STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910842	**06/05/2019**
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

A Complaint Investigation (Complaint Numbers: 2019001736, 2019005434, 2019005485, 2019008612 and 2019007643) and a Revisit to 04/11/19 Complaint Investigation (Complaint Numbers: 2019001745 and 2019002038) were conducted at Oaks of Clearwater Assisted Living Facility on 06/05/19. Deficiencies were identified at the time of survey.

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

Based on record review and interview, the Facility failed to provide supervision to meet the needs for the prevention of , precautions, and safety for four Residents (#1, #2, #3, and #4) of four sampled residents that required precautions and extra supervision.

Findings Included:

During an interview with a Department of Children and Family Service's Adult Protective Investigator (DCFAPI), conducted on at 01:53pm, the DCFAPI stated that, due to a no-call/no-show and staff that left without permission, the Facility's Memory Care Unit was left unattended on for the shift. There was no staff to attend to care needs of the Memory Care Residents diagnosed with and/or . The shift staff left at 09:00pm without permission and the shift never showed up for work. Resident #1 during this time of no supervision.

During an interview with a different DCFAPI, conducted on at 05:20pm, the DCFAPI stated that the Facility's housekeeping supervisor walked in on Resident #5 giving instructions to Resident #4 (Resident #5's) on how to rub massage the resident's private areas. According to the DCFAPI, Resident #5 had no , , Resident #4 had , , and both Resident #4 and #5 shared a room. The DCFAPI stated that Resident #4 was moved to close supervision on the sixth floor during the time of the DCFAPI's investigation on . The DCFAPI stated that the Facility waited 24-hours to remove Resident #4 out of harms' way instead of removing Resident #5 immediately upon identification of harm.

A review of the Facility's incident reports, conducted on , revealed that there were multiple incidents for Resident #3 from through (See Photographic Evidence13). There were no incident reports for Resident #1 and #2.

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A review of an Adverse Incident Report for Residents #4 and #5, conducted on , revealed that the Facility filed an Adverse Incident Report for Residents #4 and #5 in which the Housekeeping Director walked in on Resident #5 naked on the couch instructing Resident #4 on how to massage the resident's private areas. There was no indication in Resident #4 or #5's Progress Notes that this incident occurred.

A record review for Resident #1, conducted on , revealed that Resident #1's Health Care Assessment Form dated stated that the resident had and was alert and oriented times one. Resident #1 required supervision with all Activities of Daily Living and was an elopement risk (See Photographic Evidence11). Resident #1 resided in the Facility's Memory Care Unit. Resident #1's Progress Notes stated that Resident #1 had a on in which the resident's Responsible Party viewed the resident on the floor at 04:15am and came to the Facility and called 911 for assistance. Emergency personnel arrived and assisted Resident #1 off the floor at 07:15am. There was no indication in the Progress Notes that there was no staff on duty at the time Resident #1 . There was no incident report provided regarding any risk management or quality assurance for an investigation to determine the possible cause and intervention measures for prevention of future occurrence. A previous Health Assessment Form dated stated that Resident #1 required precautions and assistance with bathing , toileting, and transferring.

A record review for Resident #2, conducted on , revealed that Resident #2's Health Assessment Form dated (See Photographic Evidence12), stated that Resident #2 had a diagnosis and history of , left-sided (2018), and expressive aphasia. Resident #2 Health Assessment Form stated that the resident was " ", "not oriented to place, time, or events", "unaware of surroundings", and "needed extra supervision". Resident #2's Health Assessment Form stated that the resident had "difficulty understanding what is happening", required "close monitoring", and "medication administration". Resident #2's Progress Notes stated that on , Resident #2 was found by the housekeeper at 09:03am, "sitting in recliner with dry on and and stated that [the resident] and hit " and that the "resident last seen at 07:30am for morning [medications]". Resident #2's Medication Observation Records had all medications signed as given by unlicensed Medication Technicians and there was no documentation that Resident #2 received a prescribed medication (, ,) on and at 07:00pm. Resident #2 resided on the ninth floor in which staff was not present at all times on that floor. According to en.m.wikipedia.org/wiki/Aphasia, aphasia was the loss of ability to understand or express speech caused by damage.

A record review for Resident #3, conducted on , revealed that Resident #3's Health Assessment Form dated stated that the resident was independent with Activities of Daily Living of ambulation, , eating, toileting, and transferring and required assistance with bathing, grooming, and medications. Resident #3 had a Risk Assessment which indication that the resident was risk.

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Resident #3 had and incessantly. Although Resident #3's Responsible Party refused services due to religious convictions, the Facility failed to provide and implement appropriate interventions to meet Resident #3's needs for precautions, risk behaviors, and accident prevention. There were no intervention or prevention measures to meet Resident #3's needs for or accident prevention in conjunction with, Resident #3's and the residents Responsible Party, religious convictions found in Resident #3's record.

A record review for Resident #4, conducted on , revealed that Resident #4's Health Assessment Form dated , stated that the resident had , , alert and oriented times two, and required supervision with all Activities of Daily Living (See Photographic Evidence9).

During an interview attempt with Resident #2, conducted on at 11:22am, Resident #2 was unable to answer questions appropriately, had difficulty responding to questions or making self, understood, and was not interview-able.

During an interview with Staff U (Housekeeping Director), conducted on at 02:15pm, Staff U stated that when the staff entered Resident #4 and #5's room on , the staff found Resident #4 on the couch naked giving instruction to Resident #5 on how to massage the resident's areas. Staff U stated that the staff reported this on and not the day the incident occurred on .

During an interview with the Assisted Living Licensed Practical Nurse (ALLPN), conducted on at 10:00am, the ALLPN stated that Resident #5 had a "mindset of a six year old". The ALLPN stated that the Facility moved Resident #5 to a separate room on . The ALLPN stated, "I came into the picture on and notified DCF" and Resident #4 and #5's Responsible Party and Health Care Provider. At 01:45pm, the ALLPN stated that the Facility used to provide oversight for in which "it used to be that when a resident had three , we moved them to a higher level of care and now there is no oversight for anymore". The ALLPN was unable to provide documentation of various intervention measures for Resident #3 to prevent reoccurrence. The ALLPN was unable to provide Facility Incident Reports or their Risk Management/Quality Assurance investigation reports for Resident #1 and #2's incidences and stated that, "there was no incident report filled out for [Residents #1 and #2]". There was no evidence provided on measures put in place to ensure that the Memory Care Unit would not be left unattended by staff. There was no evidence provided on measure put in place to ensure that staff would not wait 24-hours to report possible .
Class III

0160 - Records - Facility - 58A-5.024(1) FAC

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Based on record review and interview, the Facility failed to maintain an admission and discharge log with all of the required data.

Findings Included:

A review of the admission and discharge log (A&DL), conducted on , revealed that the Facility did not maintain the A&DL with all of the required data. The A&DL did not include a specific address or Facility name from where residents were admitted from or where discharged residents went. Instead the A&DL stated, "home", "higher level of care", "behavioral", "30 or 45 day notice", or "SNF". The A&DL did not include a discharge date, place, reason, or place that the resident was discharged to when the resident expired on .

During an interview with the Executive Director, conducted on at 03:25pm, the Executive Director stated that the required data criteria would be explained to the new Assisted Living Administrator. The Executive Director agreed that Resident #5 had no discharge information in the A&DL.
Class III