STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910842	**04/11/2019**
NAME OF PROVIDER OR SUPPLIER **OAKS OF CLEARWATER, THE**	STREET ADDRESS, CITY, STATE, ZIP CODE **420 BAY AVENUE** **CLEARWATER, FL 33756**	

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

0000 - Initial Comments

Assisted Living Facility

A Complaint Investigation (Complaint # 2019001745 and 2019002038) was conducted at The Oaks of Clearwater Assisted Living Facility on . Deficiencies were identified at the time of the survey.

(License#: 4818)

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

Based on record reviews and interviews, the Facility failed to ensure that Medication Observation Records (MORs) were accurate and free from omissions and errors and were immediately updated each time medications (meds) were offered to six Residents (#1, #3, #5, #6, #7, and #8) of six sampled Residents who required assistance with self-administration of meds.

Findings Included:

A MORs (and ,) review for Resident #1, conducted on , revealed that Resident #1's MORs had meds not documented as given to the resident, which included the resident's prescribed:
- 20mg not documented as given to Resident #1 on at "AM".
- , 10mg not documented as given to Resident #1 on 003/17/19 at "HS"
- Proair Hydrofluoroalkane 90mcg Inhaler not documented as given to Resident #1 on /given on at 6pm, and at 12:00pm.
- , 75mg circled as not given from through with various reasons why the resident did not receive this med and some dates and times with no reasons provided. The reasons that Resident #1 did not receive the med included "refused", "out of building", and "doctors order". The med was discontinued by Resident #1's Health Care Provider on and this med continued to be listed on the resident's , MORs although no longer ordered.
- 25mg circled as not given to Resident #1 on and due to the unavailability of the med. However, the med was documented as given to Resident #1 on .
There was no reason documented on Resident #1's MORs as to why the resident did not received the prescribed meds for , , , Proair Hydrofluoroalkane, and on the dates and times specified. There were no specific times noted on the resident's MORs of when meds were due. Resident #1's MORs had meds scheduled with times listed as "AM", "MID", "PM", and "HS"

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A MORs (,) review for Resident #3, conducted on , revealed that Resident #3's MORs had meds not documented as given to the resident, which included the resident's prescribed:
- 50mg not documented as given to Resident #3 on at "MID".
- D-3 1000 units not documented as given to Resident #3 on at "MID"
There was no reason documented on Resident #3's MORs as to why the resident did not received the prescribed medications on the dates and times specified. There were no specific times noted on the resident's MORs of when meds were due. Resident #3's MORs had meds scheduled with times listed as "AM", "MID", "PM", and "HS"

A MOR (,) review for Residents #5, conducted on , revealed that Resident #5's MORs had no specific time noted on the resident's MORs of when the resident's prescribed meds 25mg and Baza Protectant Cream were due. There were no specific times noted on the resident's MORs of when meds were due. Resident #5's MORs had meds scheduled with times listed as "AM", "MID", "PM", and "HS".

A MORs (,) review for Resident #6, conducted on , revealed that Resident #6's MORs had meds not documented as given to the resident, which included the resident's prescribed:
- Kavinace capsules (no dose noted) not documented as offered or given to Resident #6 on 12:00pm.
There was no reason documented on Resident #6's MORs as to why the resident did not received the prescribed medications on the dates and times specified. There were no specific times noted on the resident's MORs of when meds were due. Resident #6's MORs had meds scheduled with times listed as "AM", "MID", "PM", and "HS"

A MORs (,) review for Resident #7, conducted on , revealed that Resident #7s MORs had meds not documented as given to the resident, which included the resident's prescribed:
- D-3 2000 unit not documented as given to Resident #7 on at "MID".
There was no reason documented on Resident #7's MORs as to why the resident did not received the prescribed medications on the dates and times specified. There were no specific times noted on the resident's MORs of when meds were due. Resident #7's MORs had meds scheduled with times listed as "AM", "MID", "PM", and "HS"

A MORs (,) review for Resident #8, conducted on , revealed that Resident #8's MORs had meds not documented as given to the resident, which included the resident's prescribed:
- , / , 25/250mg not documented as offered or given to Resident #8 on and at "MID".
- 50mcg Spray not documented as offered or given to Resident #8 on and

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at "MID".
There was no reason documented on Resident #8's MORs as to why the resident did not received the prescribed medications on the dates and times specified. There were no specific times noted on the resident's MORs of when meds were due. Resident #8's MORs had meds scheduled with times listed as "AM", "MID", "PM", and "HS"

During an interview with the Health and Wellness Director, conducted on at 04:10pm, the Health and Wellness Director acknowledged and confirmed that Resident #1's continued on the resident's MORs and was discontinued on . The Health and Wellness Director confirmed that Resident #1's pills continued to be present in the Facility (in the nursing office).

