STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968108	**05/11/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
L & L ASSISTED LIVING COMMUNITY INC	**4211 CHAIRES CROSS RD TALLAHASSEE, FL 32317**	

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

0000 - Initial Comments

Bienniel with LMH/ECC
On / an unannounced biennial survey (with specialty license Limited Mental Health and Extended Congregate Care) was conducted at L & L Assisted Living Community. At the time of survey there were deficiencies identified.

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

Based on observation, review of resident medication observation records, and staff interview the facility failed to administer medications in accordance with physician orders for 5 of 5 residents observed for medication administration. On / at 8:45am an unannounced entrance was made to the facility. The staff member present stated that the administrator was not at the facility, but should arrive within fifteen to twenty minutes due to the fact that she was bringing breakfast to the residents. At approximately 9:15am the administrator arrived to the facility carrying several plastic shopping bags that contained multiple disposable food containers. She asked that the surveyors relocate and escorted the surveyors to a downstairs living space. After assisting the surveyors with set-up in the downstairs area, she stated that she would have to excuse herself to go assist the staff member with serving breakfast. The administrator was asked to please alert surveyor #33394 prior to beginning medication administration with the residents due to observation requirements, to which she stated that she would. Surveyor #28379 accompanied the administrator back to the main living area of the facility. At approximately 10:00am, the administrator stated alerted surveyor #33394 that she was about to begin medication administration and an observation commenced. Resident #1 had an order for medication eye drops to be given in both eyes twice daily that was scheduled for 6:00am administration that was not observed to have been given. Resident #2 had an order for medication 20 milligrams (mg) by mouth daily before breakfast that was not observed as having been given. Resident #2 was also ordered medication 400mg by mouth twice daily; however, the bottle of medication that the resident had was labeled medication 600mg with medication D and the medication was not given. Resident #2 had orders for medication Lumigan eye drops to be instilled in both eyes twice daily and medication eye drops to be instilled once daily before bedtime. The administrator did not have these medications in supply and they were not given. Resident #3 had an order for medication 20mg by mouth daily before breakfast that was not given and an order for medication 120mg by mouth daily before breakfast that the administrator attempted to administer to the resident; however, the resident refused. Resident #3 also had an order for medication 600mg by mouth daily which was not given because the administrator did not have the medication in supply. Resident #3 also had an order for medication 10 milliliters (ml) by mouth daily that was not administered, nor was it observed to be in resident ' s stock of medication. Resident #4 had an order for medication 0.1% cream to be applied to affected areas of his body twice daily that was not administered. Resident #5 had an order for medication 20mg and medication 50mcg by mouth daily before breakfast that were not given. Review of the residents ' medication observation records (MORs) showed that the residents had orders for medications that were scheduled to be given before breakfast with administration time identified on the MOR as 6:00am. Resident #1 had an order for medication 10mg by mouth twice daily; however, the MOR showed only one time for administration with only one set of initials for an 8:00am dose, indicating that the resident

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0053 Continued From page 1

had only been receiving the medication once daily. Resident #3 had an order for medication 600mg by mouth daily; however, review of the MOR showed administration times at 8:00am and 6:00pm that were both initialed indicating that the resident had been receiving the medication twice daily. Resident #3 also had an order on the MOR for medication 50mg by mouth every morning; however, there was no documentation on the MOR that the resident had received that medication since the first of the month. At 10:41am an interview was attempted with the administrator who stated that she was a nurse and was the person primarily responsible for medication administration. She was asked who had given the residents their 6:00am medications that morning and she stated that she had. She was then asked if she had come in early that morning to which she stated that she had not. She stated that she had given the resident ' s their 6:00am medications when she had arrived. The administrator was then asked to clarify when the medication had been given as she had been in the presence of the surveyors since her arrival and neither surveyor had witnessed her administering medications until the observation had been initiated. The administrator began to raise her voice stating that she was a nurse and knew the rules for medication administration. She stated that she was allowed an hour before and an hour after the administration time to give the medications. The administrator was asked why she had attempted to give resident #3 her 6:00am dose of medication at 10:27am and she stated that if the medication was ordered for just one time daily, she could give it whenever she wanted, regardless of what the MOR showed.
Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and staff interview the facility failed to maintain proper storage of resident medications for 1 of 5 residents (#5).
On / an unannounced entrance was made to the facility at approximately 8:45am. At the time of entrance, there was one staff member " A " and five residents in the facility. Staff member " A " stated that sometimes there would be two employees at the facility, but since they were not at capacity, there had only been one person for the past several weeks.
Around 9:15am the administrator arrived at the facility and was asked about her resident population. She stated that she did not currently have any residents receiving nursing services or mental health services, stating that " all of the residents are just "
At approximately 10:00am, the facility administrator was observed assisting the residents with their medication administration. The administrator began by collecting the resident ' s medication observation record and a bag of medications that were stored in a locked cabinet in the resident ' s . The administrator gave the resident several medications from the bag that were in pill form and then stated that the resident also had two liquid medications that she needed to take. The administrator was observed to go over to a cabinet in the kitchen where food items were being stored and retrieved two bottles of medication that she then prepared for resident #5. The kitchen cabinet was not locked and there was nothing in place that would have prevented any of the facility residents from gaining access to the medications.

