| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11953284 | 12/15/2014 |
| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| Savannah Court Of Maitland | 1301 W. Maitland Blvd Maitland, FL 32751 | |
| 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 - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D

**Initial Comments**
Complaint Investigation CCR#2014009506 was conducted on Savannah Court of Maitland Assisted Living Facility had deficiencies found at the time of the visit.

**0025-Resident Care - Supervision 58A-5.0182(1) FAC**
Based on record review and interview the facility failed to ensure physician orders were followed for 1 of 6 sampled residents (#1).

Findings:

Resident record review revealed an Assisted Living Facility Health Assessment Form (1823) updated on that indicated diagnoses of and The resident needed assistance with self-administration of medications.

1. Review of a Nurses Note dated at 4 PM revealed a family member found the resident's medications near the microwave, in her There were 6 1/2 tablets in the cup. Review of a physician' order dated and review of the Medication Observation Record revealed 81 milligrams (mg) one daily at 8 AM, (for lipids) 20 mg one at 8 AM, 10 mg one daily at 8 AM, 75 mg one daily at 8 AM, (for stomach 40 mg one daily at 8 AM, for pain) one at 8 AM, and (for 12.5 mg 1/2 tab at 8 AM. The medications were charted as given on at 8 AM; there were initials in the box. The medications were left in the not given per physician's order.

In an interview with the administrator on at approximately 2 PM who stated he had completed his investigation and presented the SLM Staffing, LLC Associate Warning and Discipline Notice. Review of the Warning and Discipline notice, for violation on indicated the employee failed to have the resident take prescribed medications and left medications unattended.

2. Review of a facility note written on at 11:08 PM stated, "When I came on shift at 10:45 PM I was advised by a 3-11 med tech that a med error had occurred regarding this resident. I was told that her 4 PM dose of had been administered at 8:15 PM." "The resident's family member was concerned and I was advised that the family member wanted me to call her. Called physician to notify, awaiting call back. Call to family member at 11:03 PM who stated she would call the administrator and email him, as well as the RCD." Resident checked, no sign or symptom of hypo/hyp at this time. Resident was clinically stable.

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Review of physician orders signed for 2014 on the Physician's Order Sheet revealed (for 25 milligrams (mg) 1/2 tab ...l at 8 AM and 4 PM.

Review of the 2014 Medication Observation Record revealed 12.5 mg was charted as given at 4 PM.

In an interview with the administrator on at approximately 2 PM who stated he had written the staff person up for giving the resident her medication late.

Review of the SLM Staffing, LLC Associate Warning and Discipline Notice revealed on a medication error had occurred. The employee delivered a medication to a resident at 8:15 PM that was scheduled for 4 PM.

3. Review of a summary for resident #1 dated 2014, presented for review by the administrator revealed on an email was received from the resident's family member. She indicated the resident left the facility earlier, a family member was given the resident's medication, by the staff, to take with her and the resident was visiting at the family member's home. When the family member went to give resident #1 her 4 PM 12.5 mg, she discovered the bubble card was another resident's medication. She called the facility and found the resident's card was still in the medication cart. The resident was not given her 4 PM dose of 12.5 mg.

Review of the front and back of the 2014 MOR revealed on the 12.5 mg at 4 PM had the initials circled, as not given, the back of the MOR indicated the resident was on leave of absence with the family.

The administrator stated on at approximately 2 PM that the staff member was written up. Review of the SLM Staffing, LLC Associate Warning and Discipline Notice, for the violation on indicated the employee sent the wrong medication home with a resident, who was going home on leave of absence with the family. The medication was another resident's medication. This caused the resident, who went home, to miss a dose of her prescribed medication.

**Class III**

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**0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC**

Based on record review and interview, the facility failed to ensure that when staff provided assistance with self-administration of medications, the staff followed the appropriate procedure to take the medication, in its dispensed, properly labeled container to the resident, in the presence of the resident, read the label, open the container, remove a prescribed amount of medication from the container, close the container, return to storage and document on the Medication Observation Record for 1 of 6 sampled residents (#1) and failed to ensure when the resident was away from the facility, they family member was given the correct medication container for 1 of 6 sampled residents (#1) .

Findings:

Resident record review revealed an Assisted Living Facility Health Assessment Form (1823) updated on that indicated diagnoses of and . The resident needed assistance with self-administration of medications.

1. Review of a Nurses Note dated at 4 PM revealed a family member found the resident #1's medications near the microwave, in her . There were 6 1/2 tablets in the cup.

Review of a physician' order dated and review of the Medication Observation Record revealed 81 milligrams (mg) one daily at 8 AM, (for lipids) 20 mg one at 8 AM, 10 mg one daily at 8 AM, 75 mg one daily at 8 AM, (for stomach 40 mg one daily at 8 AM, for pain) one at 8 AM, and (for 12.5 mg 1/2 tab at 8 AM. The medications were charted as given on at 8 AM; there were initials in the box. The medications were left in the the unlicensed staff did not follow the proper procedure for assisting with self-administration of medications.

