STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965383	**06/21/2017**
NAME OF PROVIDER OR SUPPLIER **SAVANNAH COTTAGE OF LAKELAND**	STREET ADDRESS, CITY, STATE, ZIP CODE **605 CARPENTERS WAY** **LAKELAND, FL 33809**	

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

0000 - Initial Comments

Assisted Living Facility

Complaint investigations (CCR# 2017003758 and CCR# 2017004887) were conducted at Savannah Cottage of Lakeland, Assisted Living Facility, on . Savannah Cottage of Lakeland had deficiencies at the time of the visit.

(License # 9783)

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on interview and record review, the facility failed to obtain a complete medical examination form (1823 Form), within 30 days following the admission to the facility, for one (Resident #1) of four resident records reviewed.

Findings included:

A resident record review conducted on reflected that Resident #1 was admitted to the facility on . A review of Resident #1's 1823 Form found a date of examination of (photographic evidence obtained).

An interview was conducted with the Administrator at 1:08 PM on concerning Resident #1's 1823 Form. The Administrator acknowledged that the date of the 1823 Form was not in compliance with the required timeframe.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on interview and record review, the facility failed to ensure that the resident's written record was updated to reflect a significant change or other change that resulted in the provision of additional services for one (Resident #2) of four residents selected for record reviewed. Additionally, based upon interview and record review, the facility failed to properly maintain an awareness of the whereabouts of

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its residents, resulting in an elopement for one (Resident #1) of four residents reviewed.

Findings included:

1) Resident #2's hospice record " Focused and Comprehensive Assessment " dated , revealed that a facility staff member had informed hospice that Resident #2 " and is complaining of pain in his right thigh, hip and upper leg. "
Per documented visit by hospice staff " Focused and Comprehensive Assessment " dated , facility staff were not aware of Resident #2 having a . Resident was admitted to the hospital with a right hip . The "Telephone Contact Note" of at 4:50am, reflected a "Follow-up call to _____ ER and spoke to _____ RN. He reports patient being admitted _____ with right hip ."
Review of facility's incident report revealed no documentation of any by Resident #2 and no documentation of facility notifying Resident #2's responsible party of hip injury.
Further review of Resident #2's record revealed no indication that Resident #2 experienced a change in his ability to move or stand. The Resident Observation Log's latest entry for Resident #2 was on .
During an interview with the Administrator and the Resident Coordinator, conducted on , they stated that they were not made aware of any by Resident #2. The Administrator was unable to locate any documentation by the facility relating to Resident #2's hip injury that resulted in hospital services.

2) A phone interview was conducted with a family member of Resident #1 on at 10:32 AM. The family member stated that Resident #1 had eloped from the facility approximately 2 weeks after admission. The family member indicated that someone at a local restaurant saw Resident #1 and notified the local police.

An interview was conducted with the Administrator at 2:17 PM on . The Administrator stated that Resident #1 had eloped from the facility. According to staffing records, the date of the elopement was . The Administrator recalled that someone at a local restaurant saw Resident #1 and the local police were called. The Administrator stated that the police called the facility and the staff present said that no residents were missing.

Class III

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0086 - Training - ADRD - 58A-5.0191(9) FAC

Based on record review and interview, the facility failed to ensure that one (Staff A), of three employees selected for record review, completed the required 's or Related (ADRD) Levels I within 3 months of employment and Level II within 9 months of employment.

Findings included:

Record review conducted on , revealed there was no documentation found for training completion by Staff A relating ADRD Levels I and II. Staff A's documented hire date by the facility was on in a direct care position.

During interview conducted with the Administrator and the Resident Coordinator on at 03:33 p.m., they acknowledged that the documentation for training for Staff A was not found after conducting a thorough search.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview, the facility failed to ensure that the facility maintained a copy of the hospice interdisciplinary care plan for two (Resident #2 and #4) of four residents selected for record reviewed.

Findings included:

1) On , a review of Resident #2's chart revealed that Resident #2 was admitted to the facility on .

Hospice certification documentation revealed that Resident #2 was admitted to hospice on . Further review of Resident #2's chart revealed that there was no hospice interdisciplinary care plan for Resident #2.

On at 12:02p.m., The Administrator presented a copy of "MC RESIDENT FUNCTIONAL

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EVALUATION AND SERVICES PLAN" for Resident #2, which is used to determine additional monetary charges based on residents' level of care. The Administrator confirmed that it is not an interdisciplinary care plan and that the facility did not have an interdisciplinary care plan that was completed and reviewed with hospice for Resident #2.

2) On , a review of Resident #4's chart revealed that Resident #4 was admitted to the facility on . Record review also revealed that resident #4 was receiving Hospice services. Further review of Resident #4's chart revealed that there was no hospice interdisciplinary care plan.

3) On at 04:38p.m., The Administrator confirmed that the facility did not have an interdisciplinary care plan that was completed and reviewed with hospice for Resident #2 and Resident #4.

Class III