STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968108	04/20/2017
NAME OF PROVIDER OR SUPPLIER **L & L ASSISTED LIVING COMMUNITY INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **4211 CHAIRES CROSS RD TALLAHASSEE, FL 32317**	

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

0000 - Initial Comments

An unannounced bienniel survey with specialty licensure for limited mental health and extended congregate care was conducted at L & L Assisted Living Community from through . Deficient practice was identified at the time of the survey.

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

Based on observation of medication administration with registered nurse administrator, and review of resident medication orders, prescription labels and medication observation records (MORs), the facility failed to ensure that medications were administered and documented in accordance with the health care provider's order and prescription label for 3 of 3 residents observed during medication administration. (Residents #1, #2, & #3)

The Findings Include:
Observation of medication administration was conducted on with the facility administrator, who is also a currently licensed, registered nurse.

Resident #1: After review of the MOR for resident #1, the labels of the resident's prescription bottles, and review of the provider orders related to resident's medications, it was determined that resident #1 was not receiving her at ordered frequency, was not receiving ordered dose of Propanolol, the prescription label for did not match ordered or given dose, was not receiving ordered dose or ordered frequency of , and was receiving daily with D and , without a provider's order.

Resident #2: After review of the MOR for resident #2, the labels of the resident's prescription bottles, and review of the provider orders related to resident's medications, it was determined that resident #2 was not receiving her at ordered frequency, prescription label and MOR did not match for her or , and was not receiving ordered , eye drops.

Resident #3: After review of the MOR for resident #3, the labels of the resident's prescription bottles, and review of the provider orders related to resident's medications, it was determined that resident #3 was not receiving her , that was ordered to be given daily.

Interview with the administrator at the time of observation revealed that she ws unable to explain discrepancies related to medications for resident #1. She stated that she had been informed by the family of resident #2 that she no longer needed the ordered eye drops, and stated that the Laix for resident #3 was only given when the resident had of her legs and feet.

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Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on review of personnel records and interview with the facility administrator, the facility failed to ensure staff had documentation of all required trainings for 2 of 3 employees reviewed (Employees A &B)

The Findings Include:
Review of the personnel file for employee A showed a hire date of 11/ . There was no documentation in the file to indicate that employee A had received any training related to resident behavior and needs, or emergency preparedness.
Review of the personnel file for employee B showed a hire date of . There was no documentation in the file to indicate that employee B had received any training related to resident behavior and needs, emergency preparedness, or provision of assistance with activities of daily living.

Interview with the administrator at the time of review revealed that she had no further documentation to indicate staff had received all required trainings.

Class III

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

Based on observation of meal service and interview with the facility administrator, the facility failed to provide planned meals based on current dietary guidelines, failed to have menus reviewed annually by a registered dietician, and failed to have menus indicating appropriate portion sizes for 3 of 3 residents observed during facility dining. (Residents #1, #2, & #3)

The Findings Include:
An observation of the noon meal on was conducted. Review of the menu presented by the administrator revealed no portion sizes for the food items listed, and had not been reviewed by a registered dietician since .
The menu indicated that residents would be served ham, cheese grits, spinach, bread, margarine, and pineapple OR turkey sandwich, tomato soup, and spinach side salad. Beverages listed included choice of iced tea, diet lemonade, and tea or coffee.

Resident #1 had soup, tuna sandwhich, mixed fruit and tea
Resident #2 had watermelon and milk

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

Resident #3 had soup, tuna sandwich, and water

Interview with the administrator at the time of the meal observation revealed that family had come up with alternate menu items for their loved ones, as the residents did not like the approved menu.

Class III

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

Based on review of personnel records and interview with the facility administrator, the facility failed to ensure staff had documentation of limited mental health training for 1 of 3 employees reviewed (Employee B)

The Findings Include:
Review of the personnel file for employee B showed a hire date of . There was no documentation in the file to indicate that employee B had received any training related to working with individuals with mental health diagnoses.

Interview with the administrator at the time of review revealed that she had no further documentation to indicate staff B had received required training for a facility holding limited mental health specialty license.

Class III