STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964824	**11/30/2017**
NAME OF PROVIDER OR SUPPLIER **SAVANNAH COURT OF OVIEDO II**	STREET ADDRESS, CITY, STATE, ZIP CODE **395 ALAFAYA WOODS BLVD.** **OVIEDO, FL 32765**	

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

0000 - Initial Comments

A relicensure survey was conducted on , 2017. Savannah Court of Oviedo II, license #9308, had deficiencies at the time of the survey.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record reviews and interview, the facility failed to ensure the health assessment form 1823 was complete for 1 of 4 sampled residents (#1).

Findings:
Record review for resident #1 revealed a health assessment form 1823 that was dated on .

The question that pertained to special diet instructions was not answered.

On at 2 pm, the associate executive director confirmed the finding.

Class III

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

Based on observations, record review, and interview, the facility failed to ensure the unlicensed staff who assisted a resident (#10) with self-administered medications followed the correct procedure.

Findings:
Observations made during a medication pass for resident #10 on at 11:40 am revealed staff A, an unlicensed caregiver, unlocked the medication cart, removed an over the counter bottle of from the cart, then poured a pill into a medication cup. Staff A locked the cart and took the pill to resident #10, who was sitting at a dining . Staff A set the medicine cup in front of resident #10, told the resident it was her stool softener, then staff A walked away and went to the medication .

Staff A did not prepare the medication in the presence of the resident and she did not read the label to the resident, as required.

Following the medication pass, staff A confirmed the findings.

Class III

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

0057 - Medication - Over The Counter (OTC) Products - 58A-5.0185(8) FAC

Based on review of a medication container and interview, the facility failed to ensure that a resident's (#10) Over the Counter (OTC) medication container was properly labeled.

Findings:
Observations made during a medication pass for resident #10 on at 11:40 am revealed staff A, an unlicensed caregiver, unlocked the medication cart, removed an OTC bottle of from the cart, then poured a pill into a medication cup. Staff A locked the cart and took the pill to resident #10, who was sitting at a dining . Staff A set the medicine cup in front of resident #10, told the resident it was her stool softener, then staff A walked away and went to the medication .

Review of the OTC bottle of revealed it was not labeled with the name of resident #10, as required.

On at 11:45 am, staff A confirmed the finding.

Class III

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

Based on the personnel record review and interview, the facility failed to ensure that the number of hours was documented on the ( ) training certificate issued for 3 of 4 sampled staff (A, B and C) as required.

Findings:
1. Staff A's personnel record revealed date of hire . The training certificate dated was found in file but no number of hours was documented.

2. Staff B's personnel record revealed date of hire . The training certificate dated was found in file but no number of hours was documented.

3. Staff C's personnel record revealed date of hire . The training certificate dated was found in file but no number of hours was documented.

On at 2 PM, an interview with the Director of Nursing who confirmed the findings.

Class