STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910842	R 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 Revisit to 04/11/19 Complaint Investigation (Complaint Numbers: 2019001745 and 2019002038) and a Complaint Investigation (Complaint Numbers: 2019001736, 2019005434, 2019005485, and 2019007643) were conducted at Oaks of Clearwater Assisted Living Facility on . Deficiencies were identified at the time of survey.

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

Based on interview and record review, the Facility failed to maintain Medication Observation Records (MORs) that were free from errors. Furthermore, the Facility failed to have specific times that medications (meds) were due and failed to update the MORs immediately when meds were offered to four Residents (#2, #4, #10, and #11) of four sampled residents that required assistance with self-administration of meds or med administration.

Findings Included:

A record review for Resident #2, conducted on , revealed that Resident #2's Health Care Assessment Form dated stated that the resident required med administration, close monitoring, not oriented, unaware of surroundings and needed extra supervision. Resident #2's MORs did not have documentation that the resident received the resident's prescribed med , , 500milligrams (mg) on , and at 07:00pm. There was no reason described explaining why Resident #2 did not receive the med. According to Resident #2's progress notes, the Facility sent the resident to the hospital on due to hitting during a . Resident #2's hospital record indicated that the resident had a .

A record review for Resident #4, conducted on , revealed that Resident #4's Health Assessment Form dated , stated that the resident required assistance with self-administration of meds. Resident #4's MORs had the prescribed med 5% Cream documented as given for every day in , except for on , , , and . On these dates, the med was circled as not given for reason described as on "reorder" and "out of building". A review of the med order dated , the Cream prescribed to Resident #4 was as a one-time dose on .

A MORs review for Resident #10, conducted on , revealed that Resident #10 had prescribed meds not documented as given to the resident, which included:

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- / , 5-325mg was not documented as given on at "AM"
- , / , 25/250mg was not documented as given on at "MID", on at "MID", and on at "MID"
- , 500mg was not documented as given on at "MID"
- 50mcg Spray was not documented as given on at "MID", on at "MID", and on at "MID"

A MORs review for Resident #11, conducted on , revealed that Resident #11 had prescribed meds not documented as given to the resident, which included:
- 100 units/milliliter (ml) was not documented as given twelve units every evening from through
- 100 units/ml was not documented as given per from through and there was no documented test readings for the identification of the units required per

During an interview with Staff T (Medication Technician), conducted on at 01:00pm, Staff T stated that a lot of meds were "not available, a lot on all floors".

During an interview with Staff M, conducted on at 01:15pm, Staff M stated that the staff had worked all floors of the Facility (three through eleven) and since the staff started working at the Facility, the staff had found that meds were frequently not available, on all floors, every day".

During an interview with the Assisted Living Licensed Practical Nurse (ALLPN), conducted on at 10:00am, the ALLPN stated that Resident #4 had a "mindset of a six year old". At 01:45pm, the ALLPN agreed that MORs for Resident #2, #4, #10, and #10 had meds not documented as given to the residents and that Resident #4's Cream should have been discontinued off the MORs and "definitely no documented as given every day.
Class III

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

Based on observation, interview, and record review, the Facility failed to maintain centrally stored medications in a locked cabinet, cart, receptacle, or room at all times.

Findings Included:

During an observation, conducted on at 05:25am, thirty-three boxes of medications were

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observed through a window after exiting off the sixth floor elevator. Staff A was on the elevator with three Surveyors and Staff B and C exited off the other elevator at the same time. Staff B and C opened the room where the medications were on top of a desk without a key. Staff A, B, and C were asked if medications were usually left unlocked and unsecured. There was no response from Staff A, B, or C.

A review of the medication delivery manifest from the Facility's Pharmacy, conducted on , revealed that the delivery manifest was printed on at 10:28:56pm. There was no time noted as the time of delivery.

During an interview with the Assisted Living Licensed Practical Nurse (ALLPN), conducted on at 01:45pm, the ALLPN stated that the Pharmacy delivered the medications to the Facility twice every day at 12:00am and 12:00pm and the medications "should not have been left out" at 05:15am and "should have been put away by then".
Class III

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

Based on observation, interview, and record review, the Facility failed to ensure that medications were filled or refilled in timely fashion. Furthermore, the Facility failed to supervise the provision of medications by notifying Health Care Providers of refusals and ensuring that medications provided when leaving the Facility for eight Residents (#2, #3, #4, #11, #14, #15, #16, and #25) of eight sampled residents.

