STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965743	08/15/2017
NAME OF PROVIDER OR SUPPLIER **CENTURY OAKS SENIOR LIVING**	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 #2017007113 was conducted on and . Century Oaks Senior Living, License #10095, had deficiencies related to #2017007113 at the time of the visit.

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

Based on record reviews and interviews, the facility failed to prevent the development and worsening of a for 1 of 6 sampled residents (#4), failed to provide medications as ordered to 1 of 6 sampled residents (#5), and failed to make sure medications were safeguarded to ensure they were readily available to be given as prescribed by the healthcare provider for 1 of 7 sampled residents (#1).

Findings:

1. Record review for resident #4 revealed that she was admitted to the facility on . Her diagnoses included , , , generalized , Degenerative and Kyphosis. She required assistance with ambulation, bathing, dressing, toileting, , and transfers. She had short and long term memory problems.

A report, dated , indicated that she had a to her left back. A request for home health to evaluate and treat the was faxed to a health care provider on .

A home health admission note, dated , indicated resident #4 had an unstageable on her left back and a Deep Tissue Injury (DTI) was suspected. The measured 4.2 centimeters (cm.) by 3.8 cm. by 0 cm. A DTI is "a pressure-related injury to tissues under intact skin. Initially, these have the appearance of a deep . These may herald the subsequent development of a -4 even with optimal treatment." (2005, National Advisory Panel).

A health care provider order, dated , indicated that she was to take an , 500 milligrams (mg.) by mouth four times a day.

A home health note, dated , indicated that the had firm black eschar covering most of the . Her caregivers were instructed to turn her every 2 hours and offload pressure to the . Eschar is "a or piece of tissue that is off from the surface of the skin...." (wikipedia.org).

A progress note completed by a health care provider on indicated resident #4 had an

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unstageable , to her left upper back. She was chair/bed bound and when in a chair, she pressed on that side. The measured 5 cm. by 4 cm. by 0.2 cm. and contained a large amount of tissue within the bed including eschar and adherent .

A resident progress note, dated , indicated that resident #4 was admitted to the hospital for chest pain. A health assessment form 1823, dated , indicated that resident #1 had Resistant Staph ( ) in the , she was bedridden, and required 24-hour nursing or , care.

A resident progress note, dated , indicated that she returned from the hospital with in her .

A progress note completed by a health care provider on indicated that the was unstageable and there was undermining starting in the at 8 o'clock and ending at 9 o'clock, and at 10 o'clock ending at 12 o'clock.

A resident progress note, dated , indicated that a small pillow was applied to her spinal curvature and below the site.

A progress note completed by a health care provider on indicated that the was unstageable and measured 4.5 cm. by 4.5 cm. by 0.6 cm. The was surgically debrided and the post debridement stage of the remained unstageable.

A progress note completed by a health care provider on indicated that the remained unstageable and measured 4 cm. by 5.4 cm. by 0.5 cm.

A home health note, dated , indicated the had a moderate amount of drainage and measured 4 cm. by 4 cm. by 0.9 cm.

A home health note, dated , indicated that the had a moderate amount of drainage and measured 4.5 cm. by 4.5 cm. by 0.3 cm. with undermining of 2-4 cm. at 9-12 o'clock. Resident #4 described having aching pain daily that was associated with the .

A home health note, dated , indicated that the resident and caregiver were non-compliant with using a small pillow to her mid back to relieve pressure to the .

Results of a culture, dated , indicated the had a moderate growth of

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and

A health care provider order, dated , indicated that resident #4 was to be transferred to a higher level of care due to a on her back. , an , 100 mg. by mouth twice daily on day one, then 100 mg. by mouth daily for 6 days was ordered.

A resident progress note, dated , indicated resident #4 was sent to the hospital. A note dated on indicated she returned to the facility and was sent back to the hospital on . She did not return to the facility again.

Prior to and after the progress note dated , resident #4's record did not contain documentation to indicate the facility implemented any interventions to prevent the development or worsening of the .

On at 12:30 PM, the nursing director said the cause of the was from resident #4 sitting on that side of her back.

