STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967011	R 08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENS AT OAKLAND (THE)	**715 HULL ISLAND DR** **OAKLAND, FL 34787**

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

0000 - Initial Comments

A revisit to the Abbreviated Biennial re-licensure survey was conducted on . The Gardens at Oakland Assisted Living Facility license #11088 had a deficiency at the time of the visit.

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

DEFICIENCY REMAINED UNCORRECTED

Based on review of electronic medication observation record, 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 obtain and interpret vital signs to determine if the as needed medication was to be given or held for 1 of 1 sampled residents (#1)

Findings:

Record review for Resident #3 revealed an order dated that noted 0.2 1 as needed for (SBP) greater than 160. Take at 8 AM 12 noon 4 PM and 8 PM.

Review of the electronic medication observation record revealed the MOR noted 0.2 1 give 1 tablet by mouth as needed for SBP greater than 160. The electronic medication observation record for noted there were unlicensed staff initial in the spaces as giving the medication on 7/8, , , / and there were no times noted. The SBP were taken and documented as 170 on 7/8, this was the only date the SBP was noted when the medications were given. The spaces for the SBP results for corresponding dates , , and when the medication was given, only had 2 small dashes in the spaces.

On at 9:30 AM, staff B an unlicensed caregiver reviewed the electronic medication observation record and said when medications were given there would be initials in the spaces. Staff B said she would take resident #3's , and if it was less than 160 she would not give her the medications. Her initials were noted as giving on and she said the medication was given.

The unlicensed staff were obtaining and interpreting vital signs and using their judgment to administer as needed medications to resident #3, which required a nursing judgement to determine when to hold and give the medications. (Only a license staff/nurse can obtain/interpret vital signs in order give or hold as needed medication).

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SUMMARY STATEMENT OF DEFICIENCIES
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On . . . at 9:45 AM, the acting administrator said she was unaware the unlicensed staff could not interpret vital signs to determine whether to give or hold the medication.

Class III