STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965743	**02/23/2017**
NAME OF PROVIDER OR SUPPLIER **CENTURY OAKS**	STREET ADDRESS, CITY, STATE, ZIP CODE **4001 STACK BOULEVARD** **MELBOURNE, FL 32901**	

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

0000 - Initial Comments

Complaint Investigation CCR#2016014336 was conducted on , , and . Century Oaks Senior Living (license # 10095) had a deficiency at the time of the visit.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, record review and interview, the facility failed to follow physician's orders for 1 of 12 sampled residents who needed to be prep for surgery (#22): the facility failed to maintain a written record of changes in the method of medication administration for 1 of 12 sampled residents (#6): and the facility failed follow physician orders & assist with medications appropriately for resident (#8).

Findings:

1. Resident #22's record review revealed a physician order dated for the facility staff to start prepping on at 12:01 AM for surgery scheduled for . Further review revealed the physician's order documented details of the preparation for the surgery as follows: hold AM and PM medications day of surgery and prep for the day before surgery in the AM. There was no documentation that any prep was done by the facility. During a family interview on at 12:50 PM. Continue interview revealed the family took the physician order to the facility about 2 weeks prior to the surgery and spoke with the administrator. The resident's daughter also spoke with staff when visiting to remind the staff about the surgery preparation one week prior to the date of the surgery. The grievance log was checked and there was no mention of this in the resident's record. According to the resident's daughter, she completed the prep for her mother's surgery

On at 5 PM, the family member visited resident #22, assuming that the facility had already started the preparation in the morning as instructed & ordered. The family member stated she became upset and frustrated learning that the facility never begun the preparation as prescribed and ordered for the morning of . The family member began prepping the resident #22 herself at 5PM in the evening of . The family member stated she stayed all night to ensure her mother was ready for surgery the next day ( ).

An interview on at 1:30 PM with staff N, along with the Administrator and Resident Care Manager: staff N confirmed the facility received the order dated from doctor for resident #22. However, she was not sure if she could to do preparation in an Assisted Living Facility (ALF) setting. Therefore, she called the doctor and told him she was unable to do the prep. Staff N stated she then called the resident's daughter. Staff N stated that she called the resident's and she agreed to come in and prep her mother for the surgery. Staff N was asked where was the documentation of the call to the

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doctor and the resident's daughter. Staff N confirmed that she did not document, but gave a verbal update to her supervisor (Resident Care Manager).

On at 1:45 PM, an interview with Administrator and Resident Care Manager whom offered no comment and confirmed the finding.

On at 4:30 PM, an interview with the Administrator and the Director of Operations confirmed the finding.

2. Record review for resident #6 revealed a health assessment form 1823 that reflected he had diagnoses of and he required assistance with self-administration of his medications.

Review of his 2017 MOR revealed an entry for 0.25 mg, one tablet by mouth every 8 hours at 7:00 AM, 3:00 PM, 11:00 PM. The entry for the 3:00 PM dose on reflected the number 12. Review of a key on the bottom of the MOR reflected #12 meant "other." Review of the facility's missed medication by resident report revealed "other" meant the medication was not "popped within the time frame so it was not administered."

During an interview with the administrator on at 3:28 PM, she said the resident did not receive the medication because he was outside with another resident. She said a health care provider was not notified when the resident was not given the medication.

A review of a progress note for resident #6 dated reflected the facility did not have the resident's 20 milligrams (mg) and it was not given. The pharmacy was notified and indicated a 90-day supply of the medication was mail ordered on . The medication was not located in the facility. The mail order pharmacy was contacted and indicated the medication was shipped to the facility on . The package was accepted at the front desk of the facility and was given to the resident's wife who indicated she gave the medication to a staff member, but was unable to remember who specifically. The progress notes were signed by a licensed nurse.

During an interview with the administrator on at 3:45 PM, who stated she and the resident care director were unaware of the resident missing medications and were unaware that he did not receive the

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3. Resident # 8 had updated health assessment report dated that listed diagnoses of , , , , , , hip surgery, , high , and was hard of hearing. He needed assistance with self -administration of medications. The assessment indicated (,) 300 mg three times daily.

A prescription dated indicated 10 milligrams (mg) 5 tabs x 2 days , 4 tabs x 2 days, 3 tabs x 2 days , 2 tabs x 2 days and 1 tab x 2 days and , 750 mg one daily x 10 days. . The , 2017 Medication Observation Record (MOR) listed and indicated 1 tablet daily.

The , 2017 MOR listed , 100 mg take 2 capsules 3 times a day at 9 AM, 1 PM and 5 PM and had "D" as of to . The reason was changed to 300 mg from . A new line on The MOR indicated , 300 mg capsules take 1 capsule 3 times a day as of and was indicated as given 3 times on , and twice on .

Observations during a medication review on at 12:15 PM noted a prescription bottle dated that indicated , 100 mg take two (2) capsules by mouth 3 times a day for pain; 180 tables were dispensed.

In an interview on at 12:30 PM with staff L, who did not answer as to whether she gave the medication or not today, but stated that staff BBB normally worked the cart. Staff L counted the medication in the bottle.

Observations noted 56 tablets available of , were available. There were no , 300 mg pills in the medication cart. Staff L, who worked the cart that day, stated the other staff BBB was the medication tech who normally worked the cart. On at 12:30 PM staff BBB looked at the MOR and med bottle and stated "I give him 2 in AM and 2 in PM and 1 Oh that doesn't make sense and said I don't know" and walked away.

The administrator was given the opportunity to provide additional information to ensure the resident was given the , as per healthcare provider's order.

In an interview with the administrator on at 3:30 PM, who offered no comment.

Class III