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 revisit was conducted on in conjunction with a second revisit, see (Aspen Event 0YVF13). Savannah Court of Lake Wales assisted living facility had an uncorrected deficiency found at the time of the visit.	{A 000}		
{A 025}	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual. (c) General awareness of the resident ' s whereabouts. The resident may travel independently in the community. (d) Contacting the resident ' s health care provider and other appropriate party such as the resident ' s family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which	{A 025}		

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{A 025}	Continued From page 1	{A 025}		

resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.

This Statute or Rule is not met as evidenced by:
Based on observation, interview, and record review it was discovered that one out of six(#6) residents who are self- administering medications had not been assessed by the facility, not taking medications as prescribed, nor documented to do so by the Physician on the Resident Health Assessment form 1823.
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 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

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{A 025}	Continued From page 2 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 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	{A 025}		

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{A 025}	Continued From page 3 Administrator was made aware that the resident was self- administering her medications when the Resident Health Assessment stated that she required assistance. Class III	{A 025}		

AH Form Approved

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11964849	A. Building B. Wing	7/2/2012

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix A0027 Reg. # 58A-5.0182(3) FAC LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

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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