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
	AL11969022	A. BUILDING: _____ B. WING _____	R 12/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING FACILITY	2250 S SEMORAN BLVD ORLANDO, FL 32822

(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 second revisit to complaint investigation #2020012336 was conducted at Assisted Living on . A deficiency was identified at the time of survey.	{A 000}		
{A 025} SS=D	429.26(7) FS; 59A-36.007(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. 59A-36.007 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 59A-36.012, F.A.C. (b) Daily observation by designated staff of the 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.	{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
	AL11969022	A. BUILDING: _____ B. WING _____	R 12/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING FACILITY	2250 S SEMORAN BLVD ORLANDO, FL 32822

(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 (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: DEFICIENCY REMAINED UNCORRECTED Based observations, record reviews and interviews the facility failed to ensure all medications were given as ordered for 3 of 6 sampled residents (#5, 12 and 13) Findings: 1. The Medication Observation Record (MOR) for resident # 5 listed Performist 20 mcg /2 ml solution inhale 1 vial via twice daily- at 8 AM and 8 PM. The notations on the MOR indicated that the medication was not given because it was "awaiting on pharmacy , not unavailable, prior authorization" needed on , , , , at 8 AM and 8 PM; and at 8 AM , and on at 8 PM. Review of the resident's medications on at 1 PM revealed the Performist 20 mcg /2 ml was not in the medication cart along with his other medications. The Director of	{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
	AL11969022	A. BUILDING: _____ B. WING _____	R 12/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING FACILITY	2250 S SEMORAN BLVD ORLANDO, FL 32822

(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 Nursing recalled that the medication was kept in the refrigerator. Observations of the refrigerator noted a box with a prescription label dated . When dispensed the box contained 60 individually wrapped vials. The label indicated 6 refilled available. The inside of the box contained 13 individually wrapped packets. The DON said evidently the staff were not going to the refrigerator to get the medication but were indicated it was not available because it was not in the medication cart. Observations on at 9:45 AM noted staff A, an unlicensed staff E assisted residents # 12 and 13 with self - administration of medications in the following manner: 2. Staff E cleansed her . . . Reviewed the Medication Observation record (MOR), took medication from cart, brought the medication ( ) to resident # 12. Handed the bottle to the resident, the resident sprayed twice each nostril. The staff did not read the label before handing bottle to resident. The prescription label dated indicated one spray to each nostril daily. Staff E said on . . . . . at 10AM that the order before was 2 sprays. 3. Continued observations at 10:10 AM noted unlicensed staff E, cleansed . . ., reviewed MOR. She asked resident # 13 is she wanted . . . . today. The resident replied that she did not use it every day, but only when she needed it. The staff did not remind the resident the medication was to be used daily, not as needed. Individual resident record review revealed no evidence to confirm the directions for use that been changed by the residents' healthcare	{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
	AL11969022	A. BUILDING: _____ B. WING _____	R 12/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING FACILITY	2250 S SEMORAN BLVD ORLANDO, FL 32822

(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 providers. In an interview with the administrator on at 11 AM, who expressed [illegible] with the staff. Class III	{A 025}		