STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965743	05/02/2019
NAME OF PROVIDER OR SUPPLIER **CENTURY OAKS SENIOR LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **4001 STACK BOULEVARD MELBOURNE, FL 32901**	

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

0000 - Initial Comments

The re-licensure survey was conducted on at Century Oaks Serenity Assisted Living, Melbourne. Deficiencies were found at the time of the visit.

0008 - Admissions - Health Assessment - 429.26( ) FS; 58A-5.0181(2) FAC

Based on resident record review and interview, the facility failed to ensure the health assessment (AHCA form 1823) was updated after a significant change for 1 of 6 records reviewed (#7).

Findings:

On , the facility director of nursing reported resident #7 was receiving home health skilled nursing services for an open on the right great .

On at 10:50 AM, resident #7 stated his physician visited once a week and a home health nurse came times a week to clean and change the on his . He said he was told the came from the way he was walking and his shoe. He was told it was healing.

Review of the record for resident #7 revealed an admission date of . The 1823 was dated and documented diagnoses which included lymphedema. He was noted to be at risk for . He was independent with most Activities of Daily Living, but required assistance with bathing & . He ambulated with the use of a walker. The assessment documented there were no as of .

Review of the observation notes in the record found a observed on the right great on . The physician and family were notified. The provider was noted to order home health visits. The facility observation notes documented the first visit by the home health nurse was on .

Review of the home health notes found the date of onset for the on the right great was . It was assessed to be a . Measurements on the first visit on were 1.5cm x 2.5cm x 0.3cm, on , the measurements documented were 0.8cm x 0.5cm x 0.3cm, and on the measurements recorded were 0.5cm x 0.2cm x 0.2cm. The measurements were not yet due at the time of the survey, however the was showing signs of healing.

On at 4:28pm, the nurse manager stated they had not obtained an updated 1823.

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Class III

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

Based on observations, record review and interview the facility failed to follow the healthcare provider's order regarding medication for 1 of 4 sampled residents (#14).

Findings:

Observations during the facility tour on at 10:45 AM resident #14 had a note on her apartment door that indicated that she wanted her medications to given one at a time in apple sauce.

Resident record review revealed a healthcare provider's order dated that indicated patient to take all medication with applesauce for easier swallowing. The and Medication Observation Record (MOR) indicated "may crush medications in applesauce". The review revealed no evidence of a healthcare provider's order to crush medications.

In an interview with the "med tech" staff on at 2:15 PM for resident # 14 who said the resident's medications were crushed except for the softener as it was a gel capsule.

In an interview with the Resident Care Director on at 3:30 PM, who after she called the pharmacy, who are responsible to update the MOR said that the pharmacist said that take all medication with applesauce for easier swallowing was the same as may crush medications in applesauce.

Class III

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observations and interview the facility failed to ensure the unlicensed staff (D) who assisted 1 resident (#13) with self-administration of medications followed the correct procedure.

Findings:

Observations on 12:30 PM noted when staff E assisted resident #15 with self-administrations of medications she placed the resident's medications in plastic bin and went to the resident's room and told her it was time for her 12 noon medications.

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

Resident #13 was also in the room and sat to the front right of the room by a table.

Continued observations noted that on top of the table there were 2 small cups with pills inside. Resident #13 said they were hers because everything on that side of the table was hers. And she knew not to take anyone else's medications.

The staff said the medications were pills that belonged to resident #13. According to the staff the resident's daughter said she could not take all 4 tablets at once, to leave them for her to take later, as she used to take them at home. She added there was an order for the resident to self- administer the .

Resident record review for resident # 13 revealed a health assessment report dated that listed diagnoses of ( ) and mild memory loss. She needed assistance with self -administration of medications. The Medication Observation Record (MOR) listed chewable 500 milligrams take 4 tablets daily and was signed as given on at 9 AM, although the staff did not observe the resident take the medication and gave it her to take at her leisure.

In an interview with the Resident Care Director on at 3:30 PM, who offered no comment.

Class III

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

Based on observations, record review and interview, the facility failed to ensure medications (prescribed and over the counter (OTC)) were maintained in a secure location at all times for 2 of 2 residents (#13 and 15).

Findings:

Observations on 12:30 PM noted when staff E assisted resident #15 with self-administrations of medications she placed the resident's medications in plastic bin and went to resident's #15's room and told her it was time for her 12 noon medications.

Resident #13 was also in the room and sat to the front right of the room by a table . The staff placed the plastic bin on a table to the right of the room, where resident #13 sat.

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SUMMARY STATEMENT OF DEFICIENCIES
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The staff assisted resident #15 with her medications and placed the bubble pack in the bin that was on the table and walked away to explain the medication pass times to resident #15.
The staff left the bubble pack unattended on the table where resident #13 sat.

Continued observations noted that on top of the table there were 2 small cups with pills inside. Resident #13 said they were hers because everything on that side of the table was hers. Resident #13 stated she knew not to take anyone else's medications.

The staff said the medications were pills that belonged to #13. Per the staff the resident's daughter said she could not take all 4 tablets at once, to leave them for her to take later, as she used to take them at home. She added there was an order for the resident to self- administer the .

Medication review on at 2:15 PM for resident # 14 revealed , 0.25 mg twice a day as needed for , with a prescription label dated was stored in the control substance drawer in the medication cart, among resident's current medications. Further observations noted the medication had an expiration date of . The staff who worked the cart said she did not realize the medication had expired.

In an interview with the Resident Care Director on at 3:30 PM, who offered no comment and said the staff returned the , to her for disposal.

Class III