STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969022	09/19/2018
NAME OF PROVIDER OR SUPPLIER ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2250 S SEMORAN BLVD ORLANDO, FL 32822	

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

0000 - Initial Comments

A complaint investigation #2018008768 was conducted on and . Assisted Living Facility, license #12850, had deficiencies at the time of the investigation.

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

Based on record reviews and interviews, the facility failed to follow an order from a health care provider for 2 of 11 sampled residents (#1 and 5).

Findings:

1. Resident #1's record contained a facility admission date of . A most recent 1823 health assessment form, dated , indicated that his diagnoses included , of and . He required assistance with self-administered medications.

Resident #1's 2018 Medication Observation Record (MOR) contained an entry for 0.2 milligram (mg) tablet, take 1 tablet by mouth three times a day as needed for , greater than or equal to . The MOR nor his record contained documented readings.

On at 1:30 p.m. the director of nursing confirmed the findings and said the resident checked his own , then reported the reading to the staff who would then give the as needed. She said the facility never documented the readings that were reported by the resident.

2. Observations during the facility on at 10:10 AM tour resident #5 was observed to have a dressing to her right foot. She said she did the dressing herself.

Resident # 5 had a health assessment report 1823 dated that listed diagnoses of , high , iron deficiency and . She needed assistance with self-administration of medications. Prescription dated indicated 15grams/60 milliliters (ml), take 60 ml once weekly. The 2018 MOR listed the medication as ordered on however, it was not given on . The MOR indicated the medication was given on . There were no written notations to explain why the medication was not given as ordered on . Prescription dated

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ASSISTED LIVING FACILITY	2250 S SEMORAN BLVD ORLANDO, FL 32822

SUMMARY STATEMENT OF DEFICIENCIES
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indicated skilled nursing care to treat and evaluate right 3rd toe 3 times a week. There were no written notations to confirm the resident's healthcare provider was made aware and agreed for the resident to do her own care and to wait for home health care service until she moved out of the facility in the upcoming days. The resident moved out on .

In an interview with the Director of Nursing on 11:20 AM who said the doctor was aware that the resident was moving and gave daughter the order.

Class III

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

Based on record reviews and interviews, the facility failed to maintain a daily Medication Observation Record (MOR) for 1 of 6 sampled residents (#2) who received assistance with self-administered medications.

Findings:

Resident #2's record revealed a facility admission date of . A most recent 1823 health assessment form, dated , indicated that he required assistance with self-administered medications.

A health care provider's order, dated , indicated that he was to receive Norco 325 milligram (mg)-7.5 mg, 1-2 tablets by mouth every four hours as needed. 30 tablets were dispensed by the pharmacy.

Resident #2's 2018 and 2018 MORs did not contain entries to indicate the facility assisted him with the Norco.

On at 11 a.m. the director of nursing said that because judgement was required to give him either 1 or 2 tablets of the Norco, the resident's son agreed to give the medication to the resident but instead, the son gave the bottle to the resident. On the staff removed the bottle of Norco from his he appeared groggy and the staff thought he was overdosing on the medication. When the bottle was removed, it contained 26 tablets.

On at 1:45 p.m. the director of nursing said the facility stored the remaining 26 tablets of Norco and assisted the resident each time he requested it by setting the bottle down, allowing him to open the

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NAME OF PROVIDER OR SUPPLIER **ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **2250 S SEMORAN BLVD ORLANDO, FL 32822**	

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

bottle and take the pills. She said the facility did not document each time he was assisted with taking the medication.

Class III

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

Based on record reviews and interview, the facility failed to ensure that the resident record for 1 of 6 sampled residents (#2) contained an order from a health care provider to self-administer a medication.

Findings:

Resident #2's record revealed a facility admission date of . . . . . A most recent 1823 health assessment form, dated . . . . , indicated that he required assistance with self-administered medications.

A health care provider's order, dated . . . . . , indicated that he was to receive Norco 325 milligram (mg)-7.5 mg, 1-2 tablets by mouth every four hours as needed. 30 tablets were dispensed by the pharmacy.

Resident #2's . . . . 2018 and . . . . . 2018 MORs did not contain entries to indicate the facility assisted him with the Norco.

On at 11 a.m. the director of nursing said that because judgement was required to give him either 1 or 2 tablets of the Norco, the resident's son agreed to give the medication to the resident but instead, the son gave the bottle to the resident. On . . . . . the staff removed the bottle of Norco from his . . . . . he appeared groggy and the staff thought he was overdosing on the medication. When the bottle was removed, it contained 26 tablets.

Resident #2's record did not contain an order from a health care provider allowing him to self-administer the Norco.

On . . . . . at 1:45 p.m. the director of nursing confirmed the findings and was unable to provide additional documentation.

Class III

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SUMMARY STATEMENT OF DEFICIENCIES
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0163 - Records - Resident, Penalties for Alteration - 429.49 FS

Based on record reviews and interview, the facility altered a Medication Observation Record (MOR) for 1 of 6 sampled residents (#1.)

Findings:

Resident #1's 1823 health assessment form, dated . . . . . , indicated that he required assistance with self-administered medications.

On at 3:30 p.m. a request was made to review resident #1's , 2018 MOR. The director of nursing provided copies of only the front of each page of the MOR. An entry on the MOR for Lantus . . 100 units/milliliter , inject 28 units , every day was signed as being given daily from . . . through . . . . however, the initials were circled. A request was made to review the back of the MORs to determine whether documentation was present to explain why the initials were circled. The director of nursing provided additional copies of both the front and back of the MORs.

The second set of provided copies appeared to be the same as the first set however, the initials for the Lantus were not circled.

On . . . at 3:45 p.m. the director of nursing confirmed the findings and said that after the first set of copies were made and before the copies were provided to the surveyor, the staff circled the initials because the resident self-administered the . and the staff erroneously signed the MOR.

Class III