STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964749	**11/13/2017**
NAME OF PROVIDER OR SUPPLIER **SAVANNAH COURT OF OVIEDO I**	STREET ADDRESS, CITY, STATE, ZIP CODE **355 ALAFAY WOODS BLVD.** **OVIEDO, FL 32765**	

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

0000 - Initial Comments

The re-licensure survey was conducted on . Savannah Court of Oviedo I Assisted Living, license #9235, 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, medication observation record (MOR) review and interview, the facility failed to provide medications as ordered by the health care provider for 1 of 2 sampled residents (#5).

Findings:

Observations on at 10:25 AM on a table in resident #5's a small cup with 3 pills inside. The resident said the staff would bring the medication in and let her take them when she got up. The agency staff along with a Licensed Practical Nurse (LPN) returned to the resident's . The LPN removed the cup with the pills and brought them to the medication .

Review of the MOR and the medications that were in the cup along with the LPN and the associate executive director, who identified the medications as ER 1,000 milligrams (mg) twice daily (for chest pains) and 80 mg (used to treat high and triglyceride levels), one daily both were her 8 PM medications. The staff initialed the MOR on 11/ at 8 PM as an indication that the medication was given. The other pill in the cup was identified as Centrum Silver by the LPN. Further review of the MOR revealed it noted the centrum silver was discontinued on .

Record review for resident #5 revealed the resident health assessment form 1823 dated , revealed the health care provider noted she required assistance with the self-administration of her medications. Further record review revealed a health care provider's order dated to discontinue the centrum silver.

The LPN confirmed on at 11 AM, the staff left the medications in the did not make sure the resident took her medications as ordered by the health care provider. The LPN said she could not confirm what day the medications were left in the . The centrum should not have been given to the resident, because it had been discontinued.

Class III

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

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	AL11964749	11/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH COURT OF OVIEDO I	**355 ALAFAY WOODS BLVD. OVIEDO, FL 32765**

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

Based on observations, record review and interview the facility did not ensure unlicensed staff followed the correct procedure when providing assistance with self-administration of medication to 1 of 1 resident (#9).

Findings:

During observation of the medication pass at 11:35 AM, Staff A unlocked the medication cart in the nurses' [illegible] removed the Medication Observation Record (MOR) and the medication [illegible] cards and bottles for resident #5. Staff A reviewed the MOR and placed each pill in a small cup. There were 8 pills. She did not read the medication labels aloud to the resident. Resident #5 picked up the cup and put the pills in her hand. She selected 5 pills, put them in her mouth, and swallowed them with the water provided. Staff A said she would get more water for her, but resident #5 stated she was not going to take the other 3 pills at that time. She would wait until later, after lunch. The resident left the pills in the cup on the medication cart and left the [illegible]. The nurse and Staff A debated if they should dispose of the remaining pills. The nurse went after the resident to encourage her to take the pills, but the resident would not. Staff A remained at the cart and documented on the MOR, which pills, were taken. Staff A left the cup with the remaining 3 pills on the back of the cart until the resident finished lunch. The 3 pills dispensed, but not taken were: [illegible] 1000mg, prescribed for [illegible]; [illegible] 500mg, prescribed for [illegible] and [illegible]; and [illegible] 100mg, prescribed for [illegible].

Review of the record for resident #45 revealed she had a diagnosis of mild sub-arachnoid [illegible] and [illegible]. Review of MOR for [illegible] 2017 and [illegible] 2017 revealed the medications were documented as given according to orders on all other dates.

In an interview with Staff A on 11/[illegible] at 11:45AM, she confirmed she did not read the labels aloud to the resident and that she was unsure what to do about the pills that were not taken.

In an interview with the administrator on [illegible] at 1:30 PM, she said she had heard about the incident from the nurse and she would follow-up with proper retraining.

Class III

0167 - Resident Contracts - 58A-5.025 FAC

Based on resident record review and interview, the facility failed to ensure a resident contract was executed upon admission for 1 of 2 sampled residents (#4).

Findings:

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NAME OF PROVIDER OR SUPPLIER **SAVANNAH COURT OF OVIEDO I**	STREET ADDRESS, CITY, STATE, ZIP CODE **355 ALAFAY WOODS BLVD.** **OVIEDO, FL 32765**	

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

Review of the record for resident #4 revealed an admission date of and a resident contract dated . There were Health Assessments (form 1823) dated , and . The weight record for 2016 was not found in the record.

In an interview with the administrator on at 2:30 PM, she stated the resident was originally admitted to another building in their facility that has a different license number. She stated the resident was transferred from that building to this one on . The administrator provided the admission & discharge entries from both facilities to show the dates of admission to each building. She stated they did not create a new resident contract when the resident moved to the new facility. The actual admission date for resident #4 to the facility in this survey was . The administrator confirmed the findings.

Class III

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on Agency Background Screening Clearinghouse review and interview, the facility failed to register and maintain the accurate employment status of employees within the Agency's Background Screening Clearinghouse and report any changes in status within 10 business days for 6 of 6 sampled employees (A, B, C, D, E & F).

Findings:

Review of the Agency Background Screening Roster revealed one name on the facility roster.

In an interview with the administrator on at 2:30 PM, she confirmed the finding and stated the one employee stated that they must have put everyone on their other facility's roster on the same property.

Unclassified