STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966595	**12/14/2017**
NAME OF PROVIDER OR SUPPLIER **SPRING OAKS**	STREET ADDRESS, CITY, STATE, ZIP CODE **7251 GROVE RD** **BROOKSVILLE, FL 34613**	

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

0000 - Initial Comments

An unannounced Change of Ownership (CHOW) Survey was conducted on at Spring Oak Assisted Living Facility (License # 10763), Brooksville, Florida. Deficient practice was identified at the time of the survey.

0026 - Resident Care - Social & Leisure Activities - 58A-5.0182(2) FAC

Based on interview and observations the facility failed to ensure that 19 of 19 memory care unit residents were encouraged to participate in social, recreational, educational and other activities within the facility and the community.

Findings:

While conducting the facility tour, four residents were observed seated in the dining area in wheelchairs with no staff interactions. Two residents were seated in wheelchairs at the dining table. Another resident was seated in a wheelchair facing the wall. All other residents assigned to the memory care unit were located inside their . The memory care staff assigned to work were gathered at the medication cart talking amongst themselves. During the time of observation the staff did not provide any engagement or activities with the residents.

In an interview on at 10:34 am, with the Memory Care Activities Coordinator, she stated that she provides the residents with one on one interaction with activities such as balloon volleyball, spa hour, the game of memory, and current events. She confirmed the scheduled activity was Spa Hour. She also confirmed the staff hadn't conducted the scheduled activities for that time .

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on Interview and observation the facility failed to treat 61 of 61 residents with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy to ensure that the medication log books were in a secured location.

Findings:

During the facility tour, three medication carts were observed to have a pink binder labeled resident records lying on top of each cart (outside 105, 111, and 144). After reviewing the contents of the binder it was discovered the binders contained several resident's medication ( ) information.

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

During a tour of the secured memory care unit, a white binder was observed lying on top of the medication cart. Upon examination of the contents of the materials, the binder was discovered to contain several residents' medication information.

During an interview on 12. with the Resident Care Manager at 9:43 am, she confirmed the binder located on top of the medication cart outside was in fact the medication log book (narc book). She confirmed that she observed two more medication log books (narc book) on top of medication carts outside of and . She informed this team member that staff are supposed to place the binders inside the locked medication carts.

Class III