STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965589	08/14/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Savannah Court Of St Cloud	3791 Old Canoe Creek Rd Saint Cloud, FL 34769	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0167 - 58a-5.025(1) Fac - Resident Contracts S-S= B
St - A - Z827 - 408.812, Fs - Unlicensed Activity S-S= C

Specific Tag Findings:

0000-Initial Comments
A Relicensure survey was conducted on . Savannah Court of St. Cloud had deficiencies found during the visit.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observations, interviews and record review, the facility failed to provide care and services appropriate to the needs of residents accepted for admission to the facility, and did not follow healthcare provider orders for medication to 2 of 15 sample residents (#2 & 5).

Findings:

1. Observations at approximately 8:30 AM on . of the medication pass noted that staff B unlocked the medication cart, retrieved all of resident #2's medications from the cart, and reviewed them against the Medication Observation Record (MOR). She gave the resident : 160-4.5 milligrams (mg.) and stated the order changed to 2 puffs twice daily. The prescription container, dated indicated . 160-4.5 mg. one puff (twice a day).

Resident #2's record was reviewed at approximately 4 PM on . It revealed the resident was under the care of hospice. The prescription, dated , indicated to discontinue : and start /HFA mcg/spray 2 puffs inhaler every 12 hours. A hand written note on the right hand bottom of the page indicated on , that the order was faxed to Publix supermarket and included staff initials.

Another prescription dated indicated 400 mg. for 60 days for a diagnosis of anorexia, 10 milliequivilants (mEq) daily, and while asleep and out of short of breath. A hand written note on the right hand bottom of the page indicated that on , this was faxed to Publix and had lines pointing to and : 400 mg.

Page 4 of the health assessment report, dated , listed 20 mg. daily and 10 mg. daily.

The 2013 MOR listed r/HFA mEq 2 puffs every 12 hours, "Start once is done. The 2013 MOR did not list . The :2013 MOR did not list or r/HFA mEq 2 puffs every 12 hours.

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The resident care coordinator stated at approximately 5 PM on that the resident's daughter did not want to buy the medications because they were too expensive. She wanted the resident to finish the medication she had before buying others. The resident did not get or the inhaler.

2. At approximately 9 AM on staff B unlocked the medication cart, retrieved used for memory) for resident #5, and said she would get 2 pills since she needed 20 mg. The prescription label, dated read 5 mg. twice a day.

Record review at approximately 2:45 PM revealed the following. St. Cloud Hospital "universal medication form" dated indicated 5 mg., take 2 tablets by mouth twice daily. An order dated indicated 5 mg.

The 2013 MOR listed 10 mg. take one tablet by mouth once a day "Take 2 (two) 5 mg. tablets.
The 2013 MOR listed 10 mg. take one tablet once a day.

The resident care coordinator stated the ARNP told her to give 2. At 1:30 PM on the resident care coordinator stated she called CVS pharmacy and was told the prescription was 1 tablet of 5 mg. twice a day.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observations, interviews and record review, the facility failed to ensure that staff followed all the correct steps when providing assistance with self-administration of medications, did not bring the prescription container to the resident, did not read the prescription label out loud to residents (#2, 3 & 5), and assisted 1 resident with taking her medications from a weekly pill organizer (#1).

Findings:

Observations during the medication pass at approximately 8:30 AM noted the following:

1. On at approximately 10 AM, Staff B stated resident #1's daughter filled the pillboxes and she assisted the resident with taking the medication. Observations at that time found that staff B took the pill organizer, opened it, poured the medications on the resident's hand, and the resident took them. Staff B also took the resident's before getting the medications from the pillbox. Inside the box that contained the cuff was a note that read, "If was greater than 170 take which is in the pill box". When asked what the medications were, staff B replied the medication list was in her chart.

Record review for resident #1 revealed a handwritten list that indicated some medication names, prescription number, and pharmacy name. The list indicated 60 mg., 40 mg., 25 mg., 25 mg., Zolpdin 5 mg., and Alphagam. The resident care coordinator stated at approximately 3:30 PM that the resident's daughter filled the pill organizer and she had provided the facility with that list of

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medications. The 2013 MOR read, "Remind resident to take meds.

