STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963878	**02/09/2019**
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 February 9th, 2019 a Complaint Survey (CCR#2018017444, CCR#2018017939, CCR#2018018073 and CCR#2019000230) was conducted at Bradenton Oaks. At the time of the survey, the facility had deficiencies.

(License #6662)

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

Based on observation, interview, and record review, the Facility failed to ensure that required care and services were provided to meet the needs for continued residency of one Hospice Resident (#14) of one sampled Hospice resident and failed to ensure that one of one sampled residents whose health assessment indicated they required medication administration was appropriate to reside in the facility.

Findings Included:

An observation, conducted on /19 at 04:16am, revealed that one staff called over the Memory Care Director's walkie-talkie and requested additional assistance in the Memory Care Unit due to the staff working in the Memory Care Unit alone. Upon entry in to the Memory Care Unit, Resident #14 was observed lying on right side in bed and appeared with both bent and pulled toward their /.

During an interview with Staff C, conducted on 02/09/19 at 05:15pm, Staff C stated that Resident #14 was and unable to bear and the Facility's Memory Care Unit left Resident #14 unattended due to a shortage of staff in the facility.

During an interview with the Memory Care Director, conducted on 02/09/19 at 05:39pm, the Memory Care Director stated that Resident #14 was , unable to bear , and required total assistance with Activities of Daily Living. The Memory Care Director stated that Resident #14 was admitted to Hospice services on /19 but was unable to bear for a much longer period than that "greater than three months before [the resident] admitted on Hospice". The Memory Care Director

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963878	02/09/2019
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)

further stated that the Facility had a staff shortage, and that staff, disappear from work duties, which included the locked secured Memory Care Unit where Resident #14 resided.

A record review for Resident #14, conducted on 02/09/19, revealed that Resident #14 had multiple occurrences with no specific dates and times of occurrence. Resident #14's record did not include all documentation of all that the resident incurred or the inclusion of specific intervention measures implemented for prevention. The Facility also failed to obtain an updated face-to-face Health Assessment for Resident #14 when the resident had a significant decline in condition, which warranted the admission to Hospice services on /19. Resident #14's Health Assessment Form dated /18 did not specify the resident's required nursing services of Hospice or whether the resident required 24-hour care or not. Resident #14's Health Assessment Form and Interdisciplinary Care Plan did not specify care and services to meet the resident's needs for prevention. Resident #14's Progress Notes on /18 stated that the resident had "been sent to the hospital multiple times throughout the last month due to unresponsive episodes and ." The Facility did not provide documentation on when the multiple unresponsive episodes and occurred and the resident's record did not have the information documented. There was no evidence that the Facility notified Resident #14's Physician, Responsible Party, or Hospice with each and unresponsive episode occurrence.

During an interview with the Administrator, conducted on 02/10/2019 at 12:20am, the Administrator acknowledged and confirmed that the Facility did not provide any communication efforts for an attempt to coordinate care and services for provision of care needs to Resident #14 while the Facility was short-staffed.

A record review for Resident #4, conducted on 02/09/19, revealed that the resident's Health Assessment 2010 Form dated /17 stated that the resident had a diagnosis of with behavioral disturbances and required medication administration. Resident #4's January and February 2019 Medication Observation Records (MORs) had medications signed as given by the Facility's Medication Technicians (Staff A, C, E, I, and J).

During an interview with the Wellness Director, conducted on 02/09/2019 at 12:00am, the Wellness Director acknowledged and confirmed that there were no licensed nurses employed at the Facility to pass medications. The Wellness Director acknowledged and confirmed that Resident #4's Health Assessment Form indicated that the resident required medication administration and that Medication Technicians (Staff A, C, E, I, and J) signed the resident's medications as given on the resident's MORs.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963878	**02/09/2019**
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)

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, interview, and record review, the Facility failed to:
1. Notify a licensed Physician when a resident exhibited a change in condition or mental status change
2. Provide supervision to meet the needs of residents who . or were . risks or . precautions
3. Provide supervision to meet the needs of residents who had a significant weight loss
4. Update resident records of significant changes and/or illnesses

Findings Included:

An observation in the Memory Care Unit, conducted on . . . . /19 at 04:16pm, revealed that one staff called over the Memory Care Director's walkie-talkie and requested additional assistance in the Memory Care Unit due to the staff in the Memory Care Unit alone.

