STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969022	R 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 second revisit to complaint investigation #2018001731 was conducted on and in addition to complaint investigations 2018008916 and 2018008768. Assisted Living Facility, license #12850 had deficiencies at the time of the visit.

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

DEFICIENCY REMAINED UNCORRECTED

Based on observations and interview the facility failed to ensure the unlicensed staff (H) who assisted 2 resident (#4 and 5) with self-administration of medications followed the correct procedure.

Findings:

Observations during the medication pass on at 12:10 PM noted that staff H, an unlicensed staff assisted resident #4 with self-administration of medications in the following manner: washed hands, reviewed Medication Observation Record (MOR). Went to resident's the resident it was time for her 12 PM medications. Staff H went to medication cart, retrieved the 2 bubble packs, went back to the resident and read the labels to her. Staff H then went back to medication cart, put one pill from each bubble pack in a cup, secured the bubble packs, went to resident handed her the cup with 2 pills inside. She observed her take the medications and then signed the MOR.

Observation during the facility tour on at 10:10 AM noted that resident #5 had a small scuffle cup with 4 pills inside; 1 small red, 2 small white and a large white on top of a table. The resident stated she knew what the pills were and she forgot to take them. Review of the MOR noted the MOR for resident's #5 had staff initials for the morning of . Photographic evidence was taken. On at 12:10 PM the picture taken was shown and explained circumstances to Director of Nursing. Staff H was present as well. Staff stated she gave the resident her medications and did not observe resident take medications.

In an interview with the administrator on at 12 PM, who said resident #5 was a very difficult person.

Class III