| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11963719 | 06/07/2017 |
| NAME OF PROVIDER OR SUPPLIER<br>**WYNDHAM LAKES JACKSONVILLE** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**10660 OLD ST. ROAD**<br>**JACKSONVILLE, FL 32257** | |

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

**0000 - Initial Comments**

An unannounced Assisted Living Facility Complaint #2017002706 was conducted on .

Wyndham Lakes Jacksonville (License #5572) had licensure deficiencies at the time of the visit.

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

Based on record review and resident and staff interview, the facility failed to fill a prescription for 1 of 5 sampled residents, Resident #1.

The findings include:

During an observation of the medication pass on at 4:30 p.m. Resident #1 stated to Employee A, a Medication Technician that her doctor was concerned that her medication for her was not effective according to her lab work. She told Employee A that she had not been receiving any of her medication before breakfast. That was the time that it was supposed to be taken. She stated she ate breakfast at 7 a.m.

Review of the record for Resident #1 revealed she was admitted on . Her Health Assessment revealed she needed help with medications. The Resident had a physician order for tab 150 micrograms (Mcg) ( medication), take 1 tablet by mouth every morning at least 30 minutes before breakfast. It was scheduled at 6 a.m. The 2017 Medication Record for Resident #1 revealed the resident was not receiving this medication with reason of "Awaiting New " (prescription).

The resident was having and and was admitted to the hospital on . She returned to the facility on . A new health assessment was completed the same day and the 150 mcg was to be continued daily. Review of the , , , and 2017 Medication Record for this resident revealed she did not receive this medication the entire time. The entries by staff revealed "Awaiting New ".

The Resident Service Director ( ) stated on at 5:15 pm that if a medication is not available , an emergency 5 day supply from the local pharmacy should be obtained. She stated that should have been done but it was not. She confirmed the resident did not get her medication for several months.

Employee B, one of the Resident's primary nurses was interviewed on at 5:45 p.m. She stated

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SUMMARY STATEMENT OF DEFICIENCIES
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she worked the night shift and was responsible for administering all morning medications. She was aware that Resident #1 was to be getting , but it was not available from the pharmacy and that was what she was documenting. She stated that the day shift nurse was supposed to get the refill when the doctor offices were open. She stated that she did not tell the because she was already aware of it.

Class III