During an interview with the Assisted Living Administrator, conducted on at 04:25pm, the Assisted Living Administrator acknowledged and confirmed that meds were not documented as given to Residents #1, #3, #5, #6, #7, and #8.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on observation, record review, and interview, the Facility failed to ensure that prescriptions were filled or refilled in a timely fashion and failed to notify Health Care Providers for refusals of medications (meds) for three Residents (# 1, #5 , and #6) of three sampled residents that required assistance with self-administration of medication.

Finding Included:

A record review for Resident #1, conducted on , revealed Resident #1's Medication Observation Records (MORs) had the meds circled as not given, which included the resident's prescribed:
100mg circled as not given to Resident #1 from through due to not available. There was no evidence that Resident #1's Health Care Provider was notified that the resident was not receiving this med due to the unavailability of the med. There was no evidence that the Facility followed up with Resident #1's Responsible Party after the notification was made that the med was not available.

During an interview with Resident #1, conducted on at 10:45am, Resident #1 stated that the resident does not receive meds as ordered and that the meds were given late. Resident #1 stated that

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the Facility does not get meds refilled on time.

A record review for Resident #5, conducted on , revealed Resident #5's , Medication Observation Records (MORs) had the meds circled as not given, which included the resident's prescribed:
- 25mg circled as not given to Resident #5 on and at "HS" due to the resident's refusal of the med
- Baza Protectant Cream circled as not given to Resident #5 on at "AM" and , , , , , , , , and at "PM" due to the resident's refusal of the med.

There was no evidence that Resident's #5's Health Care Provider and Responsible Party was notified that Resident #5's was not receiving these meds due to refusals. There were no specific times noted on the resident's MORs of when meds were due. Resident #5's MORs had meds scheduled with times listed as "AM", "MID", "PM", and "HS".

A record review for Resident #6, conducted on , revealed Resident #6's , Medication Observation Records (MORs) had the meds circled as not given, which included the resident's prescribed:
, 500mg circled as not given to Resident #6 from through at "AM" and documented as given on at "PM" and at "AM" and "PM" and and circled as not available and . Resident #6 had meds circled as not given due to refusals, which include the resident's prescribed , , 25mg, , 500mg, Kavinace, Magtein, and 3mg. There was no evidence that Resident #6's Health Care Provider was notified that the resident was not receiving these meds due to refusals and unavailability of the meds. There was no evidence that Resident #6's Responsible Party was notified related to the resident's refusals of the meds.

During an interview with the Assisted Living Administrator, conducted on at 04:10pm, the Assisted Living Administrator acknowledged and confirmed that Resident #1, #5, and #6 had meds circled on their , MORs due to not available and refusals. The Assisted Administrator was unable to provide evidence that Resident #1, #5, and #6's Health Care Providers and Responsible Parties were notified that the resident were not receiving their meds due to refusals and unavailability of the meds.

Class III

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

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Based on interview and record review, the facility failed to ensure staff received required in-service training within 30 days of employment, for staff who provide direct care to residents for 3 (Staff A, Staff B, and Staff C) of 3 employee records reviewed.

Findings included:

Employee record review conducted on revealed Staff A with a date of hire of did not have documentation of recognizing and reporting resident , neglect, and , , and resident rights training, activities of daily living and behavioral needs training, and incident reporting training.

Employee record review conducted on revealed Staff B with a date of hire of did not have proof of resident rights training, activities of daily living and behavioral needs training, and incident reporting training.

Employee record review conducted on revealed Staff C with a date of hire of did not have proof of recognizing and reporting resident , neglect, and , , and resident rights training, activities of daily living and behavioral needs training, and incident reporting training.

During interview with the Administrator on beginning at 4:05pm, the Administrator reviewed each employee record and confirmed the missing trainings for each staff.

Class III