| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11968413 | 01/23/2019 |
| NAME OF PROVIDER OR SUPPLIER<br>**THE ROSE GARDEN OF ORLANDO** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**9309 S ORANGE BLOSSOM TRAIL**<br>**ORLANDO, FL 32837** | |

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

**0000 - Initial Comments**

A complaint investigation #2018016017 was conducted on . Plantation Oaks Senior Living license #12300 had deficiencies found at the time of the visit.

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

Based on record review and interview the facility failed to maintain an up to day Medication Observation Record (MOR) for 1 of 4 sample residents (2).

Findings:

Resident record review for resident #2 revealed an updated health assessment report dated that listed diagnoses of high , , , and . She needed assistance with all activities of daily living and medications. A healthcare provider's order dated indicated Entrancing to both , twice daily for 7 days. The pharmacy responded that Entrancing was backed ordered to an unknown date, to have the doctor order an alternate. Another healthcare provider's order dated indicated discontinue Entrancing start to both , twice daily for 5 days. The Medication Observation Record (MOR) listed Entrancing to both , twice daily for 7 days and was marked as given, although Entrancing was not available and was ordered instead.

In an interview on at 1:30 PM with the administrator, who said the resident had the corrected medication, , but the staff did not update the MOR to reflect the change. She could not have given a medication that was not available.

Class III

**0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC**

Based on observations and interview the facility failed to ensure medications were kept in a locked cabinet, locked cart, or other locked storage receptacle, room, or area at all times, out of sight of other residents and visitors.

Findings:

Observations at 10:10 AM on the 6th floor, noted the medication cart was by . The cart was

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SUMMARY STATEMENT OF DEFICIENCIES
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noted to be unlocked. Once the staff A heard the drawers open and close, she asked who was there. She said she went into the resident's room to take her . . . . , . . . . . She started to walk away again, and left the cart unlocked again.

In an interview with the administrator on at 1 PM who said she spoke with staff A regarding the medication cart.

Class III