STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968474	**04/20/2018**
NAME OF PROVIDER OR SUPPLIER **OAKMONTE VILLAGE OF LAKE MARY-CORDOVA**	STREET ADDRESS, CITY, STATE, ZIP CODE **1001 ROYAL GARDENS CIR** **LAKE MARY, FL 32746**	

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

0000 - Initial Comments

A complaint investigation #2018000661 was conducted on , , , and . Oakmonte Village of Lake Mary-Cordova, license #12350, had deficiencies at the time of the investigation.

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

Based on observations, record reviews, and interviews, the facility failed to follow a medication order from a health care provider for a resident (#1) who received assistance with self-administered medications and failed to notify the health department when 3 residents (#5, #6, and #7) tested positive for or developed symptoms of a , , .

Findings:

1. Observations made of resident #1 on at 9:49 am revealed a red was present on both of her lower legs and feet. She said it was a and was very itchy and that it was spreading. She said she notified the staff and the staff called her doctor.

Review of the record for resident #1 revealed a health assessment form 1823 that was dated on . The form indicated the resident had a diagnosis of and she required assistance with self-administration of her medications.

A health care provider's progress note, dated on , indicated that the resident had a red overlying her lateral Malleoli with .

A health care provider's progress note, dated on , indicated a new order for Lotrisone 1% cream, apply to affected areas twice daily for 4 weeks then discontinue.

Review of the resident's , 2018 and , 2018 Medication Observation Records (MORs) revealed the Lotrisone cream was scheduled to be applied twice a day at 8 am and 4 pm. The initials to indicate the cream was applied on , , , , through , and through were circled.

Documentation on the MORs indicated that on , , , , and the cream was not delivered yet from the pharmacy. On , , , and the cream was not in the cart. On , the cream was discontinued and not available. On , , , , and the resident

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self-medicated the cream. The resident's record did not contain a health care provider's order to indicate the resident was able to self-administer the cream.

The documentation on the , 2018 and , 2018 MORs indicated the Lotrisone cream was signed as given on through and through , which was less than the 4 week duration that was ordered. The resident's record did not contain an order from a health care provider to indicate the cream was discontinued before the original stop date of 4 weeks.

A health care provider's progress note, dated on , indicated the Lotrisone cream was to be continued to the resident's ankles daily for an additional 14 days then discontinue. The resident's , 2018 MOR did not contain documentation to indicate the cream was applied, as ordered.

On at 2:45 pm, the director of resident care confirmed the findings.

2. On at 10:20 am, the executive director and resident care director said some residents developed and a few months ago. The director of resident care said there were four resident cases of the flu and two residents who were sent to the hospital for , illnesses tested positive for the flu while in the hospital. She said the health department was not notified because the number of cases did not meet the threshold of the reporting requirements.

Review of an control log provided by the director of resident care indicated the resident #5 had an with an onset date of . The resident was sent to the hospital, and had a positive culture while in the hospital.

Resident #6 had a , with an onset date of and had a positive culture while in the hospital.

Resident #7 had a with an onset date of and had a positive culture while in the hospital.

The record for resident #5 contained a progress note, dated on that indicated the resident was sent to the hospital for generalized , and low saturation.

The record for resident #6 contained a progress note, dated on that indicated the resident was sent to the hospital following a . A progress note, dated on , indicated the resident was in a Progressive Care Unit (PCU) and on ( ) for a .

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The record for resident #7 contained a progress note, dated on that indicated the resident's daughter took her to a doctor's appointment and she was sent to the emergency . A progress note, dated on , indicated the resident returned from the hospital on with the flu and an

During a phone interview with a representative from the Seminole County Health Department on at 8:49 am, the representative said the facility did not report any flu cases to the department.

A review conducted on at 9 am of hospital records for resident #7 revealed she was admitted to the hospital on with a diagnosis of health care associated . Results of a nasal swab culture that was completed on revealed a PCR and a H3 PCR were detected.

During a phone interview with a representative from the Seminole County Health Department on at 11:15 am, the representative said the facility was required to contact the health department if there was a positive case of the flu in conjunction with additional residents who experienced symptoms.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record reviews and interview, the facility failed to ensure the Medication Observation Record (MOR) was updated for a resident (#1) who required assistance with self-administered medications.

Findings:

Review of the record for resident #1 revealed a health assessment form 1823 that was dated on . The form indicated the resident had a diagnosis of and required assistance with self-administration of her medications.

A health care provider's progress note, dated on , indicated a new order for Lotrisone 1% cream, apply to affected areas twice daily for 4 weeks then discontinue.

Review of the resident's 2018 MOR revealed two separate entries, started on , for (Lotrisone) cream, apply to affected areas once daily for 14 days then

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discontinue, which did not match the health care provider's order. One entry was scheduled at 8 am and one was at 4 pm.

In addition, the directions for use of the cream did not contain a specific site in which to apply the cream. The resident's record did not contain documentation to indicate the facility contacted a health care provider for clarification.

On at 2:41 pm, the director of resident care confirmed the findings.

Class III

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

Based on record reviews and interview, the facility failed to ensure a resident record (#1) contained an order from a health care provider to self-administer a medication.

Findings:

Review of the record for resident #1 revealed a health assessment form 1823 that was dated on . The form indicated the resident had a diagnosis of and required assistance with self-administration of her medications.

Review of the resident's , 2018 Medication Observation Record (MOR) revealed an entry for Lotrisone cream that was blocked off to be given for 12 days from through . However, the boxes were blank, not signed as given, and "self" was in the box where an administration time would customarily be located.

The resident's record did not contain an order from a health care provider to indicate the resident could self-administer the cream, as required.

On at 2:38 pm, the director of resident care confirmed the findings and said a facility nurse decided to allow resident #1 to self-administer the cream.

Class III