Findings Included:

During an observation and medication (med) reconciliation for the fourth and ninth floor med carts, conducted on , the fourth and ninth floor med carts had multiple empty med box containers in several drawers of the med carts, which had the reorder stickers pulled off. On the fourth floor included, but not limited to, Residents #3, #13, and #25.
- Resident #3's prescribed 60mg, , 25mg containers were empty, and the meds were not available for the resident to take. Resident #3 had six unopened/sealed pills of the Resident's prescribed , 500mg ( ) capsules. Resident #3's Medication Observation Records (MORs) indicated that the resident refused this med six times on , , , and . Resident #3's MORs had documentation that the resident frequently refused meds (See Photographic Evidence14).
- Resident #13's prescribed D-3 200 unit container was empty and the med was not available for the resident to take.

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- Resident #25's prescribed , 5mg container was empty and the med was not available for the resident to take.
On the ninth floor included, but not limited to, Residents # 2 and #14.
- Resident #2's prescribed , 15mg, , 40mg, and 15mg containers were empty and the meds were not available for the resident to take.
- Resident #14's prescribed , 25mg container was empty and the med was not available for the resident to take.

A review of Resident #2's MORs, conducted on , revealed that Resident #2's prescribed med 50mg was documented as not given to the resident due to not available and on "reorder" from through . Resident #2 required medication administration according to the resident's Health Assessment Form dated . (See Photographic Evidence12)

A review of Resident #4's MORs, conducted on , revealed that Resident #4's prescribed meds were frequently documented as not given to the resident due to the meds were on "reorder" for many meds, dates, and times noted on the resident's MORs. There was no provision of meds when Resident #4 was "out of the building" on and (See Photographic Evidence19).

A review of Resident #9's MORs, conducted on , revealed that Resident #9's prescribed meds were frequently documented as "refused" for many meds, dates, and times noted on the resident's MORs (See Photographic Evidence21).

A review of Resident #11's MORs, conducted on , revealed that Resident #11's prescribed meds were frequently documented as not given to the resident due to the meds were on "reorder" for many meds, dates, and times noted on the resident's MORs. There was no provision of meds when Resident #11 was "out of building" on . (See Photographic Evidence16).

A review of Resident #15's MORs, conducted on , revealed that Resident #15's prescribed meds frequently documented as not given to the resident due to "refused" for many meds, dates, and times noted on the resident's and MORs (See Photographic Evidence17 and 18).

A review of Resident #16's MORs, conducted on , revealed that Resident #16's prescribed meds were frequently documented as not given to the resident due to "refused" for many meds, dates, and times noted on the resident's MORs (See Photographic Evidence20).

During an interview with Staff T, conducted on at 01:00pm, Staff T stated that all floors had meds not available for resident frequently.

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During an interview with Staff M, conducted on [redacted] at 01:15pm, Staff M stated that the staff had worked all "floors, three through eleven [and had] found that the meds were frequently not available on all floor, every day".

During an interview with the Assisted Living Licensed Practical Nurse (ALLPN), conducted on [redacted] at 01:45pm, the ALLPN was unable to provide documented evidence that Health Care the Facility notified Residents #2, #3, #4, #11, #14, #15, #16, and #25's Health Care Providers that the resident did not receive their prescribed meds. The ALLPN stated that, "I don't have time to notify everyone every time residents don't take their meds". The ALLPN stated that "I had no idea that the meds were out this frequently" and that "there is no system in place for making sure that a resident takes their meds when they leave for the day". The ALLPN stated that "not reordering meds is a big issue that we have had with [Medication Technician and] we have had three trainings with staff".
Class III

0058 - Pharmacy & Dietary; Uncorrected Deficiencies - 429.42( ) FS; 58A-5.033(3)(a) FAC

Based on record review, observation, and interview the facility failed to ensure documented class III deficiencies regarding medicinal drugs were corrected as required.

Findings Included:

During a survey conducted on [redacted], the Facility was cited for two medication related Class III Deficiencies, which included medication records and medication labeling and orders.

During a follow-up survey conducted on [redacted], the facility had continued non-compliance related to medication records and medication labeling and orders. The Facility was cited for medication storage.

Based on this ongoing medication non-compliance, the Facility is required to retain the services of a licensed Pharmacist of licensed Registered Nurse consultant until the Agency determines that such consultation services are no longer required which was explained to the Executive Director at the exit conference at 03:25pm. The Executive Director stated understanding of the services that the Facility is required to obtain.
Class III