Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964849	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH COURT OF LAKE WALES	12 EAST GROVE AVENUE LAKE WALES, FL 33853

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments Assisted Living Facility A second revisit was conducted on in conjunction with a revisit, see (Aspen Event XB4912). Savannah Court of Lake Wales had two uncorrected deficiencies cited: A 0052 & A 0055.	{A 000}		
{A 052}	58A-5.0185(3) FAC Medication - Assistance with Self-Admin (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) For facilities which provide assistance with self-administered medication, either: a nurse; or an unlicensed staff member, who is at least , trained to assist with self-administered medication in accordance with Rule 58A-5.0191, F.A.C., and able to demonstrate to the administrator the ability to accurately read and interpret a prescription label, must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. (b) Assistance with self-administration of medication includes verbally prompting a resident to take medications as prescribed, retrieving and opening a properly labeled medication container, and providing assistance as specified in Section 429.256(3), F.S. In order to facilitate assistance with self-administration, staff may prepare and make available such items as water, juice, cups, and spoons. Staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, shall not be returned to the container. (c) Staff shall observe the resident take the medication. Any concerns about the resident ' s	{A 052}		

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{A 052}	Continued From page 1	{A 052}		

reaction to the medication shall be reported to the resident ' s health care provider and documented in the resident ' s record.
(d) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:
1. The health care provider may prescribe a medication schedule which coincides with the resident ' s presence in the facility;
2. The medication container may be given to the resident or a friend or family member upon leaving the facility, with this fact noted in the resident ' s medication record;
3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident ' s medication record; or
4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging;
(e) Pursuant to Section 429.256(4)(h), F.S., the term " competent resident " means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication.
(f) Pursuant to Section 429.256(4)(i), F.S., the terms " judgment " and " discretion " mean interpreting vital signs and evaluating or assessing a resident ' s condition.
(4) Assistance with self-administration does not include:
(a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.

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{A 052}	Continued From page 2	{A 052}		

(b) The preparation of syringes for injection or the administration of medications by any injectable route.
(c) Administration of medications through intermittent positive pressure breathing machines or a .
(d) Administration of medications by way of a tube inserted in a cavity of the body.
(e) Administration of preparations.
(f) Irrigations or debriding agents used in the treatment of a skin condition.
(g) , , or preparations.
(h) Medications ordered by the physician or health care professional with prescriptive authority to be given " as needed, " unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident.
(i) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.

This Statute or Rule is not met as evidenced by:
Based on observation, interview, and record review the facility failed to ensure that a resident who was self- administering their own medication had been properly assessed to do so and that contaminated medication was disposed of properly.
Findings include:
On .2012 an onsite revisit was conducted at the facility. An interview was conducted at approximately 11:15 a.m. with resident #6 in her . The resident was admitted to the facility on . She stated that she keeps her medications in her self-administers. She opened the drawer to a small table and

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{A 052}	Continued From page 3 showed where she kept the medications. Present in the drawer was / tab 50-12.5, one tab po daily for ; tab 20 mg, one tab po at bedtime for . The resident stated she takes the between 10:00 am and 11:00 am; 25 mg tab, take 1 tab every day at bedtime. She said that she does not take the and that it is prescribed to help her sleep; 20 mg, take 1 tab once a day at bedtime. She stated that she never has taken and that it is prescribed to help her from getting stressed. Also Bayer 81 mg at 12pm, 1 tab. Lying on her counter was cap 40 mg CR, one cap by mouth daily for . She said that she leaves the medication lying on the counter to remind her to take before breakfast. Also present on the counter was Twisthaler 220 mcg and Metronidazol gel .75 mg. At 11:55 a.m. an interview was conducted with staff member/medication tech #1. She said that if a resident self-administers they check every day to make sure they are taking their medications. She asks verbally and looks at their bottle. She said that if the family and the Physician feels they are able to self- administer they are able to do so. She said that she really wouldn ' t know if they are actually taking the meds until after she checks to see that the bottle or card is getting empty. The med tech stated that an assessment is completed when a resident is admitted to the facility to assess their ability to self -administer medications. She acknowledged that an assessment had not been completed for resident #6. At 3:15 p.m. the Administrator and the surveyor went to resident #6 ' s . The resident showed the Administrator the medications lying	{A 052}		

