RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

September 1, 2015

Administrator
Spring Oaks
7251 Grove Road
Brooksville, FL 34613

RE: CCR #2015005726

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on September 1, 2015 by a representative of this office.

Enclosed is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than September 1, 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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. Should you have any questions please call this office at (386) 462-6201.

Sincerely,

Kristen J. Mennella for

Kriste J. Mennella
Field Office Manager

KJM/amw
Enclosure

XG90

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966595	08/18/2015
NAME OF PROVIDER OR SUPPLIER **SPRING OAKS**	STREET ADDRESS, CITY, STATE, ZIP CODE **7251 GROVE RD** **BROOKSVILLE, FL 34613**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

On unannounced complaint survey CCR #2015005726 was conducted at Spring Oaks Assisted Living Facility in Brooksville Florida. Discernible deficiencies were identified as a result of this survey. The facility was not in compliance at this time.

0053 Medication - Administration

Based on observations and interviews the facility failed to ensure that a licensed person administered medication for 5 of 5 residents observed (#4, 12,13,14,15).

Findings:

On at approximately 3:30 PM unlicensed staff G was observed assisting five residents with self-administration of medication in the memory care unit.

It was observed staff G obtained resident #12 prescription card which contained the medication . Staff G popped the medication from the prescription card into a small cup. He then carried the medication over to resident #12, who was sitting on the couch. Staff G handed the small cup with the medication to the resident and stated "Stan here's your medication" and the resident took it.

It was observed staff G obtained resident #13 prescription card which contained mapap 500 tab. Staff then popped the medication from the med card into a small cup. Staff G then carried the small cup over to were resident #13 was sitting. Staff G then stated "Len I have your |" and gave the resident the cup that contained the pill.

It was observed staff G obtained resident #14 prescription card which contained 0.25 from the medication cart. Staff then popped the medication from the prescription card into a small cup and carried it over to resident #14 was sitting on the couch. Staff stated to resident #14 "here take your medication, its just one".

It was observed staff G obtained resident #4 prescription card which contained mapap 500 from the medication cart. He popped two pills from the card into a small plastic bag and crushed the pills. After crushing the pills he placed them into a small cup and added apple sauce. He mixed the medication with the apple sauce with a spoon and carried the medication over to where the resident #4 was sitting. Staff stated "I have your medicine here" He attempted to give the resident the spoon, but when she refused he took the spoon and scooped out the medication and fed it to the resident.

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It was observed staff G obtained resident #15 prescription cards which contained atenolo 25 mg, 600 mg, glimepride 2 mg, 1000 mg. He popped the medication from the med cards into a small cup. He then called resident #15 over to the medication cart and stated "I have all your medicine here, take your medicine".

On at approximately 4:25 PM an interview was conducted with staff G. He was asked if he was a nurse which he stated no. He was asked if he took the assistance with self-administration of medication class, which he stated yes both the 4 hour class and the 2 hour update. He was asked if he knew the difference between assistance with self administration and administration which he stated yes. He said he knows he administered resident #4 her medication, sometimes she will do it on her own and sometimes she needs help. He stated yes he knows he is suppose to read the medication label in the presents of the resident and did not do so.

Class III

0056 Medication - Labeling and Orders

Based on interviews and record reviews the facility failed to fill or refill medication and failed to obtain medication orders within 10 days for 2 of 7 residents (#6 and #7).

Findings:

On at approximately 1:50 PM an interview was conducted with family member F who is the wife to resident #6. During the interview F stated that her husband had gone without his 5 mg tab for unknown amount of time because of insurance issues. When she found out she immediately went out and bought the medication.

On a record review was conducted on resident #6. It was observed his medical history and diagnoses consists of hyperchousterouma, , , , and . A review of his medication observation record revealed that resident #6 went twelve days without from to .

On at approximately 5:10 PM an interview was conducted with LPN B about the medication not being ordered in a timely manner. She stated that she was not working at the facility when this occurred but the LPN responsible at the time has been terminated. She has called the insurance since she found out and they have delivered the medication since then.

On during a record review of resident #7 it was observed that a nurses note dated

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states the family wants to know why the resident was not receiving her which was brought to the facility in 2015. The medication was located in the med cart and the facility nurse faxed a medication error order to the physician which he signed and sent back. The resident's medication sat in the facility for over two months without a physician's order.

Class III