Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963878	A. BUILDING: _____ B. WING _____	10/04/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A Biennial Re-licensure Survey with Generator Monitoring, a Complaint Investigation (Complaint Numbers: 2019010885, 2019010917, and 2019011032), a Revisit to 08/02/19 Complaint Investigation (Complaint Numbers: 2019007002 and 2019009608), and a Revisit to 08/02/19 Generator Monitoring were conducted at Bradenton Oaks Assisted Living Facility on 10/03/19 and 10/04/19. Deficiencies were identified at the time of survey.	A 000		
A 025 SS=D	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963878	A. BUILDING: _____ B. WING _____	10/04/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 1 activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to provide care and services appropriate to meet the needs of residents that were admitted to the Facility and at risk for and failed to contact residents' Health Care Providers and responsible Parties and follow their own policy and procedures for incident reports and updating two Residents' (#2 and #24) Service/Care Plans and implementing interventions appropriate to reduce the residents' risk for . Findings Included: During an observation of Resident #24, conducted on at 01:00pm, Resident #24 was observed ambulating with a walker and had obvious difficulty in managing/maneuvering the walker. The walker had two rolling wheels on the	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963878	A. BUILDING: _____ B. WING _____	10/04/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 2 front [illegible] and the [illegible] had a rubber type stopper. The [illegible] of the walker were catching/scraping across the linoleum floor and the resident appeared to have difficulty walking with it. Resident #24 had a hospital [illegible] dated [illegible] around the right [illegible] and the resident's left upper arm was wrapped in a bandage. Staff J confirmed that Resident #24 was just in the hospital due to a [illegible]. Resident #24 resided in the Memory Care Unit. A review of an Adverse incident report dated [illegible], conducted on [illegible], revealed that Resident #24 had a [illegible] and was sent to the hospital for complaint about arm [illegible] and the resident did not have a call pendant. The Facility's corrective action for this Memory Care Resident was to educate the resident regarding the use of the call pendant. A record review for Resident #24, conducted on [illegible], revealed that Resident #24 had diagnoses of [illegible] and [illegible]'s as was at risk for [illegible] and required [illegible] precautions. There was no documentation in the resident's record regarding any [illegible] and notification that were made to Resident #24's Health Care Provider and Responsible Party. There were no in-house incident reports created with each [illegible] the resident had. The Facility did not update Resident #24's Service/Care Plan according to their policy each time the resident [illegible] to include appropriate interventions for [illegible] prevention. A record review for Resident #2, conducted [illegible], revealed that Resident #2 had numerous [illegible] since [illegible]. The incident reports reviewed had no evidence that Resident #2's Health Care Provider and Responsible Party were notified with each [illegible] that the resident had	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963878	A. BUILDING: _____ B. WING _____	10/04/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 3 and not complete according to their policy. The Facility did not update Resident #2's Service/Care Plan according to their policy each time the resident to include appropriate interventions for prevention. A review of the Facility's Policy and Procedure, conducted on , revealed that residents were to be assessed for risk "prior to move-in and on an ongoing basis" and that the results of the assessment would be "reflected in the resident's Service Plan". The Policy and Procedure stated the Wellness Director would notify the resident's Health Care Provider and Responsible Party, complete a Investigation Checklist, complete a Risk Assessment, and revised the resident's Service Plan accordingly and "it may be appropriate to review the Community's residency criteria to determine whether the resident may need to move to another setting". During an interview with the Regional Director of Care, conducted on at 04:17pm, the Regional Director of Care stated that resident's Service Plans were created initially upon move-in, annually, and with changes in condition. The Regional Director of Care stated that the Facility did not have a program in place but that the Facility would enroll a resident that was falling in physical or , and work closely with third party services. The Regional Director of Care stated that the Wellness Nurse and Administrator evaluated incident on a weekly basis and discussed meeting the resident's needs at those meeting and contacted resident's Health Care Provider and Responsible Party. During an interview with the Wellness Director, conducted on at 04:30pm, the Wellness	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963878	A. BUILDING: _____ B. WING _____	10/04/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 4 Director agreed that the Facility was no following their and Incident Reporting Policies and Procedures. The Wellness Director agreed that would be considered a change in condition and agreed that there was a lack of notifications to Health Care Providers and Responsible Parties with each occurrence and there was a lack documentation regarding the in the residents' record. The Wellness director was unable to provide any Investigation Checklist, Risk Assessment, or updated Service Plans for Resident #2 and #24. The Wellness Director was unable to provide documentation of the types of appropriate interventions that the Facility put in place as prevention measures to reduce Resident #2 and #24's risk for falling. Class III	A 025		
A 162 SS=D	58A-5.024(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name; 2. ; 3. Race; 4. Date of birth; 5. Place of birth, if known; 6. Social security number; 7. Medicaid and/or Medicare number, or name of other health insurance ; 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and 9. Name, address, and telephone number of the health care provider and case manager, if applicable.	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963878	A. BUILDING: _____ B. WING _____	10/04/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 162	Continued From page 5 (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in Rule 58A-5.0181, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, ... , or other services to be provided, supervised, or implemented by the facility that require a health care provider ' s order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 58A-5.020, F.A.C., if applicable. (e) The resident care record described in paragraph 58A-5.0182(1)(e), F.A.C. (f) A ⌄ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ⌄ recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 58A-5.0181, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 58A-5.0185, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 58A-5.025, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963878	A. BUILDING: _____ B. WING _____	10/04/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 162	Continued From page 6 fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 58A-5.0181, F.A.C. (o) The resident ' s , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement; 2. The resident demographic data required in this paragraph; 3. The health assessment described in Rule	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963878	A. BUILDING: _____ B. WING _____	10/04/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 162	Continued From page 7 58A-5.0181, F.A.C.; 4. The resident's contract described in Rule 58A-5.025, F.A.C.; and 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to obtain a -to- Health Assessments with all required data documented completely on the Agency for Health Care Administration's Form 1823 (1823) as required for five Residents (#1, #5, #6, #13, and #18) of five sampled residents. Findings Included: A record review for Resident #1, conducted on , revealed that Resident #1's 1823 dated did not stated the type of assistance that the resident required for medication administration; did not have the Examiner's telephone number and address; and, did not state the resident's name and date of birth at the top of pages two and three.	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963878	A. BUILDING: _____ B. WING _____	10/04/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 162	Continued From page 8 A record review for Resident #5, conducted on . . . . . , revealed that Resident #5's 1823 dated . . . . . did not stated the type of assistance that the resident required for medication administration; and, did not have the Examiner's telephone number and address. A record review for Resident #6, conducted on . . . . . , revealed that Resident #6's 1823 did not have the date of the examination; did not state the resident's diet; did not state whether the resident's needs could be met in an assisted living facility; did not have the Examiner's name, title, license number, telephone number, or address. A record review for Resident #13, conducted on . . . . . , revealed that Resident #13's 1823 did not have the date of the examination. A record review for Resident #18, conducted on . . . . . , revealed that Resident #18's 1823 did not have the date of the examination. During an interview with the Wellness Director, conducted on . . . . . , the Wellness Director agreed that Resident #1, #5, #6, and #8's 1823s had missing required data and incomplete. Class III	A 162		