STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910564	**07/24/2017**
NAME OF PROVIDER OR SUPPLIER **SOUTHERN LIVING FOR SENIORS**	STREET ADDRESS, CITY, STATE, ZIP CODE **765 NE DELPHINIUM DRIVE** **MADISON, FL 32340**	

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

0000 - Initial Comments

An unannounced Change of Ownership survey with Limited Mental Health and Limited Nursing Services was conducted on at Southern Living for Seniors Assisted Living Facility (license #6020). Deficiencies were found at the time of the survey.

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation and interview, the facility failed to ensure that unlicensed staff did not administer medications fror 1 of 4 of residents observed during medication administration (resident #10).

Findings Include:

A medication observation for resident #10 was conducted on at 2:10pm. The administrator was observed to remove the medications for resident #10 from the medication , which she then took to the resident #10. She was then observed to take the medications from the packet with her hands, instructed the resident to open his mouth, and placed the medications in the mouth of resident #10.

An interview was conducted with the Administrator on at 4:10pm. The administrator stated, "The first one I put it in his mouth to show him where it was supposed to go." She confirmed she was not supposed to place the medicine in the resident's mouth.

Class III

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

Based on observation and staff interview, the facility administrator failed to update the Medication Observation Record (MOR), immediately after medication was given for 1 of 4 residents (#9) observed during medication observations.

Findings include:

A medication observation was conducted on at 12:23 pm. The administrator was observed to remove medication from the medication , and gave it to resident # 9, but was not observed to initial the MOR to indicate the medication had been given.

An interview was conducted with the Administrator on at 4:10pm. The Administrator stated, "I

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documented on the MOR when I took his medication out of the medication . I documented the one at lunchtime before I left the med I could not bring the book out with me at that time, but I am supposed to document right after I give it to the resident, not before."

Class III

0092 - Food Service - General Responsibilities - 58A-5.020(1) FAC

Based on observation, staff interview, and record review, the facility failed to ensure the food service designee (staff B, the cook) completed the food and nutrition services module of the core-training course.

Finding Include:

Staff B was observed preparing meals on at 11:15am. Staff B advised she was the cook for the facility Monday through Friday.

A record review was conducted of the employee file for Staff B. The completed training certificate for food and nutrition services could not be found, nor could any continuing education related to food service.

An interview was conducted with the administrator on at 4:10pm. She confirmed that Staff B was the food service designee for the facility. She reviewed the employee file for Staff B, and confirmed the absence of training related to food and nutrition services.

ClassIII

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation and staff interview, the facility failed to ensure the menu was posted and available to residents.

Findings Include:

A tour was conducted on at 9:45am of the facility. During the tour, there were no signs of the menus posted in the facility. There was an observation of a dry erase board that did not have the current menu for the upcoming meal.

An interview was conducted with Staff B (cook) on at 10:00am. Staff B stated, "I write the

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individual meal each day, before each meal, on the dry erase board posted outside of the kitchen." Staff B confirmed that the menu on the dry erase board was not the correct menu for that day, and that the facility did not post the full menus.

ClassIII

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the facility failed to ensure a safe and sanitary living environment for the residents by failing to maintain the facility free of rodents. This practice had the potential to affect all 21 residents residing at the facility.

Findings Include:

A tour was conducted on at 9:35am of the facility. During the tour, a mouse was found under the sink in a between two residents (photo evidence obtained).

An interview was conducted on at 9:48am with the Operations Manager. He confirmed the mouse in the stated that pest control had been to the facility last week to treat the problem, and that was why the mouse was found." He was asked to produce an invoice for the pest services provided and he stated, "I will get it for you."

An interview was conducted on at 10:49am with resident#1. She stated, "The facility had rats."

An interview was conducted on at 11:00am with resident #7. She confirmed the facility had rats.

Another interview was conducted on at 2:15pm with the Operations Manager. He stated, "I still do not have the documentation for pest control, I am waiting on them to call me back." The Operations Manager exited the property and never returned.

The pest control invoice was not produced by the facility prior to exiting the facility.

Class III