2. On at approximately 10:15 AM, staff B unlocked the medication cart, retrieved all of the resident #2's medications from the cart, and reviewed them against the MOR. She then, took one pill and said, "This is you water pill" She poured one pill at a time in small scuffle cup, brought it to resident and said, "This is for your and "This is for your too" (Dilitiazem). She gave and said nothing. She also gave and , one at a time, and inhaler but said nothing.

3. On at approximately 10:30 AM, staff B unlocked the medication cart, retrieved all of residents #5's medications from the cart, and reviewed them against the MOR. She did not read the label out loud to the resident. Instead, she took , poured it in a cup and brought it to the resident. She followed the same process for , Lebatol and For she said "This is for your , took and said "This is for your too", , and said, "This is for your and said "This is for your sugar". and said "This is for iron." She gave C and and said nothing.

4. On at approximately 10:40 AM, staff B retrieved resident #3's medication, 1 milligram (mg.) from the cart, and reviewed it against the MOR. She then poured the pill in small scuffle cup, brought to resident and said "This is your pill."

When told about the medication pass at approximately 5:15 PM on the administrator thought the staff had followed all the correct steps.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on observations and interviews the facility failed to ensure that prescription medications were not kept or given by the facility, including assistance with self-administration of medication, unless properly labeled and dispensed in accordance with FS 465 and 499 and 64 B-16-28.108, FAC for 1 of 15 sampled residents (#5), and did not place an "alert" change label on the medication container to direct staff to examine the revised directions for use on the medication observation record (MOR) or obtain a revised label from the pharmacist for 1 of 15 sampled residents (#2).

Findings:

1. Observation during the medication pass at approximately 8:30 AM noted that staff B unlocked the medication cart, retrieved resident #2's medications from the cart, and reviewed them against the MOR. She then put 2 pills inside the small scuffle cup, brought the cup to the resident and stated "This is you water pill" Staff B said she gave 2 pills, because the order was changed. The medication container label, dated , indicated 20 milligrams (mg.) daily. The prescription, dated , read to

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discontinue 20 mg. and start 40 mg. daily. The medication container did not have an alert label.

The prescription container, dated , read 10 mg. one (twice a day)." Staff B said the order was changed to once daily. Page 4 of the health assessment report, dated , listed 20 mg. daily, 10 mg. daily. The medication container did not have an alert label to direct staff to examine the revised directions for use on the MOR.

2. Staff B unlocked the medication cart, and retrieved Donezapil CHL 5 mg. for resident #5. The prescription label, dated , indicated Donezapil CHL 5 mg. one daily, a number 2 was handwritten over the number 1, to indicate to take 2 tablets instead 1.

The prescription label dated, indicated 50 micrograms (mcg.) daily. Handwritten over the prescribed amount was "2/1/2 tabs start

The resident care coordinator stated at approximately 4 PM on that the resident's family changed the label.

Class III

0078-Staffing Standards - Staff 58A-5.019(2) FAC
Based on observations, record review and interviews, the facility failed to ensure that all staff were assigned duties consistent with his/her level of education, training, preparation, and experience, and allowed unlicensed staff to exercise judgment as to when a resident needed a medication (#1), applied and removed compression stockings (#15), and assisted 2 residents with (#1 & 2).

Findings:

Staff B stated at approximately 9:15 AM on that resident #1's daughter filled the pill boxes and she assisted the resident to take the pills. Inside the box that contained the cuff was a note that read, "If was greater than 170 take which is in the pill box."

Observation at that time found an concentrator. Resident #1 stated staff helped her with the because she was and unable to do it herself.

Record review revealed a log that indicated on:

AM - was "Gave

AM - was "Gave pill"

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PM was "Gave pill"

PM was "Gave pill"

The health assessment, dated indicated assistance was needed with self-administration of medications and the resident was had hearing and vision and

2. Resident #2 was observed in bed using nasal via cannula. When asked if she managed her alone, she shook her head "no". When asked if she needed help and if the staff helped her, she nodded "yes".