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{A 052}	Continued From page 4	{A 052}		

on and in the drawer. The resident said there was another medication card under a magazine in her drawer. It was 20 mg, one tab a day. The resident stated in front of the Administrator that she does not take the medication. She also stated she did not take 2 of the other prescription medications prescribed to her. The resident began crying stating that she was feeling depressed and really stressed out. She said she had been afraid to take the because she didn ' t know if it would make her pass out.

The resident ' s Health Assessment form 1823 dated was reviewed. Section 2 of the form has yes checked for the question asking if the resident is in need of help with taking her medication. Also checked is that she needs total assistance with administration of meds. The Administrator was made aware that the resident was self- administering her medications when the Resident Health Assessment stated that she required assistance.

An observation was made at approximately 4:15 p.m. of the assistance of self administration of medications. While preparing resident #1 ' s medication staff member #B spilled the bottle of pills directly on the medication cart. She then picked up the pills with her bare hand and placed them back in the pill container. When she took the resident ' s medications into the did not lock the med cart. She then prepared to give the resident her treatment when she realized she left the Iprat-Albut medication sitting on top of the medication cart in the hallway. She retrieved the medication, picked the mouthpiece up that had been sitting directly on the desk top, handed the mouthpiece to the resident who then placed it into her mouth. She did not clean the mouthpiece prior to the resident putting it into her mouth.

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{A 052}	Continued From page 5 Class III Isolated	{A 052}		
{A 055}	58A-5.0185(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises; or in their or apartments, which must be kept locked when residents are absent, unless the medication is in a secure place within the or apartments or in some other secure place which is out of sight of other residents. However, both prescription and over-the-counter medications for residents shall be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility shall maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents; or 6. The facility ' s rules and regulations require central storage of medication and that policy has been provided to the resident prior to admission	{A 055}		

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{A 055}	Continued From page 6	{A 055}		

as required under Rule 58A-5.0181, F.A.C.
(b) Centrally stored medications must be:
1. Kept in a locked cabinet, locked cart, or other locked storage receptacle, , or area at all times;
2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration shall be refrigerated. Refrigerated medications shall be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which refrigerator is located locked;
3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration, or administering medication. Such staff must have ready access to keys to the medication storage areas at all times; and
4. Kept separately from the medications of other residents and properly closed or sealed.
(c) Medication which has been discontinued but which has not expired shall be returned to the resident or the resident ' s representative, as appropriate, or may be centrally stored by the facility for future resident use by the resident at the resident ' s request. If centrally stored by the facility, it shall be stored separately from medication in current use, and the area in which it is stored shall be marked " discontinued medication. " Such medication may be reused if re-prescribed by the resident ' s health care provider.
(d) When a resident ' s stay in the facility has ended, the administrator shall return all medications to the resident, the resident ' s family, or the resident ' s guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident ' s medications are still at the facility, the medications shall be considered abandoned and

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{A 055}	Continued From page 7	{A 055}		

may disposed of in accordance with paragraph (e).
(e) Medications which have been abandoned or which have expired must be disposed of within 30 days of being determined abandoned or expired and disposition shall be documented in the resident ' s record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness.
(f) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C.

This Statute or Rule is not met as evidenced by:
Based on observation, interview, and record review the facility failed to ensure medications were stored in a secure manner and that one (#5) out of four residents reviewed for medication availability had medication onsite.
Findings include:
An interview was conducted with resident #5 at approximately 10:55am. She was asked if she had received her medications on time. She responded that several weeks ago she ran out of her medication and did not receive it for several days. She said she did not remember the name of the medication, but that it " keeps her hands from shaking " . She said that she told staff she needed the medication, but did not feel they were getting the prescription refilled for her so she called the pharmacy herself. She said she was " very discussed with them " . She said she called Pharmacy and that they sent someone out at 10:00 pm with the medication. She stated, " They don ' t order on time. If they did they wouldn ' t run out " .
At 2:20 pm an interview was conducted with the Administrator and staff member #A who is a

