RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

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

Dear Administrator:

This letter reports findings of an Extended Congregate Care monitoring visit survey that was conducted on . 2015 by representative(s) of this office. Attached is the provider's copy of the State (5000-3547) Form, which indicates there were no discernible deficiencies noted on the date of the survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Kriste J. Mennella at (386) 462-6201.

Sincerely,

for
Kriste J. Mennella
Field Office Manager

KJM/jjh
Enclosure

1GGN

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965486	**03/30/2015**
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 TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced Extended Congregate Care monitoring visit was conducted at Oakridge Assisted Living Facility on . Deficient practice was identified at the time of the survey.

0052 - Medication - Assistance with Self-Admin - 58A-5.0185(3) FAC

Based on observation and interview, the facility failed to properly assist 1 of 2 residents with the self-administration of medication by not reading the label preparing the medication in the presence of the residents and not reading the label in the presence of the resident (Resident #1).

The findings include:

On at approximately 11:05 a.m. Staff A removed a packet containing multiple pills for Resident #1 from the medication cart while. Staff removed the medication from the original packaging and poured them into a small cup. Staff A walked across the hall with the medication in the cup and entered Resident #1 ' s . Staff A stated to Resident #1, " I have your medicine, it is the medicine that you get. "
On at 11:10 a.m. and interview was conducted with Resident #1. Resident #1 stated he does not know which medication were given to him.
On at 11:17 a.m. Staff A was interviewed. Staff A stated the rule is to is to tell residents which medications they are taking and pour the medications in the cup in front of the residents. Staff A confirmed she is not a licensed nurse.
Class III