STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965661	**05/03/2017**
NAME OF PROVIDER OR SUPPLIER **SPRING HILLS LAKE MARY**	STREET ADDRESS, CITY, STATE, ZIP CODE **3655 W. LAKE MARY BLVD.** **LAKE MARY, FL 32746**	

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

0000 - Initial Comments

The re-licensure survey including Limited Nursing Services was conducted on . Spring Hills Lake Mary Assisted Living Facility License Number 10007 had deficiencies at the time of the visit.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and interview, the facility failed to ensure the health assessment form 1823 was complete for 1 of 3 sampled residents (#11.)

Findings:

Resident #11 was admitted to the facility on . A review of his health assessment form 1823 dated revealed the question that pertained to whether his needs could be met in an assisted living facility was not answered.

There was no documented evidence either in the record to indicate the facility obtained the omitted information orally or in writing from a health care provider.

On at 4:00 pm, the administrator confirmed the finding.

Class III

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

Based on observations, record reviews, and interviews, the facility failed to ensure the unlicensed staff who assisted 1 of 1 sampled residents (#11) with self-administration of medications followed the correct procedure.

Findings:

Observations made during the medication pass for resident #11 on at 12:52 PM revealed the unlicensed caregiver washed her hands, removed the medication card from the medication cart, compared the label to the electronic Medication Observation Record (MOR,) popped the pill into a soufflé cup, and placed the medication card back into the cart. She approached resident #11 in his handed him a cup of water and the pill. Resident #11 took the medication without any assistance.

The caregiver did not read the medication label and did not prepare the medication in the presence of resident #11, as required.

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Review of a health assessment form 1823 dated for resident #11 revealed he required assistance with self-administration of his medications.

The finding was discussed with and acknowledged by the nursing director on at 1:15 pm.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record reviews and interviews, the facility failed to ensure staff were qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience and allowed unlicensed staff to make a judgement as to whether or not a medication would be given for 1 of 3 sampled residents (#1).

Findings:

Record review for resident #1 revealed a health assessment form 1823 dated that reflected she required assistance with self-administration of her medications and she had a diagnoses of .

Review of her , 2017 Medication Observation Record (MOR) revealed an entry for , 5 milligrams (mg) by mouth one time a day for , hold for (SBP) less than 100 and Diastolic (DBP) less than 60. It was scheduled to be given daily at 8:00 AM and the MOR contained staff initials from through .

During an interview with the nursing director on at 3:40 PM, he said the staff initials were those of unlicensed caregivers who assisted resident #1 with her medications. He said the unlicensed caregivers checked the , of resident #1 and reported the results to a licensed nurse. The nurse would tell the caregivers whether the medication was to be held.

The , 2017 MOR indicated that on at 8:00 AM, the medication was held and a reference was made to see the progress notes. The progress notes indicated that on , her , was .

During an interview on at 3:47 PM with the caregiver who assisted resident #11 with her medications on , she said before she assisted resident #11 with her , medication, she checked her , and if the SBP was less than 100 and the DBP was less than 60, she

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would not give her the medication. She said she would document on the MOR that she held the medication then she would notify the nurse that she held it.

Administration of the , , required judgement based on her , , reading. A licensed person can only do the , readings.

The nursing director acknowledged the findings on at 4:00 pm.

Class III