STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968920	03/05/2018
NAME OF PROVIDER OR SUPPLIER **LODGE AT LUTHERAN HAVEN (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **2035 W RD 426** **OVIEDO, FL 32765**	

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

0000 - Initial Comments

A re-licensure survey with Extended Congregate Care was conducted on . The Lodge at Lutheran Haven, license #12811, had deficiencies at the time of the survey.

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

Based on observations, record reviews, and interview, the facility failed to ensure the unlicensed staff who provided assistance with self-administration of medications followed the correct procedure for 1 of 1 medication passes (9).

Findings:

Observations on at 9:15 AM during the medication pass noted that staff A, an unlicensed staff, took medications to the resident's . She told the resident here is your , your , your , for high , and Oxybutin. She handed the medications to the resident and observed her take the medications. She had a cup with mixed with water. The staff handed the cup to the resident. The staff returned to medication cart and left the resident with the cup with . She returned to the resident's encouraged the resident to take some more of the medication. The resident refused. The staff marked the medication as taken although the resident did not drink it all. She did not measure the medication that was discarded. The staff did not read the prescription label aloud to the resident.

In an interview on at 9:15 AM staff A confirmed she was not a nurse.

In an interview on at 2 PM with the nursing director, who said the staff should have read the label to the resident and measured the left over medication.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on resident record review and interview, the facility failed to ensure that an informed consent was obtained for residents requiring assistance with self-administration of medications that included whether or not a licensed nurse would supervise it for 2 of 4 sampled residents (#1 & #5).

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

Findings:

Review of the records for residents #1 and #5 revealed informed consents allowing unlicensed staff to assist with self-administration of medications for these residents. The consent form did not include a statement indicating if this would be supervised, or not supervised by a licensed nurse.

In an interview with the resident are coordinator on at 2:30 PM, she confirmed the consent form did not include that information.

Class