In an interview with the administrator on at approximately 2 PM who stated he had completed his investigation and presented the SLM Staffing, LLC Associate Warning and Discipline Notice. Review of the Warning and Discipline notice, for violation on , indicated the employee failed to have the resident take prescribed medications, and left medications unattended.

2. Review of a summary for resident #1 dated 2014, presented for review by the administrator, revealed on ; an email was received from the resident's family member. She indicated the resident left the facility earlier, a family member was given the resident's medication, by the staff, to take with her, and the resident was visiting at the family member's home. When the family member went to give resident #1 her 4 PM 12.5 mg, she discovered the bubble card was another resident's medication. She called the facility and found the resident's card was still in the medication cart. The resident was not given her 4 PM dose of 12.5 mg.

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Review of the front and back of the 2014 MOR revealed on the 12.5 mg at 4 PM had the initials circled, as not given, the back of the MOR indicated the resident was on leave of absence with the family.

The unlicensed staff did not read the medication label to ensure the medication for the correct resident was given to the resident's family member, when the resident went on leave of absence with the family member.

The administrator stated on at approximately 2 PM that the staff member was written up. Review of the SLM Staffing, LLC Associate Warning and Discipline Notice, for the violation on indicated the employee sent the wrong medication home with a resident, who was going home on leave of absence with the family. The medication was another resident's medication. This caused the resident, who went home, to miss a dose of her prescribed medication.

**Class III**

**0054-Medication - Records 58A-5.0185(5) FAC**
Based on record review and interview the facility failed to ensure staff maintained an accurate, daily Medication Observation Record (MOR) for 1 of 6 sampled residents (#1).

Findings:

Resident record review revealed an Assisted Living Facility Health Assessment Form (1823) updated on that indicated diagnoses of and The resident needed assistance with self-administration of medications.

1. Review of a Nurses Note dated at 4 PM revealed a family member found the resident's medications near the microwave, in her There were 6 1/2 tablets in the cup. Review of a physician' order dated and review of the Medication Observation Record revealed 81 milligrams (mg) one daily at 8 AM, (for lipids) 20 mg one at 8 AM, 10 mg one daily at 8 AM, 75 mg one daily at 8 AM, (for stomach 40 mg one daily at 8 AM, for pain) one at 8 AM, and (for 12.5 mg 1/2 tab at 8 AM. The medications were charted as given on at 8 AM; there were initials in the box. The medications were left in the not given per physician's order. The MOR was not accurate.

In an interview with the administrator on at approximately 2 PM who stated he had completed his investigation and presented the SLM Staffing, LLC Associate Warning and Discipline Notice. Review of the Warning and Discipline notice, for violation on indicated the employee failed to have the resident take prescribed medications, and left medications unattended.

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2. Review of a facility note written on at 11:08 PM stated, "When I came on shift at 10:45 PM I was advised by a 3-11 med tech that a med error had occurred regarding this resident. I was told that her 4 PM dose of had been administered at 8:15 PM." The resident's family member was concerned and I was advised that the family member wanted me to call her. Called physician to notify, awaiting call back. Call to family member at 11:03 PM who stated she would call the administrator and email him, as well as the RCD. Resident checked no sign or symptom of hypo/hyp at this time. Resident was clinically stable.

Review of physician orders signed for 2014 on the Physician's Order Sheet revealed (for 25 milligrams (mg) 1/2 tab at 8 AM and 4 PM.

Review of the 2014 Medication Observation Record revealed 12.5 mg was charted as given at 4 PM. The MOR was not accurate.

In an interview with the administrator on at approximately 2 PM who stated he had written the staff person up for giving the resident her medication late.

Review of the SLM Staffing, LLC Associate Warning and Discipline Notice revealed on a medication error had occurred. The employee delivered a medication to a resident at 8:15 PM that was scheduled for 4 PM.

3. Review of a summary for resident #1 dated 2014, presented for review by the administrator revealed on an email was received from the resident's family member. She indicated the resident left the facility earlier, a family member was given the resident's medication, by the staff, to take with her, and the resident was visiting at the family member's home. When the family member went to give resident #1 her 4 PM 12.5 mg, she discovered the bubble card was another resident's medication. She called the facility and found the resident's card was still in the medication cart. The resident was not given her 4 PM dose of 12.5 mg.

Review of the front and back of the 2014 MOR revealed on , the 12.5 mg at 4 PM had the initials circled; as not given, the back of the MOR indicated the resident was on leave of absence with the family. The MOR was not accurate.

The administrator stated on at approximately 2 PM that the staff member was written up. Review of the SLM Staffing, LLC Associate Warning and Discipline Notice, for the violation on indicated the employee sent the wrong medication home with a resident, who was going home on leave of absence with the family. The medication was another resident's medication. This caused the resident, who went home, to miss a dose of her prescribed medication.

**Class III**

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2015

Administrator
Savannah Court Of Maitland
1301 W. Maitland Blvd
Maitland, FL 32751

**RE: CCR #2014009506**

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2014 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 [redacted] 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 407-420-2502.

Sincerely,

for Theresa DeCanio, RN
Field Office Manager

TDC:clr
Enclosure

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com