STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967011	**05/18/2017**
NAME OF PROVIDER OR SUPPLIER **GARDENS AT OAKLAND (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **715 HULL ISLAND DR** **OAKLAND, FL 34787**	

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

0000 - Initial Comments

An abbreviated re-licensure survey was conducted on . The Gardens at Oakland Assisted Living Facility License Number #11088 had deficiencies at the time of the visit.

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

Based on observations, record review and interview, the facility failed to provide Medications as Ordered by the Physician to 1 of 1-sampled residents (#3).

Findings:

Record review for Resident #3 revealed a resident health assessment form (1823) dated and was signed by the health care provider. The 1823 included the following medications: The Preser Vision-1 daily, ( ) 81 Milligrams (mg)-1 daily and eye drops each eye 6 times daily. 5 mg as needed at bedtime and 0.2 mg twice daily as needed for greater than . The 1823 noted she required assistance with the self-administration of her medications.

Staff B (an unlicensed caregiver) was observed placing the eye drops in the resident's eye on at 12:20 PM, Staff B was asked to provide the Medication Observation Record (MOR) for Resident #3. Staff B said on at 12:30 PM, she did not have a MOR she would just write on a tablet each time the medications were given.

Review of a small yellow tablet provided by Staff B revealed there was no Preser Vision-1 daily, ( ) 81 mg-1 daily and eye drops in each eye 6 times daily written on the tablet. Review of the Medication Cart revealed the Preser Vision, ( ) 81 mg were both inside of the cart. Further review of the tablet revealed next to Wednesday was written " 8-12-4-8" the 4th line under Wednesday was written " ."

Staff B said on at 1:45 PM, she did not know Resident #3 was to be given the Preser Vision-1 daily and ( ) 81 mg-1 daily. She said she gave the eye drops twice daily, she was not aware it was to be given 6 times a day. Staff B said at the time that meant she gave the at night and the was given at 8 am-12 PM-PM and -PM." Staff B was informed at the time that the and were as needed medications. Staff B said she gave the medications according to what the family told her because the pharmacy had not loaded a MOR electronically for Resident #3.

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Review of the Prescription label for the revealed it noted the resident was to take two twice daily as needed. The prescription label for the noted 50 mg at bedtime as needed.

Resident #4 said on at 12:50 PM, she thought she was to receive the drops 4 times a day, because that is how she took them at home before coming to the facility last week.

Resident #3 was asked at the time if she was aware of what and were needed for, Resident #3 said she did not what they were needed for.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on Facility record review and interview the facility failed to maintain Medication Observation Record (MOR) for 1 of 1 sampled residents (#3).

Findings:

Record review for Resident #3 revealed a resident health assessment form (1823) dated that was signed by the health care provider. The 1823 included the following medications: The Preser Vision-1 daily, ( ) 81 Milligrams (mg)-1 daily and eye drops each eye 6 times daily, 5 mg daily in the AM, 0.2 mg twice daily as needed for greater than , Active one daily, Dulco Ease one at bedtime 50 mg at bed time as needed, 0.5 mg four times daily as needed, 12.5 mg every 12 hours as needed.

The 1823 noted she required assistance with the self administration of her medications.
Staff B (caregiver) was observed placing the eye drops in the resident's eye on at 12:20 PM., Staff B was not observed documenting that she had given the eye drops.

Staff B was asked to provide the Medication Observation Record (MOR) for Resident #3. Staff B said on at 12:30 PM, she did not have a MOR she would just write on a tablet each time the medications were given.

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Review of a Small yellow tablet provided by Staff B revealed there was no Preser Vision-1 daily, ( ) 81 mg-1 daily and eye drops each eye 6 times daily written on the tablet.
The tablet noted the following:

Tuesday above Resident's First name, with a 4 that was circled and " P84"
Next Line- 0.2 mg there was a 4 circled next to it
Next line- 0.5 mg there was a 4 with a circle ,
Next line was a (^) sign pointing up to the and "7:30 PM "

Next Line-Wednesday " noon circled"
Next line "^" sign- night and "

Next Line-Wednesday " 8-12-4-8"
The next line had the sign (^) 5 mg
The line noted "
The next line noted "night "
The next line noted "

Thursday noted
Next line 5 mg
Next line with an eight circled
Next line-"
Next line-"

Review of the Prescription bottle label for the revealed it noted the resident was to take two twice daily as needed. The 0.2 prescription bottle label for the noted one twice daily.

