RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Oakridge Assisted Living Facility
297 SW County Road 300
Mayo, FL 32066

Dear Administrator:

This letter reports the findings of a complaint, CCR #2014005275, inspection survey, conducted on , 2014 through 2014, by representatives of the Agency for Health Care Administration (Agency). Enclosed is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **ten business days** of receipt of this hand delivered report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0027 - 58a-5.0182(3) Fac - Resident Care - Arrangement For Health Care S-S= G
St - A - 0029 - 58a-5.0182(5) Fac - Resident Care - Nursing Services S-S= G
St - A - 0077 - 58a-5.019(1) Fac - Staffing Standards - Administrators S-S= G
St - A - 0165 - 429.23(1-4 & 6-10) Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Directed Corrective Actions:

1. The Assisted Living Facility is required to develop and implement a policy and procedure to address residents who require emergency services, including residents who are found unresponsive. The policy and procedure must:

a. identify the employee on shift who will be responsible for calling emergency services as well as the resident's responsible party, if applicable.

b. Include directions on calling first calling emergency service personnel after identifying an emergent need for such services.

c. Include directions for staff on the importance of initiating unless a resident has a

d. Include a plan for making all resident records (including medical records, medication records, resident emergency contacts and available for emergency personnel.

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2. The Assisted Living Facility is required to train all current and future employees on the new policy and procedure referenced above. The facility must maintain documented proof that employee has attended and completed this training. The documentation must remain on the premises of the facility for Agency review.

3. The Assisted Living Facility is required to develop and implement a policy and procedure for reporting Adverse Incidents according to the 58A-5.0241 F.A.C. The policy must identify the person(s) in charge of Adverse Incident reporting to the Agency.

4. The Assisted Living Facility is required to train all current and future employees on incident reporting and reporting Adverse Incidents. Documentation of said training shall be maintained of the premises of the facility for Agency review.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call . . Jasmine Hayes, Health Facility Evaluator Supervisor at (386) 462-6201.

Sincerely,

Kristen J. Mennella
Field Office Manager

KJM/jjh

Received by: Administrator or Representative

Date

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965486	06/20/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Oakridge Assisted Living Facility	**297 Sw County Road 300 Mayo, FL 32066**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
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Specific Tag Findings:

0000-Initial Comments

On . . unannounced **complaint survey,** CCR #2014005275, and Extended Congregate Care monitoring was conducted at **Oakridge** Assisted Living Facility in Mayo, Florida. Discernible deficiencies were identified as a result of this survey. The facility was not in compliance at this time.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on record reviews and interviews the facility failed to have a current 1823 health assessment for 1 of 3 residents (#1).

Findings:

1. On . . during a record review of resident #1 records it was observed that her most current 1823 health assessment was last done on , which was more than three years ago. Resident #1 was due for a new assessment on .

2. On . at approximately 5:10 pm the administrator was asked if resident #1 had a newer 1823 health assessment then the one dated . She stated she could not locate a more recent assessment.

Class III

0027-Resident Care - Arrangement for Health Care 58A-5.0182(3) FAC
Based on interviews and record reviews the facility failed to provide emergency medical transportation in a timely manner for 1of 3 sampled residents (resident #1).

Findings:

1. On . at approximately 11:25 am an interview was conducted with the Administrator about the three hour delay in calling emergency medical transport services for resident #1 who had . on herself and was being unresponsive to staff who were trying to wake her. The Administrator said it was true and she takes full responsibility for the incident.

2. On . at approximately 2:00 pm an interview was conducted with direct care staff member B. She stated on . at 12:00 am she saw the light on in resident #1 . was out of the ordinary. When she went into the residents . found her sitting in her chair with her eyes closed with . . . all over the front of her clothes. She said she could see that the resident was breathing and she tried to wake her by calling her name,

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but the resident did not respond. Staff B stated she went and got another staff member who was pulling private duty to assist her. When they returned to resident #1 attempted to wake her by lightly shaking her shoulder. Staff B stated the resident pulled her shoulder away from her but would not respond to her beyond that. Staff B stated she called the administrator and told her the condition of the resident and the Administrator told her to monitor the resident to see if she gets worse and let her know. Staff B stated she asked the Administrator, "What does worse look like?" Staff B stated she then was instructed to monitor the residents and if it gets worse call her back. Staff B stated she took the residents every 30 minutes until 3:00 am and because the resident was still not responding she called the Administrator back and she was told to call Emergency Medical Services which was three hours after the Administrator was first notified.

