STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967667	**05/02/2019**
NAME OF PROVIDER OR SUPPLIER **OAK VALLEY ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **4488 HWY 79** **VERNON, FL 32462**	

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

0000 - Initial Comments

An unannounced abbreviated biennial licensure survey and Limited Mental Health monitoring visit was conducted in conjunction with a complaint survey (#2019002536) on at Oak Valley ALF (Assisted Living Facility). At the time of the survey, deficient practice was identified.

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

Based on observation of centrally stored resident medications, record review of facility's Medication Observation Record (MOR) and resident medical record, and interview with facility Administrator and Office Manager, the facility failed to remove medications from service when the physician order ended or the medication expired for 1 of 9 medications reviewed, resident #7.

The findings include:

On at approximately 11:40 AM observation of medication storage with the Office Manager showed a 100,000 USP/Gram prescribed to resident #7 with an order fill date of and a discard date of with the directions for use being "Use two times a day for 14 days". Record review of resident #7's medical record at approximately 12:00 PM showed the most current order for 100,000 USP/Gram was dated with the directions for use being "Use (twice a day) x 14 days". The Facility Administrator and Office Manager confirmed the date on the order and confirmed this was the most current order for the use of the prescribed 100,000 USP/Gram. In interview at that time the Administrator and Office Manager confirmed that the medication had been given for self-administration to the resident since the order fill date of . Record review of the MOR at approximately 12:15 PM showed that the medication had been documented as being given most recently as of at 6:00 AM.

Class III

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

Based on observation of assistance with medication self-administration, record review of facility's Medication Observation Record (MOR) and resident 7's medical record, and interview with facility Administrator and Office Manager, the facility failed to maintain a copy of the prescribing Physician's medication order for 2 of 9 medications reviewed.

The findings include:

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On at approximately 11:30 AM observation of assistance with medication self-administration with facility Office Manager showed , , , and as 1 tablet, and 90mcg inhaler handed to resident #7 after identifying the resident and reading the medication labels to resident. Record review of MOR at approximately 12:00 PM revealed both of these medications were listed as current medications to be given. Record review of resident 7's medical record at this time showed no order by a physician for , , , and as 1 tablet nor 90mcg inhaler. Facility Administrator and Office Manager at that time confirmed there was no order in the medical record for either medication.

Class III

0075 - Use of Personnel; Emergency Care ( ) - 429.255( ) FS

Based on observation of the facility's Automated External Defibrillator ( ), record review of the 's operating manual, and interview with the facility's Administrator and Office Manager, the facility failed to have an operational on premise for an assisted living facility with 17 or more beds for 1 of 1 's reviewed.

The findings include:

On at approximately 2:30 PM, observation of the facility's with Administrator and Office Manager showed pads with an expiration date of confirmed by the Administrator and Office Manager. The failed to turn on after several attempts made by the Administrator and Office Manager, both confirmed a red blinking light on the status indicator. A record review of the operating manual at that time noted that a red light blinking on the status indicator indicated the device has failed internal self-test or that service is required. The Administrator confirmed the device is not operational at that time.

Class III

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

Based on staff record review and staff interview, the facility failed to ensure employees completed 2 hours of preservice orientation for 2 of 3 sampled employees (B & D).

The findings include:

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On reviews of the employee personnel records were conducted for 3 employees. Employee B, a care giver, was hired on . There was no signed statement of completion of the 2 hour preservice orientation prior to interacting with residents. Employee D, a care giver, was hired on . There was no signed statement of completion of the 2 hour preservice orientation prior to interacting with residents.

On at approximately 3:00 PM,, an interview was conducted with the Administrator who stated he was not aware of this requirement but would make sure it is done going forward.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observation, record review, and interview the facility failed to demonstrate a 72 hour supply of generator fuel onsite, and failed to provide a written notification to residents/ resident representatives of the implementation of their Emergency Environment Control Plan which has the potential to affect 20 of 20 residents in the event that an alternate power source was required by the facility.

The findings include:

On at approximately 1:00 PM, record review of the facility's "Generator Addendum to Oak Valley Assisted Living's Comprehensive Emergency Management Plan (CEMP)" showed that the facility had in place a propane powered fixed generator that would supply alternate power to the entire facility to ensure temperatures within the facility would be maintained at or below 80 degrees Fahrenheit for a minimum of 96 hours with a fuel requirement of 288 gallons of propane to achieve this. The addendum also stated that the facility had a total fuel capacity of 525 gallons. At that time the Administrator stated that onsite he currently had approximately 96 gallons of fuel. The Administrator stated that the fuel estimates were high, and would be revised. During hurricane Michael, the generator 1.9 gallons /hour and the tank lasted 11 days.

The CEMP failed to document notification to the residents/resident representatives of the implementation of their Emergency Environment Control Plan. In interview with the facility Administrator at approximately 1:15 PM he stated that he had not given any written notice to the residents/resident representatives of the implementation of their Emergency Environment Control Plan.

On at approximately 1:30 PM, observation of the facility's generator showed a fixed propane fueled generator. Observation of the generator being operated showed that the generator functioned,

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but the Administrator had to physically hold a mechanical component in place to regulate the power. The Administrator expressed concern of the generator damaging electrical components if ran unattended. Further review of the fuel tanks confirmed by the fuel level indicator dials that there was approximately 18.5% of the fuel tank capacity of 525 gallons, totaling approximately 96 gallons. Facility Administrator confirmed these findings and immediately ordered additional fuel.

Class III