Class III

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0090 - Training - - 58A-5.0191(11) FAC

Based on record review and staff interview the facility failed to ensure that 4 of 4 employees (#A, #B, #C and #D) received the one hour of training in the facility's policy and procedures regarding ( )

The Findings:

On / a record review was conducted of four employee's personnel files in regards to the one hour of training in the facility's policy and procedures regarding . The personnel files did not have the training included in the files.

On / at approximately 3:00pm an interview was conducted with the Administrator who reported that she was not aware of the training and confirmed that she and staff members did not have the training's.

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

Based on record review and staff interview the facility failed to ensure that all regular and therapeutic menus used by the facility were reviewed annually by a licensed or registered dietitian.

The Findings:

A record review was conducted of the facility's menus for regular and therapeutic meals and the last review date by the licensed dietitian was on .

On / at approximately 2:57pm an interview was conducted via telephone with the facility's registered dietitian who reported that she could not remember the last time that she reviewed the facility's menus. Stated that she would review the menus whatever the regulations require.

On / at approximately 3:00pm an interview was conducted with the Administrator who reported that she thought that the menus supposed to be reviewed every two years when she renew her license. The Administrator stated that it is very expense to have a dietitian review her menus annually.

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

Based on observation and staff interview, the facility failed to maintain an environment free of hazards by having two electrical outlets with no protective covering.
At approximately 8:45am on / an unannounced entrance was made to the facility. During the initial tour of the facility, there was a downstairs common area observed to be furnished with six reclining chairs that had tables in between them. Some of the tables were labeled with the names of the residents and contained personal resident belongings. The space also contained a large table with six chairs and there were various board games observed to

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0152 Continued From page 3

be stacked neatly against one of the walls in the .
At approximately 9:15am the administrator arrived to the facility and asked that the surveyors relocate to the downstairs living space. A closer inspection of the downstairs space showed two electrical outlets that were missing their covers. The outlets were located close to each other on the right side of the , in front of two of the resident ' s recliners. Area was observed to be fully accessible by the residents.
A subsequent interview with the administrator at approximately 9:30am revealed that the used on a regular basis by the residents and was the primary location for resident activities. The administrator was asked about the uncovered outlets, and stated " I will fix them. "

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on observation and interview, the facility failed to maintain resident records for 2 of 5 residents (#1 and #5) in a manner that would make them readily available for review.
At approximately 12:30pm the facility administrator was asked to produce the records for resident #1 and resident #5 for review. The records, contained in three ring binders, were supplied within ten minutes; however, review showed that the records did not contain all necessary components. At approximately 12:45pm, the administrator was asked to produce copies of the resident contracts and weight records for both residents. She returned within ten minutes with the contract for resident #1, but stated that she was still looking for the contract for resident #5 and had not found weight records for either resident. The administrator excused herself to assist with the lunch meal for the residents. At approximately 1:45pm the administrator was again asked for the contract for resident #5 and the weight records for both resident #1 and resident #5. She again stated that she would go look for them and felt like the contract for resident #5 would be in the storage building outside since the resident had been living at her facility for an extended time. At approximately 2:30pm, the administrator was alerted that all others phases of the survey had been completed except for the records she had been asked for and had not yet provided. She stated that she would have them within fifteen minutes. She did return and provide the contract for resident #5 at approximately 2:40pm; however, she was not able to produce weight records on either resident #1 or resident #5.

Class III

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(8) FAC

Based on record review and staff interview the facility failed to ensure that 4 of 4 employees (#A, #B, #C and #D) received training in limited mental health (LMH) within 6 months after receiving a limited mental health license.

The Findings:

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SUMMARY STATEMENT OF DEFICIENCIES
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L243 Continued From page 4

On / a record review was conducted of four employee's personnel files in regards to the limited mental health training within 6 months after receiving a limited mental health license. The personnel files did not have the training included in the files.

On / at approximately 2:27pm an interview was conducted with the Administrator who reported that she was not aware that she or staff needed LMH training. The Administrator reported that being a registered nurse and received training in and she did not think that she needed the LMH training.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
L & L Assisted Living Community Inc
4211 Chaires Cross Rd
Tallahassee, FL 32317

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 by representatives 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 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 surveyors. Should you have any questions please call me at 850-412-4493.

Sincerely,

Donah Heiberg, M.S.W.
Field Office Manager

DH/kc
Enclosure
XG90

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