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
	AL11968474	A. BUILDING: _____ B. WING _____	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKMONTE VILLAGE OF LAKE MARY-CORDOVA	1001 ROYAL GARDENS CIR LAKE MARY, FL 32746

(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 complaint investigation #2024005955 and generator monitoring was conducted at Oakmonte Village of Lake Mary on . The facility had a deficiency at the time of the survey.	A 000		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the	A 054		

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A 054	Continued From page 1 medication. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure 1 of 4 sampled residents maintained a daily medication observation record who receives assistance with self-administration of medication. (#1). Findings: A record review of Resident #1 revealed an admission date on . A 1823 Health Assessment Form indicated a medical history of 's , Body ( ), (HLD), Prostatic Hyperplasia ( ), memory , short term memory and needs assistance with self-administration. On at 2:35pm the family member of Resident #1 stated the facility documented and signed off that they gave , -Levo ER 50-200 but did not actually administer it. He stated the staff falsified the report. As far as I know, Resident #1 was getting his medications. I was asked by the Administrator to leave his meds at the facility while they get him set for delivery with Bay Pharmacy. I first heard he did not get his meds beginning , . On at 9:50am Unlicensed Care staff A stated, "I do not pass meds. Yes, I know Resident #1. He was quiet and a wonderful resident. Unlicensed Caregiver D passed meds to Resident #1. She's no longer here and was terminated." On at 9:56am Unlicensed Caregiver	A 054		

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A 054	Continued From page 2 C stated, "yes I pass meds in memory care. I do not update the Medication Observation Record (MORs) until the resident has taken the medications. Yes, there was someone named Unlicensed Caregiver D. She wasn't here that long. She used to be a med tech." On at 10:08am Unlicensed Caregiver H stated, "no, I do not pass meds, I only provide care to the residents. Yes, I know Resident #1. He lived here maybe 2 months ago. Unlicensed Caregiver D was here but not too long. She was let go. Yes, she gave meds to Resident #1." A review of Resident #1's Medication Observation Record (MORs) revealed on Unlicensed Caregiver D documented Resident #1 was out of his 8pm -Levo ER 50-200 stating Resident doesn't have any extra of med to give no bottle." A review of Resident #1's MORs revealed all meds on hold through 12am. Resident out building. A review of Resident #1's MORs revealed on at 8pm Unlicensed Caregiver E documented -Levo ER 50-200 awaiting pharmacy. A review of Resident #1's MORs revealed on and Unlicensed Caregiver E documented -Levo ER 50-200 was administered at 8pm. On at 2:42pm Unlicensed Caregiver D was contacted via phone and a voice message was left for a call . On at 2:50pm Unlicensed Caregiver	A 054		

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A 054	Continued From page 3 E stated, "I don't recall all the medications that I gave to Resident #1. I know I was rushing one day, and I documented what I gave but the medication was not actually on the cart. I told the lead med tech and I put a note. She told me to tell the nurse the next day. I threw out the note because I was coming the next day to work and I told her before my shift." On at 3:15pm the Administrator stated, "once the resident returned to the facility it was discovered the meds were not on the cart. We contacted the family to determine if they took the meds with them. The family member stated they did not take any medications from the facility. Unlicensed Caregiver D started searching for the cart to prove it was there. We immediately removed her from the cart. After interviewing Unlicensed Caregiver E based on her documentation from - . She stated she documented the MORs as administered even though the meds were not on the cart. She stated another care staff told her to do it." (photographic evidence obtained) Class III	A 054		