STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953679	03/15/2016
NAME OF PROVIDER OR SUPPLIER SAVANNAH GRAND OF SARASOTA	STREET ADDRESS, CITY, STATE, ZIP CODE 7130 BENEVA ROAD SARASOTA, FL 34238	

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

0000 Initial Comments

An unannounced Relicensure survey was conducted through / / at Savannah Grand, an Assisted Living Facility in Sarasota, Florida.

The following is a description of the deficiencies found at the time of the visit.

0031 Resident Care - Third Party Services

Based on record review and interview, the facility failed to abide by their policy to require third party services to coordinate with the facility regarding the Resident's condition and the services being provided for Resident #5.

The findings included:

Review of the Assisted Living Facility records revealed there was minimal communication with the home health agency nurses and the Assisted Living Facility staff regarding ( ) administration time ordered by the Health Care Provider daily for 5 days.

During an interview with Staff A on at 2:00 p.m., she reported there was little or no communication from the home health agency nurses and facility staff regarding administration time. Staff A said that she thought the was administered at 5:00 p.m., when it actually was administered by the home health agency nurses at 1:00 p.m.

Class III

0056 Medication - Labeling and Orders

Based on record review, and interview, the facility failed to have directions promptly recorded on the Medication Observation Record (MOR) for 1 (Resident #5) out of 3 resident records reviewed.

The findings included:

Resident #5 had a change in directions for (pain med) ordered by the Resident's physician dated / for; "20mg/1 ml, 5 mg by mouth every 6 hours as needed." Recorded on medication label and MOR was: " 20 mg/1ml, take 0.25 ml, 5 mg by mouth /under tongue every 6 hours." The medication label and MOR did not match the health care provider order.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953679	03/15/2016
NAME OF PROVIDER OR SUPPLIER **SAVANNAH GRAND OF SARASOTA**	STREET ADDRESS, CITY, STATE, ZIP CODE **7130 BENEVA ROAD** **SARASOTA, FL 34238**	

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

During Interview on / / at 1:00 p.m. with Staff A, she reported she was not aware the medication label and MOR did not match the health care provider order from / .

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Savannah Grand Of Sarasota
7130 Beneva Road
Sarasota, FL 34238

Dear Administrator:

This letter reports the findings of a state licensure survey that was completed on , 2016 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 this office at (239) 335-1315.

Sincerely,

Jon Seehawer, R.N.
Field Office Manager

sh
Enclosure: State Form

XG90

Fort Myers Field Office
2295 Victoria Avenue,
Fort Myers, FL 33901
Phone:(239) 335-1315; Fax:(239) 338-2372
AHCA.MyFlorida.com