During an interview with Staff C, conducted on 02/09/19 at 05:15pm, Staff C stated that the Facility's Memory Care Unit was left unattended due to a shortage of staff.

During an interview with the Memory Care Director, conducted on 02/09/19 at 05:39pm, the Memory Care Director stated that the Facility maintained low-staffing levels, and that staff, disappear from work duties, which included the locked secured Memory Care Unit.

A record review for Resident #2, conducted on 02/01/19, revealed that Resident #2's Health Assessment Form dated . . /19 stated that the resident had difficulty walking and required assistance with bathing, dressing, grooming, toileting, transferring, and with self-administration of medication. Resident #2's Progress Notes documented that the resident had an unresponsive episode on . . . . . /18. Resident #2's record did not have documentation that the Facility notified the resident's Physician or Responsible Party. Resident #2's Progress Notes also stated that the resident "takes own medication" and self-medicates". There was no documented evidence that the resident capable to self-medicate and no Physician order that Resident #2 may self-medicate.

A record review for Residents #3, conducted on 02/09/19, revealed that Resident #3's Health Assessment Form dated /18 stated that the resident had an overactive , fatigue, ... , and history of repeated . . and required supervision with eating and assistance with ambulation, bathing, dressing, grooming, toileting, and transferring. Resident #3 had a significant weight loss. Resident #3 weighed pounds on . . /18 and weighed pounds on . . . . . /19. Resident

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963878	02/09/2019
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)

#3's Progress Notes also had a late entry documented regarding a that occurred on /19 in which the resident sustained a , of the , and . Resident #3's record did not have documentation that the Facility notified the resident's Physician or Responsible Party of the or the weight loss. Resident #3's Progress stated that the resident had a on /18 and sustained a , . Resident #3's record did not have documentation that the Facility notified the resident's Physician or Responsible Party. Resident #3's record did not have documented intervention measures put in place with each to prevent Resident #3's occurrences and had multiple occurrences and no documented risk assessments or updated Service/Care Plans specifying interventions implemented for prevention with each occurrence. Resident #3's Physician and Responsible Party were also not notified with each occurrence.

A record review for Resident #4, conducted on 02/09/19, revealed that the resident's Health Assessment 2010 Form dated /17 stated that the resident had , difficulty walking, and with behavioral disturbance. Resident #4 had a significant weight loss in which the Facility failed to notify the resident's Physician and Responsible Party. Resident #4 weighed pounds on /17 and weighed pounds on /17. Resident #4 weighed pounds on and weighed pounds on /19. There were no documented interventions documented in Resident #4's of any notifications or follow-up regarding the weight loss.

A review of the Facility's tracking report, conducted on 02/09/19, revealed that the Facility had twenty-five documented , which occurred from /19 through /19. There were no tracking data provided for before /19.

A review of the Facility's ' Risk Management Policy and Procedure (undated), conducted on 02/09/19, revealed that the Facility failed to follow their Policy and Procedure and investigate a , complete a risk assessment, update a resident's Service/Care Plan with each occurrence, and notify the residents' Physician and Responsible Party.