3. On resident #1's Heath Care Surrogate (HCS) was interviewed. The HCS stated resident #1 had a history of have what was described as The HCS wen on to say in the past the like episodes would only last for no longer than 15 minutes.

4. On a record review was conducted on the facility's hospital transport log. It revealed resident #1 was transported to the hospital on by and never returned to the facility.

5. A review of the Emergency Management Systems report revealed received a call to respond to resident # 1 at 3:15 am on

Class II

0029-Resident Care - Nursing Services 58A-5.0182(5) FAC
Based on interviews and record reviews the facility which has an Extended Congregate Care specialty license failed to provide the taking of vital signs or the supervision thereof for 1 of 3 sampled residents (resident #1).

Findings:

1. On at approximately 2:00 PM Staff B was interviewed. Staff B stated on at 12:00 am she found resident #1 in her in her chair with all over her front and not responding to her verbal commands. She called the Administrator who told her to monitor her and if it gets worse send the resident out to the hospital. Staff B stated she took the residents every 30 minutes from 12 am-3 am and it did not change. Staff B stated she called the Administrator back at 3:00 am and told her resident #1 was still not responding to her and she was told by the Administrator to call Emergency Medical Services and have her taken to the hospital.

2. On at approximately 11:25 am the Administrator was asked why they do not have a nurse available when they have an ECC license. She said they have a contract nurse but not a registered nurse which works for the facility because it's too expensive.

3. On at 3:58 PM an interview was conducted with the facility's contracted Extended Congregate Care (ECC) nurse, a registered nurse. The ECC nurse confirmed she is contracted with the facility to provided nursing services. The ECC nurse stated no one from the facility called her or notified her as to resident #1 being unresponsive on she further stated she was not aware of the event of until several days later when she saw the resident #1 in the hospital. The ECC nurse added she lives five (5) minutes away from the facility and would have went there if she had been notified.

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4. A record review was conducted on Staff B's training record. It was observed that she did not have certification as a nursing assistant.

Class II

0077-Staffing Standards - Administrators 58A-5.019(1) FAC
Based on interviews and record reviews the Administrator failed ensure the provision of appropriate care for 1 of 3 sampled residents by instructing an unlicensed staff member to monitor a resident who was found unresponsive (resident #1).

Findings:

1. On at approximately 11:25 am an interview was conducted with the Administrator regarding resident #1 not receiving medical attention for 3 hours after being discovered sitting in her responsive with all over the front of her, on at 12:00 am. The Administrator stated she was contacted by staff at 12:00 am with the above description of resident #1. The Administrator said she thought the resident had an mini and she was going to be ok. She said she told the staff member to continue to attempt to wake the resident and monitor her. The Administrator said she back to sleep and was waken by another phone call at 3:00 am by staff advising her that the resident was still being non responsive, and at that time she told staff to call emergency medical services to transport resident #1 to the hospital for an evaluation.

2. On at approximately 2:00 pm during an interview with Staff member B, she stated she found resident #1 sitting in her running down the front of her. B said she attempted to wake the resident by calling her name and the resident did not respond to her. She went and got another staff member who was doing private duty and they both attempted to wake the resident who was not responding. Staff B called the Administrator and informed her that resident #1 needed to go to the hospital but the Administrator said the family did not want the resident to go out and she needed to monitor and see if she comes out of it or not. Staff B stated at 3:00 am she contacted the Administrator again and the Administrator said to send her out to the hospital for evaluation.

3. A review of the Emergency Medical Service report revealed was called on at 3:15 a.m. to respond to resident #1's needs.

4. A review of the hospital admission report, dated for resident revealed resident #1, "clinically she appeared to have had a

Class II

0165-Risk Mgmt & QA; Adverse Incident Report 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC
Based on an interviews and record reviews the facility failed to file an adverse incident report for 1 of 3 residents (#1) after an adverse incident.

Findings:

1. On during a record review of the adverse incidents reporting system it was discovered that an adverse incident was not filed by the Oakridge Assisted Living Facility in reference to an adverse incident evolving

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resident #1 which may have contributed to her . . . . . Resident #1 was not sent to the hospital for three hours after being discovered by a staff member sitting in her . . . . . and covered in . . . . . It was discovered the resident had a . . . . and required a higher level of care where she latter expired.

2. On . . . . . at approximately 11:25 am an interview was conducted with the Administrator in reference to why the facility did not file an adverse incident report with the Agency. The Administrator stated she did not file and adverse incident report because she felt what happened to the resident was a result of the residents condition and was not an event which staff could have exercise control over.

Class III