On at 1:45 PM Staff B said she gave the medications according to what the family told her because the pharmacy had not loaded a MOR electronically for Resident #3. She said she was the only staff that had worked at the facility since the resident was admitted on . She used the tablet to document the results. She said the circles meant the time the medication was given.

On at 2 PM, the acting administrator said Resident #3 was just admitted on . She said the facility used the electronic MOR's and they were trying to get Resident #3's MOR's into their system form the Pharmacy.

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The facility did not maintain a MOR that included the name of the resident and any known the resident may have. The name of the resident's health care provider, the health care provider's telephone number; the name, strength, and directions for use of each medication; and a chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors.

Class III

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

Based on Observations, record review and interview the facility failed to ensure all staff were assigned duties consistent with their level of education, training and preparation and experience and allowed unlicensed staff to give medications with parameters to 1 of 1 sampled residents (#3).

Findings:

Record review for Resident #3 revealed a resident health assessment form (1823) dated and was signed by the health care provider. The 1823 noted she required assistance with the self administration of her medications.
On at 12 Noon Observations, revealed Staff B was leaving resident #3's a machine. Staff said at the time resident #3 would not be receiving her medication 12 PM medication because her was less than 160 and she held it. Staff B was asked at the time if she was a nurse. Staff B said that she was not a nurse.

Staff B was asked on at 12:30 PM to provide the Medication Observation Record (MOR) for Resident #3. Staff B said at the time, she did not have a MOR she would just write on a tablet each time the medications were given.

Review of a Small yellow tablet provided by Staff B revealed following:
Tuesday was written above Resident #3's First name, with a 4 that was circled and " P84"
Next Line- 0.2 mg there was a 4 circled next to it
Next line- 0.5 mg there was a 4 with a circle,
Next line was a (^) sign pointing up to the and "7:30 PM "

Next Line-Wednesday " noon circled"
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Next Line-Wednesday " 8-12-4-8"
The next line had the sign (^) 5 mg
The line noted "
The next line noted "night "
The next line noted "

Thursday noted
Next line 5 mg
Next line with an eight circled
Next line-"
Next line-"
Staff B said on at 12:45 PM

Further review of the 1823 revealed it noted 0.2 mg twice daily as needed for greater than . The prescription bottle label for the 0.2 mg noted one twice daily.

Staff B said on at 12:45 PM said she gave the medications according to what the family told her, the circles meant the time the medication was given.

The unlicensed staff was administering medications with parameters that required a nursing judgement to determine when to hold and give medications.

On at 2 PM, the acting administrator said the unlicensed staff should not be providing the medications that required judgement.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on staff schedule review and interview, the facility did not maintain written work schedules that reflected its 24-hour staffing pattern for a given time period.

Findings:

Review of the staff schedule for 2017 revealed on 5/1, 5/7, 5/8, and staff D was listed as working from 7 AM-7 PM. The schedule also noted she was the only staff listed for further dates on , and from 7 AM-7 PM. There was no other staff listed on that day after 7 PM.

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On at 9:45 AM Staff B reviewed the schedule and said it was a mistake and staff D worked 24 hour shifts.

Class

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on Observations, Menu review and Interview, the facility did not follow the menu prepared by the dietitian by not providing Milk or diary substitution for meals.

Findings:

Review of the menu for the day that was prepared by the dietitian revealed it noted breaded fish with lemon, cup of rice, green beans, peach slices, 1 cup of Milk and Beverage of choice.

Observations during lunch at 12:45 PM revealed there was no Milk served.

On at 1 PM- staff B was asked why the milk was not served. Staff B said the Residents received the cranberry juice during Lunch. She was informed at the time that milk was to be served and beverage of choice. Staff said she only gave milk for breakfast. Staff was informed the facility's menu had milk noted for all three meals and if the residents did not want milk that would be the resident's choice or another dairy product could be offered.

Resident #3 was asked on at 1:02 PM if she would have liked milk for lunch. Resident #3 said, "Yes I would, I can drink milk at any time."

The other 2 residents were not interviewable due to their .

On at 1:06 PM Staff B gave Resident #3 a glass of milk while she sat on the sofa.

Class III