and a clear juice/punch bowl were used as a waste basket.

During interview with Resident #11, on at approximately 11:00 a.m., the resident stated that

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there was no waste basket in the desired to have one in the .

During interview with Resident #5, on at 11:20 a.m., resident's observed with no waste basket, Resident #5 stated that a big trash can outside of the facility was used to throw trash away.

During interview with Resident #13 on at 12:03 p.m., the resident indicated that there was no waste basket and no nightstand or dresser in their . Resident #13 stated that the facility removed the night stand without informing the resident of the reason and only left a stand-alone closet. Resident #13's observed with no waste basket and only a stand-alone closet for storage of clothing and belongings.

During interview with Resident #10 on at 12:12 p.m., resident's with no waste basket. Resident #10 stated that it would be nice to have a trash can in the .

During interview with Resident #9 on at 12:19 p.m., the resident stated that there was no trash can in the , and that trash was thrown away in the community .

During interview with Staff B on at 02:00 p.m., the staff stated that some of the had trash cans, but most did not have one. Staff stated that the residents used the waste baskets located in the community .

During interview with the Assistant Administrator, on at 02:59 p.m., she confirmed that residents did not have trash cans in the because some residents use the trash cans for . The Assistant Administrator also stated that the facility understood that the residents should have a dresser or a closet.

Throughout the survey on , multiple residents also reported being bitten at night and stated multiple had a bug infestation, believed to be bed bugs.

A review of a report from the local county health department dated revealed that the health department inspection was unsatisfactory. Violations noted included infestation/presence, damaged walls, lighting and window screens.

Class III