STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969036	10/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SHERIDAN AT LAKEWOOD RANCH	11705 EVENING WALK DR BRADENTON, FL 34211

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

0000 - Initial Comments

Assisted Living Facility

Three complaint investigations, (CCR# 2017010065, CCR# 2017010538, CCR# 2017009583 & CCR# 2017008728) were conducted at The Sheridan at Lakewood Ranch on , in conjunction with a LNS monitoring visit. Deficient practice was identified relative to CCR# 2017010065.

(License # 12858)

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation, records review and interview, the facility failed to verbally prompt residents to take medications as prescribed for 1 of 4 residents (#8).

Findings included:

During a medication observation at 9:00am on , Staff E was preparing to provide Resident #8 with medications. While reviewing the medication observation record for Resident #8, the electronic record showed that Resident #8 had 6 medications due at that time. Staff E located 5 of the medications on the cart, but failed to locate the 6th medication. When asked where the medication was, Staff E responded that it was not on the cart because the facility ran out and it still had not come from the pharmacy.
Staff E then put Resident #8's medications in a basket, knocked on the door, and entered the , to Resident #8 that it was time for the resident's "morning medications." Staff E popped the medications into a cup of pudding and handed the medications and a spoon to the resident. Staff E did not inform the resident what medications were being provided, nor did Staff E mention the fact that 1 of the medications, that was due at the time, was missing. Staff E observed resident taking medications.
In an interview with Resident #8 at 9:10am, the resident expressed no knowledge of what medications they were receiving and that it was probably their fault for not knowing because they had been taking the same medications for so many years.

Class III

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	AL11969036	**10/10/2017**
NAME OF PROVIDER OR SUPPLIER **THE SHERIDAN AT LAKEWOOD RANCH**	STREET ADDRESS, CITY, STATE, ZIP CODE **11705 EVENING WALK DR** **BRADENTON, FL 34211**	

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

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

Based on observation, records review and interview, the facility failed to properly label medications for 1 of 4 residents (#10) and failed to make every reasonable attempt to insure that medication orders were filled on a timely manner for resident's requiring assistance with medication self-administration for 2 of 4 residents (#8 and #11).

Findings included:

During a medication observation at 9:00am on , Staff E was preparing to provide Resident #8 with medications. While reviewing the medication observation record for Resident #8, the electronic record showed that Resident #8 had 6 medications due at that time. Staff E located 5 of the medications on the cart, but failed to locate the 6th medication. When asked where the medication was, Staff E responded that it was not on the cart because the facility ran out and it still had not come from the pharmacy. The electronic record showed that the medication had been electronically re-ordered from the pharmacy on , 3 days before.

During a medication observation at 11:15am on , Staff I was preparing to provide Resident #10 with medications. While reviewing the medication observation records for Resident #10, the electronic record showed that Resident #10 was to receive a medication, , Levadopa , with the frequency of 2 tablets 4 times every day. The label on the , Levadopa medication bottle said "10 tablets per day in divided doses as directed". The was no notice on the label that the medication order had been changed and to refer to the medication observation record and orders. Resident #10's 1823 assessment was reviewed at 12:30pm and the , Levadopa medication order in the record stated a frequency of 2 tablets 4 times every day.

During a medication observation at 11:30am on , Staff J was preparing to provide Resident #11 with medications. While reviewing the medication observation record for Resident #11, the electronic record showed that Resident #11 had 2 medications due at that time. Staff J located 1 of the medications on the cart, but failed to locate the 2nd medication. When asked where the medication was, Staff J responded that it was not on the cart because the facility ran out and it still had not come from the pharmacy. The electronic record showed that the medication had been electronically re-ordered from the pharmacy on , the previous day.

In an interview with the Health and Wellness Director at 12:00pm, the Health and Wellness Director stated that the facility was recently made aware that there were problems with the medication ordering,

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

labeling and assistance with self- administration and that they were in the process of conducting an audit of their whole system with plans to correct the problems.

Class III