STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965048	**01/10/2018**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE OVIEDO**	STREET ADDRESS, CITY, STATE, ZIP CODE **1725 PINE BARK** **OVIEDO, FL 32765**	

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

0000 - Initial Comments

Complaint investigation #2017013020 was conducted on . Brookdale Oviedo Assisted Living, license #9525, had deficiencies at the time of the investigation.

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

Based on observation, record review and interview the facility failed to provide care and services appropriate to the needs of 1 of 4 sampled residents and did not follow provider orders for prescribed medications. (#2).

Findings:

Observation of resident #2 during an interview on at 10:15 AM with the resident in her she was sitting on the edge of her bed, had removed her shoes and was waiting for the podiatrist to come see her. During an interview with resident #2 revealed, she goes to the med it is time for her medications and has never run out of any medications. She told me she was able to take the medications provided to her in a small cup. She said the staff always told her what the pills were and watched while she swallowed the pills with water they provided in a cup.

Record review for resident #2 revealed she was admitted on and had a health assessment (1823) dated that indicated diagnoses that included 's and . She was assessed to be at risk for . The assessment documented she was independent with all Activities of Daily Living. The 1823 also documented she required Medication Administration, which required a licensed nurse to provide the medication.

Review of the Medication Observation Records (MORs) for , & 2017 revealed no holes, no missed medications. However, all medications were documented as being given by unlicensed staff.

Interview with the Health & Wellness Director at 1:30 PM on , she confirmed the 1823 was marked for medication administration and said that it had been overlooked. She stated the resident is capable of taking her medications and confirmed that unlicensed staff were providing the medications for resident #2.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

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

Based on observation, record review and interview the facility failed to have staff qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience and allowed an unlicensed staff to administer medication to a resident who was assessed to need medication administration, which must be performed by a licensed nurse for 1 of 4 sampled residents (#2).

Findings:

Record review for resident #2 revealed she was admitted on and had a health assessment (1823) dated that indicated diagnoses that included 's and . She was assessed to be at risk for . The assessment documented she was independent with all Activities of Daily Living. The 1823 also documented she required Medication Administration, which required a licensed nurse to provide the medication.

Review of the Medication Observation Records (MORs) for , & 2017 revealed no holes, no missed medications. However, all medications were documented as being given by unlicensed staff.

Interview with the Health & Wellness Director at 1:30 PM on , she confirmed the 1823 was marked for medication administration and said that it had been overlooked. She stated the resident is capable of taking her medications and confirmed that unlicensed staff were providing the medications for resident #2.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on the admission and discharge log review and interview, the facility did not maintain an accurate and up to date log as required by 58A- 5.024(1) (b) FAC.

Findings:

Review of the Admission and Discharge log revealed residents were entered with either an admission date or a discharge date, but not both. When searching for the admission date for a specific resident, the business manager said she could look for it elsewhere, but she only had the book back to when she started at the facility. Many discharge dates did not include the reason and/or location to which the resident was discharged.

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

On at 10:45 AM, the administrator confirmed the log was not accurate.

Class III