Record review revealed a prescription dated for via nasal cannula. Another order, dated read while asleep and out of short of breath." The health assessment indicated diagnoses of acute hypoxic, failure, and She was alert with

The and 2013 MORs indicated the resident needed assistance with use when she goes to bed. Staff initials were seen on the MORs at 8 PM for both and 2013 to assist the resident with use when needed for

3. At approximately 8:15 AM on during the facility tour and medication pass, resident #15 was not in his Observations during lunch noted resident #15, who sat at the right side of the dining , had white waist high compression stockings. Staff B stated at that time that other staff put the hose on and removed them. She showed the 2013 MOR to ensure the hose was put on and removed daily.

Interview with resident #15 stated that direct care staff assisted him with donning his compression stockings every morning and taking them off every night, seven days a week. He was unable to put them on or remove them by himself.

The health assessment, dated indicated a diagnosis of The and 2013 MOR indicated to assist with stockings on at 7 AM and OFF at 7 PM. The face sheet read, "needs with compression stockings". A healthcare provider's order was not available.

At approximately 5 PM on , the manager and the resident care coordinator offered no comment

Class III

0167-Resident Contracts 58A-5.025(1) FAC
Based on record review and interview, the facility failed to ensure that resident contracts contained all the necessary requirements for 2 of 15 sampled residents (#12 & 13).

Findings:

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Record review for residents #12 and 13 at approximately 2 PM on revealed that the contracts did not include a statement to inform the residents or responsible party that as part of the continued residency criteria, a resident must have a face-to-face medical examination by a licensed health care provider at least every 3 years after the initial assessment, or after a significant change, whichever came first.

At approximately 2 PM on , the manager confirmed the findings.

Class

Z827-Unlicensed Activity 408.812, FS
Based on observation, record review and interview, the facility failed to obtain a Limited Nursing Services license before performing the services for 3 of 15 sampled residents (#1, 2 & 15).

Findings:

Review of the facility's posted license revealed a Standard Assisted Living License that expired on

1. Staff B stated at approximately 9:15 AM that resident #1's daughter filled the pill boxes and she assisted the resident to take the pills. Observations in the resident's a box that contained the cuff and in the inside the box a note read, "If was greater than 170 take which is in the pill box."

At this same time, an concentrator was seen. The resident said staff helped her with use because she was and unable to do it herself.

Record review revealed a log:

AM - the was "Gave

AM - was "Gave pill"

PM - was "Gave pill"

PM - was "Gave pill"

A health assessment, dated , indicated assistance was needed with self-administration of medications and the resident had , hearing and vision , and

2. Resident #2 was observed in bed using via nasal cannula. When asked if she managed her alone, she shook her head "no". When asked if she needed help and if the staff helped her, she nodded "yes".

Record review revealed a prescription, dated that indicated via nasal cannula. Another order, dated , indicated while asleep and out of short of breath. The health assessment indicated diagnoses of acute failure, , chronic

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, and

She was alert with

The and 2013 MORs indicated the resident needed assistance with use when she goes to bed. Staff initials for both and 2013 at 8 PM were seen indicating assistance with use was provided to the resident for when needed.

3. At approximately 8:15 AM on during the facility tour and med pass, resident #15 was not in his Observations during lunch noted resident #15, who sat at the right side of the dining , had white waist high compression stockings. Staff B stated at the time that other staff put the hose on and removed them. She showed the 2013 MOR to ensure the hose was put them on and removed daily.

Interview with resident #15 stated that direct care staff assisted him in putting on his compression stockings every morning and taking them off every night, seven days a week. He was unable to put them on or remove them himself.

A health assessment, dated indicated diagnosis of . The and 2013 MORs indicated staff were to assist with stockings on at 7 AM and OFF at 7 PM. The face sheet read, "needs assistance with compression stockings". A healthcare provider's order was not available.

At approximately 5 PM on , the manager and the resident care coordinator offered no comment.

Unclassified

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Savannah Court Of St Cloud
3791 Old Canoe Creek Rd
Saint Cloud, FL 34769

Re: Biennial relicensure

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2013 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates 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 after **, 2013,** 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(s). Should you have any questions please call Lorraine Henry at .

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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