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{A 055}	Continued From page 8	{A 055}		

medication tech regarding the resident. The administrator stated the medication was changed and that was what caused the lapse in having the medication on hand. Documented on the Medication Observation Report (M.O.R.) was that the change occurred on . The missed dosage in the M.O.R. was the dated the and for the medication . The change was from 3 pills a day to 4 pills a day. Staff member #A stated that a note was made on the M.O.R. to change to 4 times a day so on the 3rd she began giving the resident pills 4 times a day. She stated that she did not get a Physician order for the change. The Administrator acknowledged they did not have a Physician order as of this date. Staff member #A stated that she used the old medication card that said 3 times a day to begin giving out 4 pills a day. The resident ran out of medication on the 17th and was still without medication on the 18th. It wasn ' t until the evening of the that she received the . Staff member #A acknowledged that she had increased the resident ' s medication from 3 to 4 pills a day without a Physician order.
At 4:15 pm staff member/Medication tech #2 began her med pass. She stated that Resident #1 ran out of her medication the prior night and subsequently was unable to give it this day as there was none available. The M.O.R. was initialed as being given that morning. Staff member #B stated she didn ' t know how it could have been given this morning when they were out of it for the resident. She said that the medication comes in a punch card and it was not in the med cart.
At approximately 12:15 p.m. Staff member #A was observed assisting resident #7 with administering of flexpen. The staff member handed the resident an ' and then the flexpen. The resident injected the

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{A 055}	Continued From page 9	{A 055}		

into his stomach. The tech was not wearing gloves. She then took the flexpen and with bare hands unscrewed the needle and disposed of it in a red container. She then wrote in the log. At 12:27 p.m. without washing her hands or using hand sanitizer staff member #A got out the medication for resident #5 and put it into a plastic cup. She took the med cup and a cup of water to the resident ' s the resident took the medication.

Upon returning to the med cart in the hallway the medication was checked. The door was found unlocked. The staff member was shown the unlocked door. There was a refrigerator in the medication contained prescription medications and was unlocked. The med tech said that she did not have a lock for the refrigerator.

An interview was conducted with resident #1 in her approximately 11:10 a.m. A was observed on her desk in her . The mouthpiece was observed lying directly on the desk surface. She said that she had not received the breathing treatment yet this day.

An observation was made at approximately 4:15 p.m. of the assistance of self administration of medications. While preparing resident #1 ' s medication staff member #B spilled the bottle of pills directly on the medication cart. She then picked up the pills with her bare hand and placed them back in the pill container. When she took the resident ' s medications into the did not lock the med cart. She then prepared to give the resident her treatment when she realized she left the Iprat-Albut medication sitting on top of the medication cart in the hallway. She retrieved the medication, picked the mouthpiece up that had been sitting directly on the desk top, handed the mouthpiece to the resident who then placed it into

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{A 055}	Continued From page 10 her mouth. She did not clean the mouthpiece prior to the resident putting it into her mouth. Class III	{A 055}		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11964849	A. Buildi B. Wing	

Name of Facility	Street Address, City, State, Zip Code
SAVANNAH COURT OF LAKE WALES	12 EAST GROVE AVENUE LAKE WALES, FL 33853

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix A0058 Reg. # 429.42 FS; 58A-5.033 FAC LSC	Correction Completed	ID Prefix A0074 Reg. # 58A-5.019(3)(b) LSC	Correction Completed	ID Prefix AZ815 Reg. # 408.809, 435.02(2), 435.06 LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency ✓	Reviewed By [signature]	Date: 7/13/12	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on:			Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES NO

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Savannah Court of Lake Wales
12 East Grove Avenue
Lake Wales, FL 33853

Dear Administrator:

This letter reports the findings of a second state licensure survey revisit and a state licensure survey revisit that were conducted on , 2012, by a representative of this office.

Attached are the provider's copies of the State (3020) Forms, which indicate the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

For Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosures: State Forms 3020/Revisit Reports

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