STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965135	08/16/2018
NAME OF PROVIDER OR SUPPLIER **FORSYTH HOUSE**	STREET ADDRESS, CITY, STATE, ZIP CODE **5887 BERRYHILL RD** **MILTON, FL 32570**	

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

0000 - Initial Comments

On [redacted], 2018, an unannounced complaint survey for allegations contained within CCR# 2018008174 was conducted at Forsyth House Assisted Living Facility (9549). At the time of this survey deficient practice was identified.

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

Based on record reviews and staff interviews, the facility failed to maintain updated medication observation records (MOR) for 2 of 3 (#1 and #2) sampled residents.

The findings were:

Resident #1
On [redacted], a review of the MOR was conducted for resident #1 and revealed there were no staff initials to indicate the following medications were administered on :
1. [redacted] /dipyrida, an [redacted] medication, 25-200 milligram(mg) by mouth twice daily. The morning dose was not documented as being given.
2. [redacted], a stool softener, 100 mg by mouth twice daily. The mornings dose was not documented as being given.
3. [redacted], a medication for [redacted], 50 microgram (mcg) was not documented as being given.
4. [redacted] patch, a pain relief patch placed on the skin, once a day, was not documented as being given.
5. Lorsarten/ [redacted] 100-12.5 mg, a medication to treat high [redacted], by mouth once daily, was not documented as being given.
6. [redacted] 10 mg, a medication used to treat [redacted]'s [redacted], by mouth twice daily, was no documented as being given not given
7. [redacted] 40 mg, a medication used to treat [redacted], by mouth once daily, was not documented as being given.
8. [redacted] 40 mg, a medication used to treat high [redacted], by mouth once daily, was not documented as being given.

Resident #2
On [redacted], a review of the MOR for resident #2 was conducted and revealed there were no staff initials to indicate the following medications were administered on :
1. [redacted] D3 2000 unit capsule by mouth once daily for [redacted] d deficiency.

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2. , 81 mg 1 tab by mouth once daily.
3. , 10 mg tab, a medication used to treat 's , by mouth once daily
4. , 10 mg, a medication used to treat , by mouth once daily.
5. , 10 mg, a medication used to treat high , by mouth twice daily.

On at approximately 12:43 PM, an interview was conducted with staff C, a medication tech. Staff C stated if a resident refuses a medication or if the resident is not in the building during the time the medication was due, it should be documented on the MOR. Staff C stated, "a blank space means someone did not document at that time if the medication was refused or if the resident was not available, it should still be documented and not left blank."

On at approximately 1:00 PM, an interview was conducted with the Director of Resident Care (DOC) . The DOC stated she did not know why staff had not documented on the above days and times the medications were due. The DOC stated, there should have at least been a justification for why the medication was not given. The DOC stated, "A blank space means someone did not document."

Class III