A review of the Facility's Incident Reporting Policy and Procedures (undated), conducted on 02/09/2019, revealed that the Facility's definition of incident or unusual occurrence defined as "any accident or episode, involving a resident, staff member, or other individual in the Community which presents a risk to the health, safety, or wellbeing ..." and included the following:
- The Director of Wellness (or trained designee) will complete an incident report after taking the proper steps to see that the resident or parties involved receive necessary interventions (incidents may include the following elopements, falls, medication errors, death, skin tears, resident's sent to the emergency room, alleged abuse, and an alleged violation of resident rights)
- The outcome of any hospital visits or tests warranted by an incident and the "notification of

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963878	02/09/2019
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)

responsible person and physician where appropriate will be recorded on the original incident report" The Facility failed to follow their ' and Incident Report Policy and Procedures' by failing to include all Facility required incident reporting data which included but not limited to:

- Completing incident reports for each incident occurrence
- Providing dates and times of incidents
- Describing each incident
- Notifying resident's Responsible Parties and Physicians with each incident
- Investigating each incident occurrence
- Updating each resident's Service/Care Plan with each occurrence

A record review for Resident #18, conducted on 02/09/19, revealed that the resident's Health Assessment Form dated /17 stated that the resident had a diagnosis of and a history of falling and was a risk and required supervision with bathing. There was no Service/Care Plan in Resident #18's record specifying care and services that the resident required for prevention.

A record review for Resident #6, conducted on 02/09/19, revealed that the resident's Health Assessment Form dated /17 stated that the resident had a history of recurrent and with general and required assistance with ambulation, bathing, dressing, grooming, toileting, and transferring. There was no Service/Care Plan in Resident #6's record specifying care and services that the resident required for prevention.

A record review for Resident #19, conducted on 02/09/19, revealed that the resident's Health Assessment Form dated /18 stated that the resident had a diagnosis of ; had an unsteady gait with poor safety awareness; was a risk; and, required physical assistance with ambulation, bathing, dressing, eating, grooming, toileting, and transferring. There was no Service/Care Plan in Resident #19's record specifying care and services that the resident required for prevention.

A record review for Resident #20, conducted on 02/09/19, revealed that the resident's Progress Notes had eight documented from /18 through /19. Resident #20 did not have documented intervention measures put in place with each to prevent Resident #20's occurrences. Resident #20's Physician and Responsible Party not notified with each occurrence. The Facility failed to address Resident #20's documented "unsteady gait, impulsive behaviors, and refusals or non-compliance with the use of the call pendent" until /19 with no further documentation. The Facility failed to update Resident #20's Service/Care Plan with each occurrence specifying intervention implemented with each for the resident's prevention. Resident #20 did not have documentation of a risk assessment in the resident's record.

A record review for Resident #21, conducted on 02/09/19, revealed multiple occurrences and no

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963878	02/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADENTON OAKS COURTYARD	**1015 7TH AVENUE EAST BRADENTON, FL 34208**

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

documented risk assessments or updated Service/Care Plans with each occurrence specifying interventions implemented for the resident's prevention. Resident #21 had a documented change in mental status on /19. The Facility had no documented evidence that the Resident #21's Physician or Responsible Party notified of the resident's change in condition.

During an interview with the Wellness Director, conducted on 02/09/2019 at 10:00pm, revealed there were no incident reports for Resident #2's unresponsive episode and hospitalization on /18. At 10:40pm, the Wellness Director stated that the Facility did not complete investigation checklists or performed risk assessments on residents who . The Wellness Director unaware that a investigation and risk assessments required by the Facility. The Wellness Director acknowledged and confirmed that the Facility did not utilize a Program. The Wellness Director acknowledged and confirmed that the documented on incident reports inconsistent with documentation in resident records. The Wellness Director acknowledged and confirmed the lack of documented evidence that the Facility notified each resident's Responsible Party and Physician with each incident occurrence. The Wellness Director acknowledged and confirmed that the Facility failed to follow their ' and Incident Reporting Policy and Procedures'. The Wellness Director acknowledged and confirmed that the Facility failed to update Service/Care Plans for each resident who while residing in the Facility. The Wellness Director acknowledged and confirmed that the Facility lacked documented evidence of interventions implemented with each resident's to prevent reoccurrence. The Wellness Director acknowledged and confirmed that the Facility had no documented evidence that Resident #3 and #4's Responsible Party and Physician notified regarding their loss. The Wellness Director stated that the Facility had nothing in place for or tracking before the Wellness Director's date of hire 01/2019.

