RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Springs of Lady Lake, The
620 Griffin Avenue
Lady Lake, FL 32159

Dear Administrator:

This letter reports the findings of a biennial inspection survey conducted on . 2015, by representatives of the Agency for Health Care Administration. Enclosed is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **ten business days** of receipt of this report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0053 - 58a-5.0185(4) Fac - Medication - Administration S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0091 - 58a-5.0191(12) Fac - Training - Documentation & Monitoring S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= B
St - A - E207 - 58a-5.030(8) Fac - Ecc - Services S-S= D

Directed Corrective Actions

The Assisted Living Facility is required to:

1. **Review all orders for all residents in the facility for accuracy. Promptly record the orders on the medication observation record, then file a copy of the order in the resident's record.**

2. **Develop a detailed written policy and procedure for reporting a medication error. Train all staff responsible for assisting residents with the self-administration of medication and medication administration on the policy and procedure. Documentation of the completed training and all attendees must remain on file in the facility for Agency review.**

3. **Designate a licensed registered nurse to review all medication observation records on a weekly basis to check for accuracy of transcription and changes.**

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14101 N W Hwy 441, Suite 800
Alachua, FL 32615-5669
Phone:(386) 462-6201; Fax:(386) 418-5300
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Springs Of Lady Lake (the)
. 2015

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact Jasmine Hayes at this office, Area 3, 386-462-6201.

Sincerely,

Kriste J. Mennella
Field Office Manager

KJM/aw

Received by: Date:

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965130	05/06/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
SPRINGS OF LADY LAKE (THE)	620 GRIFFIN AVE. LADY LAKE, FL 32159	

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

0000 - Initial Comments

A biennial survey was conducted at Springs of Lady Lake, an assisted living facility on and Deficient practice was identified at the time of the survey.

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

Based on observation interview and record review, the facility failed to accurately administer based on a physician orders for sliding scale for 2 of 2 residents observed receiving injections (Resident #1 and #3).

The findings include:

1. On at 11:21 a.m. Staff A, a Licensed Practical Nurse (LPN), was observed checking Resident #1 ' s glucose sugar) levels. Staff A reported Resident #1 ' s glucose level as 264 mg/dL. Staff A returned to the medication cart and drew 2 units of into a syringe then injected the medication into Resident#1 ' s arm.
A review of Resident #1 ' s medication label revealed the label ' s sliding scale parameters were, to inject 4 units of if Resident #1 ' s glucose level is between 200-299 mg/dL (photographic evidence obtained).
A review of Resident #1 ' s record revealed a physician order for dated, The order confirmed Resident #1 should have received 4 units of for glucose levels between 200 (mg/dL) and 299 (mg/dL).
A review of Resident #1 ' s Medication Observation Record (MOR) for the month of 2015 revealed on Resident #1 ' s glucose was recorded as 204 mg/dL, he received 2 units of . On Resident #1 ' s glucose was recorded as 229 mg/dL, he received 2 units of .
A review of Resident #1 ' s MOR for the month of 2015 revealed on at approximately 4:00 p.m. Resident #1 ' s glucose level was recorded as 267 (mg/dL). at approximately 11:30 a.m. Resident #1 ' s glucose was recorded as 256 (mg/dL) and the received 2 units of . On 11:30 a.m. Resident #1 ' s glucose was 264 (mg/dL), he received 2 units of .
On at 11:06 a.m. Staff A, an LPN, was observed checking for Resident #3 ' s glucose level. The LPN announced Resident #3 ' s glucose was 203 (mg/dL). At 11:39 a.m. Staff A returned to Resident #3 ' s injected 8 units of into the resident ' s stomach.
A review of Resident #3 ' s label revealed instruction were to: inject 6 units under the skin three times daily with meals.
A review of Resident #3 ' s physician ' s order revealed two orders for . The first dated, , stated the resident was to receive 6 units of with food three times a day. The second stated to perform an with meals and at night with, " slide scale coverage. " An order clarification, dated showed Resident #3 should receive 4 units of coverage for glucose levels between 201 (mg/dL) and 250 mg/dL.
On at 11:52 a.m. Staff A was interviewed. Staff A confirmed she gave Resident #3 2 units of when he should have received 4 units of . At 12:56 p.m. Staff A confirmed she did not give the correct dosage of to Resident #3. She stated she read the sliding scale instructions incorrectly for Resident #3.

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On at 12:56 a.m. the Administrator was interviewed. She stated she transcribed the sliding scale on the MOR for Resident#3. She stated she did not have the actual physician ' s order in front of her when she transcribed the sliding scale on the MOR. She added she copied the sliding scale from the Medication Administration Record (MAR) at the neighboring skilled nursing home (the place from which Resident #3 was admitted).
On Resident #1 ' s physician was interviewed. He stated if the residents consistently did not get the correct dosage of would be a problem and it would mean the resident ' s sugar (glucose) is not well managed.

Class II

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on observation interview and the facility failed to promptly record changes in the directions of use for 1 of 4 medication observation records reviewed (Resident #2).
The findings include:
A review of Resident #2 ' s Medication Observation Record (MOR) for the month of 2015 revealed a transcribed order for The instructions were documented as, " take 1 tablet by mouth 3 times a day. "
A review of Resident #2 ' s physician ' s order revealed Resident #2 ' s order for Premidone was changed to 75 mg PO (by mouth) on
On at 11:07 a.m. Staff A, a Licensed Practical Nurse (LPN), was observed administering Premidone to Resident #1. Staff A was observed writing the change from 1 tablet (50 mg) of Primodeone to 1 ½ tablets (75 mg).
On at 12:01 a.m. Staff A was interviewed. Staff A confirmed she recorded the change in direction for use on
Class III

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

Based on observation interview and record review, the facility failed to ensure all training certificates for 3 of 3 employees reviewed contained documentation of the number of training hours for all required in-service trainings (Staff A, B and C).
The findings include:
A review of Staff A, Staff B and Staff C ' s in-service training certificates revealed there was no documentation of the number of hours for each training program.
On at approximately 7:14 the administrator was interviewed. She confirmed there were no hours on the training certificates.
Class III

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

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Based on record review an interview, the facility failed to maintain regular and therapeutic menus as served, with substitutions noted on file for six months.
The findings include:
A review of the facility ' s dining records revealed there was only documentation of substitution for the month of 2015. There were no additional records of menu substitutions on file.
On at 8:30 a.m. the nutritional director was interviewed. He stated the only information for menus substitutions he could find is for 2015.
Class

E207 - ECC - Services - 58A-5.030(8) FAC

Based on observation interview and record review, the facility failed to ensure Extended Congregate Care (ECC) services were offered as authorized by a physician ' s order and pursuant to a plan of care for 1 of 12 residents sampled.
On at 10:03 a.m. an interview was conducted with the administrator. She stated there were no residents currently receiving ECC service in the facility.
On at 9:49 a.m. an interview was conducted with resident#11 ' s husband. He stated his wife sustained an injury in the facility which left a on her leg. He further stated the bandages on her had not been changed for a couple days and he felt someone should come in and change the dressing on his wife ' s At 7:30 p.m. Resident #11 ' s husband was re-interviewed. He stated the facility changed his wife ' s dressing by the facility nursing staff three times since the date of the injury occurred.
at 7:31 a.m. Resident #12 stated she does not remember when she sustained the injury and agreed with the statements of her husband.
On at approximately 7:45 p.m. the Administrator was interviewed. She stated she was unaware Resident #11 was receiving care in the facility for a She stated she would put Resident #11 on ECC services.
A review of records revealed there was no copy of a physician ' s order, assessment or a plan of care prior to