STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911086	**08/10/2017**
NAME OF PROVIDER OR SUPPLIER **FIVE OAKS REST HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **611 OLD WELAKA ROAD** **WELAKA, FL 32193**	

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

0000 - Initial Comments

An unannounced biennial licensure with limited nursing services survey was conducted on at Five Oaks Rest Home Assisted Living Facility (license # 5705). Deficient practices were identified during the survey.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on the record review and interview, the facility failed to maintain an interdisciplinary care plan indicating the services being provided by the facility for 1 of 3 residents on hospice (resident # 8)

Findings:

On , a record review was conducted for resident # 8, who was on hospice. Review of her interdisciplinary care plan by Haven Hospice dated indicated that the services being provided by the facility were not included in the care plan.

On at approximately 3:55 PM, an interview was conducted with the co-administrator, who confirmed that the services being provided by the facility were not included in the hospice care plan. The co-administrator stated that she would obtain the missing information from the hospice.

Class III

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

Based on observations and interviews the facility failed to insure unlicensed staff provided assistance with self administration of medications as required for 4 of 4 residents observed of Resident #1 , #4, #5, and #7.

Finding:

On , 2017, at approximately 11:00 am, unlicensed staff A was observed to provide assistance with self administration of medications for Resident #5. Staff A presented medication to Resident #5 stating, " Here is your ". Staff A did not read the medication label in the presence of the resident which stated: inhalation solution 0.09% 25 mg/3 ml one in 4 times daily.

On , 2017, at approximately 11:15 am unlicensed staff A was observed to provide assistance with self administration of medications for Resident #1. Staff A presented medication to Resident #1 stating, " Here is your Inhaler". Staff Adid not read the medication label in the presence of the resident

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which stated: Proair inhaler 8.5gms with count 90 mcg. 2 puffs every 4 hours.

On , 2017, at approximately 12:15 am unlicensed staff A was observed to provide assistance with self administration of medications for Resident #7. Staff A presented medication to Resident #7 stating, " Here is your ". Staff A did not read the medication label in the presence of the resident which stated: 14 units with each meal , 600 mg 1 tablet 3 times a day. Staff A also observed placing the needle onto the pen before handing it to Resident #7.

On , 2017, at approximately 12:25pm unlicensed staff A was observed to provide assistance with self administration of medications for Resident #4. Staff A presented medication to Resident #4 stating, " Here is your and your ".
Staff A did not read the medication label in the presence of the resident which stated: liquid gels 200 mg 1 every 4-6 hours as needed for pain. Maximum 6 tablets in 24 hours 1 tablet 3 times a day.

On at approximately 12:45 PM, an interview was conducted with unlicensed staff A regarding her training on assistance with self-administration of medication, and reading the medication label to the residents as part of the training. She replied: "Yes, I was taught to read the label to the residents. I didn't do that today with the residents". When staff A was asked if placing the needle on the pen was part of her training. Staff A replied: "I did put the needle on the pen for him. He has trouble with that, and I wasn't sure what the rule was for doing that. Staff A confirmed that she administered the medication instead of providing assistance with self-administration of medication to all 4 of 4 residents observed (Residents # 1, 4, 5, and 7)

Class III

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

Based on observation and interview, the facility failed to store sufficient amount of water for 3 day emergency supply for 22 of 22 residents.

Findings:

On , at approximately 1:30 PM, an observation was made of the facility's emergency water supply. It was observed that the facility had five packages of 32 bottles, 16.9 Oz each totaling approximately 21 gallons for 22 residents for 3 days. This amount was insufficient. (Photo evidence available).

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On [redacted] at approximately 2:30 PM, an interview was conducted with the co-administrator, who confirmed that the facility failed to store sufficient water supply for 3 days for 22 residents. The co-administrator also confirmed that they had no contract for water supply in an emergency.

Class III