STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910053	**10/18/2017**
NAME OF PROVIDER OR SUPPLIER **GRACE MANOR AT LAKE MORTON, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **610 EAST LIME STREET** **LAKELAND, FL 33801**	

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

0000 - Initial Comments

Assisted Living Facility

A complaint investigation (CCR 2017009612) was conducted at Grace Manor at Lake Morton on . Grace Manor at Lake Morton had deficiencies at the time of the investigation.

(License #5217)

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

Based on record review and staff interview, the facility failed to provide care and services appropriate to the needs of the residents accepted for admission to the facility.

The findings included:

Facilities must offer personal supervision for each resident including daily observation and awareness of the general health, safety, and well-being of the resident; contacting the resident's health care provider and other appropriate party, if the resident exhibits a significant change; and maintaining a written record of any significant changes resulting in provision of additional services.

Review of Resident #10's progress notes in the Resident Record revealed the following hospitalizations:
for " hematoma, ."
for "."
for " low sugar of 47."

Record review of facility Incident Reports revealed:
-found on floor.
-found on floor.
-found on the floor.
- found on floor.
- , hallucinations.

Review of facility Admission/Discharge Log revealed on , resident was discharged to "(local hospital)", higher level of care." (after hospitalization on)

On at 2:15 p.m., when the Administrator was asked, "What does the facility do about frequent low sugars?" she stated, "The home health nurse contacts the doctor. I can't honestly say I'm

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aware. I can't even tell you what happened."

When asked, "What did the facility do about the frequent ? What interventions were put into place to prevent reoccurrence?" she stated, "We tried to keep him in the common area more. He wasn't able to safely transfer alone. I don't remember."

CLASS III

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

Based on record review and staff interview, the facility failed to make every reasonable effort to ensure that medications were filled or refilled in a timely manner for 1 (Resident #10) of 4 Resident Medication Observation Records reviewed.

The findings included:

On , a review of 4 Resident MORs revealed on , , 3, 7, 9, 10, 16, 17, 23, and 24, 2017, Assisted Living Facility staff placed their initials on Resident #10's Medication Observation Record, with a note stating, "Do not have medication."

On at 2:15 pm, the Administrator stated, "If anything's not available, (Resident Care Coordinator) orders them."

CLASS III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the facility failed to provide a safe living environment and ensure that all electrical systems were maintained in good working order for three (Resident #7, Resident #8, and Resident #12) of three residents' observed.

Findings included:

During a tour of the facility conducted on , the by Residents #7 and #8 was observed. Upon entering the , vinyl gloves were observed on the dresser closest to the door. On the floor, next to the bed closest to the door, was a crushed grape which presented a potential slip and hazard. The by the two residents was observed and on the floor was a used, soiled bandage.

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An interview was conducted with Staff A at 10:17 AM on in the by Residents #7 and #8. Staff A was alerted to and observed the vinyl gloves on the dresser, the crushed grape on the floor, and the used bandage on the . Staff A stated that these concerns should not be there.

A test of the facility's call light system, that is utilized by residents to alert staff of the need for assistance, was conducted on . At 2:30 PM, the call light cord located in Resident #12's pulled. At 2:46 PM, there was still no response from the staff.

Staff F was interviewed at 2:47 PM on in the facility's common area. Staff F was asked how they were alerted to residents' call light assistance requests and they stated that they were notified by a pager. Staff F was asked if they got paged to attend to Resident #12's . Staff F stated that they did not. Staff F looked at their pager and stated that there was no notification for Resident #12's .

The Resident Care Coordinator was interviewed at 2:50 PM on and asked what the expected response time was expected of employees once a resident utilized the call light system. The Resident Care Coordinator stated that staff had 7 minutes to respond. It was explained to the Resident Care Coordinator that 16 minutes had elapsed after pulling the card in Resident #12's , , there was no response from staff, and that a staff member stated that there was no notification on their pager. The Resident Care Coordinator went to Resident #12's observed the call light system in the . The Resident Care Coordinator observed the device and stated that it wasn't working.

Class III