During an interview with the administrator on at 1 PM, she said the facility should not have accepted resident #4 back to the facility on . She said that when resident #4 returned to the facility from the hospital on and , the facility staff did not call her, and they accepted resident #4 back.

2. Health assessment report for resident #1, dated , listed diagnoses of , paraplegic, high , , , , and . He was alert and oriented, and needed assistance with self-administration of medications. The review revealed a prescription, dated , for IS 15 mg. 4 times a day. One hundred twenty pills were to be dispensed.

The facility's "In and Out" sheet indicated that on , the resident had 120 tablets available. A pharmacy delivery receipt indicated that 120 tablets were delivered for resident #1 on . The count sheet revealed a pharmacy label dated that indicated 120 tablets were dispensed on that date. The count sheet indicated that on at 8:20 AM, an tablet was given and 1 tablet remained. On at 12:30 PM, 1 tablet was given, with zero (0) remaining.

The MOR listed the and indicated it was given on at 9 AM, 1 PM, 5 PM and 9 PM, although the medication was missing, and a new ordered arrived on and was given to the

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resident at 4:42 PM.

The review revealed the advanced registered nurse practitioner (ARNP) wrote an order on for 120 tablets to be dispensed (a month's worth).

An adverse report dated indicated that on , the resident's healthcare provider, an ARNP was called by the pharmacy, and a new order for was requested for resident #1. The ARNP notified the administrator of the request and went to the facility on . There she discovered the staff were looking for the missing tablets.

The facility concluded in their investigation that after a search of all medication areas, 60 pills were unaccounted for. A total of 120 tables were delivered on , therefore, a bubble pack of 60 tablets was missing and a police report was made.

On at 11:46 AM, the resident said he was not aware that any of his medications were missing.

On at 3 PM, the administrator stated the ARNP called her because the pharmacy told her it was too early for a refill of the and a new refill would require a new prescription because it is a controlled substance. Once an investigation was conducted and the medication was deemed missing, the police were called to conduct an investigation. A staff member was terminated and the facility brought the resident a supply of the medications. That was why there was a prescription dated 2017 for the .

3. Resident #5's record revealed a health assessment form. dated , that included diagnoses of on , and severe .

A health care providers order, dated , noted , an , 5 milligrams (mg.) ( ) 1 tablet six days a week and 1 and 1/2 tablets (7.25 mg.) on Wednesday. " is used to prevent , , and clots in veins and ." (drugs.com).

Review of the electronic Medication Observation Record (MOR) for revealed it noted 2.5 mg. at bedtime and on Wednesday every week, take 1 tablet along with 5 mg. on Wednesday for a total dose of 7.5 mg.
On at 8 PM, there were staff initials in the space underneath the staff initials was "5" on the MOR. Review of the legend that was located on the last page of the MOR revealed the "5" meant "medications not available."

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Further review of the MOR revealed 5 mg., 1 tablet at bedtime every day was left blank on , , and . There was no way to determine whether the resident received his medication as ordered.

On at 2 PM, the administrator said she reviewed the MOR and could not provide any evidence that the resident received his medications as ordered.

Class II

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

Based on observations, record reviews and interviews, the facility failed to provide assistance to 1 of 4 residents (#6) who required assistance with self-administration of their medications.

Findings:

Observations made during a medication pass on at 2:15 PM for resident #6 revealed that staff E, an unlicensed caregiver, handed a bottle of eye drops to resident #6. The resident tilted his head back and without pulling his lower eyelids down, he squeezed the bottle and multiple drops of medication dropped onto his eyes. He blinked while he applied the drops which caused the liquid to onto his eye lid and not into his eyes. Staff E then instructed resident #6 to apply more drops. When questioned why she did not assist resident #6 with applying the drops, staff E said the administration told her that she was not allowed to assist the residents with eye medications.

Review of resident #6's 2017 Medication Observation Record (MOR) revealed an entry for Tears 1.4% eye drops, apply 1 drop to each eye four times a day.

A health assessment form 1823, dated , indicated that resident #6 required assistance with self-administration of his medications.

During an interview with the nursing director on at 10:55 AM, she said the unlicensed staff were told they were not allowed to pull down the lower eyelids of residents who received eye medications.

Class III