STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953196	**01/17/2019**
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

A Complaint Survey (CCR#: 2018016356 and 2019000535) was conducted at Shady Oaks Living Center Assisted Living Facility on . Shady Oaks Living Center Assisted Living Facility had deficient practice identified at the time of the survey.

(License#: 8450)

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

Based on record review and interview, the Facility failed to employ or contract with a licensed nurse to administer medications to one Resident (#4) of one sampled resident who required Medication Administration.

Findings Included:

A record review for Resident #4, conducted on , revealed that the resident's admission Health Assessment Form dated stated that the resident required Medication Administration on page one and page four. A review of Resident #4's Medication Observation Records showed that the Facility's unlicensed Medication Technicians signed all of the resident's medications as given. Resident #4 was admitted to the Facility on .

A review of the Facility's Staff List, conducted on , revealed that the Facility did not employ licensed nurse to administer medications.

During an interview with the Assistant Administrator, conducted on , the Assistant Administrator acknowledged and confirmed that the Facility did not employ or contract with a licensed nurse to administer Resident #4's medications and that the Facility's Medication Technicians signed Resident #4's Medication Observation Records for medications given to the resident.

Class III

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

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

Based on record review and interview, the Facility failed to update Medication Observation Records (MORs) immediately when medications (meds) were offered; and, failed to document the reasons meds were not given to three Residents (#3, #5, and #6) of six sampled residents who required assistance with self-administration of meds.

Findings Included:

A MORs review for Resident #3, conducted on , revealed that the resident had meds not signed as given which included Resident #3's prescribed med:
- Divalproax DR 250mg not signed as given on and at 05:00pm; and, on at 12:00pm

The Facility staff did not provide an explanation on the of Resident #3's MORs as to the reason this med not given on the aforementioned dates and times. There were no orders to hold this med in the Resident #3's record.

A MORs review for Resident #5, conducted on , revealed that the resident had meds not signed as given which included Resident's prescribed meds:
- 100mg not documented as given on , , , , and at 08:00pm
- 10mg not documented as given on at 08:00pm
- , 25mg not documented as given on at 08:00pm

The Facility staff did not provide an explanation on the of Resident #5's MORs as to the reason this med not given on the aforementioned dates and times. There were no orders to hold this med in the Resident #5's record.

A MORs review for Resident #6, conducted on , revealed meds frequently circled as not given which included Resident #6's prescribed meds:
- 0.5mg circled as not given on , , , , and at 08:00am; and, on , , , , , and at 05:00pm
- 30mg circled as not given from through at 08:00pm
- Divalproax 500mg circled as not given from through

The Facility staff did not provide an explanation on the of Resident #3's MORs as to the reason this med not given on the aforementioned dates and times.

During an interview with the Assistant Administrator, conducted on , the Assistant Administrator acknowledged and confirmed that missing documentation that Resident #3 and #5 that meds given to the residents as prescribed every day. The Assistant Administrator acknowledged and confirmed that

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

Resident #6's MORs did not stated a reason for each time that the medication offered to the resident. The Facility was also unable to provide documentation that Resident #6's Physician and Designee aware of med refusals.

Class III

0077 - Staffing Standards - Administrators - 429.176 FS; 429.52( ),58A-5.019(1) FAC

Based on observation, record review, and interview, the Facility failed to have a Core trained Assistant Administrator serving as the Facility Manager.

Findings Included:

During the Entrance Conference, conducted on , the Assistant Administrator identified herself as the Assistant Administrator in charge of the Facility. The Administrator was not present in the Facility on the day of survey.

A review of the Facility's Background Screening Employee Roster, conducted on , revealed that the Assistant Administrator wasidentified on the Facility's Background Screening Employee Roster as the Assistant Administrator.

A review of the Floridahealthfinder.gov website revealed that the administrator of record was listed as the administrator of three separte facilities.

An employee record review for the Assistant Administrator, conducted on , revealed that the Assistant Administrator had a Core Training Certificate in the employee's record dated . There were no number of hours completed stated on the training certificate and no indication that a passing Core Training test completed. There were only three hours of continuing education for the years 2017 and 2018 in the employee's record. The Assistant Administrator had a hire date of .

During an interview with the Assistant Administrator, conducted on , the Assistant Administrator stated that, "I did not keep up with the continuing education for Core Training; I was told that I did not have to because of the Administrator's [Core Training]."

Class III