During an interview with the Administrator and Wellness Director, conducted on 02/10/19 at 12:20am, the Administrator unaware of the staffing shortage for /19 on the 3-11 shift and the 11-7 shift and the Wellness confirmed with the Administrator that the Facility had staff who called off duty and not replaced. The Facility had four staff on duty on the 3-11 shift for a census of 116 in-house residents. The Facility had two staff on duty on the 11-7 shift for a census of 116 in-house residents. The Facility consisted of two buildings. One building consisted of five stories and housed seventy-two residents and a one-story building with two units, which included a secured Memory Care Unit.

Class III

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

Based on record review and interview the facility failed to ensure 1 (Staff D) of 3 employees whose

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963878	**02/09/2019**
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)

records were reviewed included written documentation from a health care provider stating they are free of communicable disease within 6 months prior to hire or within 30 days of hire and documentation of a negative tuberculosis (TB) examination on an annual basis.

Findings included:

An employee record review was conducted for Staff D on 2/9/19, with a date of hire of 11/20/13 Staff D's record did not include written documentation from a health care provider stating they are free of communicable disease within 6 months prior to hire or within 30 days of hire and documentation of a negative tuberculosis (TB) examination on an annual basis.

During an interview conducted on 2/9/19 at 9:52pm, the Business Office Manager acknowledged and confirmed the lack of documentation from a health care provider stating Staff D is free of communicable disease within 6 months prior to hire or within 30 days of hire and documentation of a negative tuberculosis (TB) examination on an annual basis. The Business Office Manager stated "I know we did it, but I can't find it."

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on interviews, observations, and record review, the facility failed to provide adequate amount of staff in order to meet the needs of the residents.

Findings Included:

During an interview with the Memory Care Supervisor conducted on 02/09/2019 at 4:22pm, the Memory Care Supervisor confirmed that the facility was short staffed and at this moment, there was only one staff working in Memory Care, one staff in the Towers and one staff in the courtyard.

Record review of the facility's census on the date of survey revealed the census was 116 total residents.

Staff interview conducted on 02/09/2019 beginning at 5:15pm and throughout the survey revealed the facility "runs on short staff." There are times when there is only one staff for the Towers which consists of five floors.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963878	**02/09/2019**
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)

An observation in the Memory Care Unit, conducted on 02/09/19 at 04:16pm, revealed that one staff called over the Memory Care Director's walkie-talkie and requested additional assistance in the Memory Care Unit due to the staff in the Memory Care Unit alone.

During an interview with Staff C, conducted on 02/09/19 at 05:15pm, Staff C stated that the Facility's Memory Care Unit was left unattended due to a shortage of staff.

Resident interviews conducted on 02/09/2019 beginning at 6:38pm and continuing throughout survey, revealed multiple residents have concerns there is not enough staff and that the staff do not have time to check on the all the residents and do their job efficiently.

Observation conducted on 02/09/2019 from 4pm until 11pm, there were one staff in the Towers, one staff in the courtyard, one staff in memory care and one manger on duty.

Review of the facility's staffing schedule for 2/3/2019 until 2/10/2019 revealed on 02/09/2019 for the 3pm to 11pm shift, there was one staff member scheduled to work the Towers which occupies 72 residents and five (5) floors, there was one staff scheduled Memory Care and one staff scheduled for the Courtyard.

During the exit conference conducted on 02/10/2019 at 12:17am, the Wellness Director confirmed they are responsible for scheduling the direct care staff for the facility. The Wellness Director revealed they used a company matrix in order to determine the number of staff that are to be scheduled. The Administrator reveled the matrix included Memory Care Unit one staff for every 10 residents, Towers one staff for every 35 residents and the Courtyard there one staff for every 20 residents. The Administrator confirmed that according to the facility's staffing matrix and schedule they are currently under staff. The Administrator confirmed there are not enough staff on the premises to meet the needs of the residents.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2-3) FAC

Based on record review and interview the facility failed to ensure two (Staff B and C) of three employees hired after 5/10/18 whose records were reviewed included documentation of a preservice orientation of at least 2 hours to all new assisted living facility employees prior to interacting with residents.

Findings included:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963878	**02/09/2019**
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)

An employee record review was conducted for Staff B on 2/9/19, with a date of hire of 6/16/18 Staff B's record did not include documentation of a preservice orientation of at least 2 hours to all new assisted living facility employees prior to interacting with residents.

An employee record review was conducted for Staff C on 2/9/19, with a date of hire of 9/22/18 Staff C's record did not include documentation of a preservice orientation of at least 2 hours to all new assisted living facility employees prior to interacting with residents.

During an interview conducted on 2/9/19 at 10:39pm, the Business Office Manager acknowledged and confirmed the lack of documentation for Staff B and C of a preservice orientation of at least 2 hours to all new assisted living facility employees prior to interacting with residents. The Business Office Manager Stated "I didn't know about the preservice training."

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 ensure the facility residents resided in a clean and decent living environment.

Findings Included:

An observation during entry in to the Courtyard building, conducted on 02/09/19 at 04:00pm, revealed a strong musty/urine like odor near the entry/lobby area. The odor was also present in the resident's television area and the carpeting in the area appeared, dirty, tattered, and old (Photographic Evidence obtained). The odor in both the entryway and television of the Courtyard building was present during the entirety of the survey, which concluded on 02/10/19 at 12:45am.

During a tour of The Courtyard building on 2/9/19 at 5:18pm the following was observed:
The tile floor outside the resident laundry was dirty.
The resident laundry room floor was dirty.
The ceiling tiles outside the laundry storage room were stained.
(photographic evidence obtained)

During a tour of room 61 on 2/9/19 at 5:49pm the following was observed:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963878	**02/09/2019**
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)

The plaster wall above the air conditioning unit was damaged.
(photographic evidence obtained)

During an interview conducted on 2/9/19 at 10:24pm, the Administrator acknowledged and confirmed that need for cleaning and repairs. The Administrator stated regarding stained ceiling tiles "We need to change those out." and stated regarding the damaged wall in room 61 "We need to fix that and have a contractor come out." and stated regarding the dirty tile floor "You should have seen it before."

During an interview with the Administrator, conducted on 02/10/2019 at 12:20am, the Administrator acknowledged and confirmed the musty/urine odor at the front entrance of the Courtyard and in the resident's television area and that, the area contained carpeting that appeared old, tattered, worn, and malodorous.

Class III

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

Based on record review and interview, the facility failed to maintain the employment status of all employees within the Agency for Health Care Administration (AHCA) Background Screening Clearinghouse Roster within 10 business days for four (Executive Director, Staff C, G and H) of eight employee records reviewed.

Findings included:

Review of the AHCA Background Screening Clearinghouse Roster Agency Website revealed that the Executive Director, Staff C with a date of hire of 9/22/18 and Staff H with a date of hire of 7/28/18 and a termination date of 12/27/18 were not listed on the AHCA Background Screening Clearinghouse Roster.
(photographic evidence obtained)

Review of the AHCA Background Screening Clearinghouse Roster Agency Website revealed that Staff G with a date of hire of 10/23/18 and a termination date of 1/11/19 had no end date on the AHCA Background Screening Clearinghouse Roster.

During an interview conducted on 2/9/19 at 7:44pm, the Business Office Manager acknowledged and confirmed that the AHCA Background Screening Clearinghouse Roster was not current. The Business Office Manager Stated "I didn't know I needed to update that?"

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963878	**02/09/2019**
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)

Unclassified