STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965678	01/24/2018
NAME OF PROVIDER OR SUPPLIER **SAVANNAH COURT OF LAKELAND**	STREET ADDRESS, CITY, STATE, ZIP CODE **6550 N SCORUM LOOP ROAD** **LAKELAND, FL 33809**	

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

0000 - Initial Comments

Assisted Living Facility

Complaint investigations, (CCR# 2017014226, CCR# 2017014220, CCR# 2017014011, CCR# 2017013945, and CCR# 2017013725), were conducted in conjunction with a biennial state relicensure survey at Savannah Court of Lakeland, Assisted Living Facility, on . Savannah Court of Lakeland, Assisted Living Facility, had deficiencies at the time of the visit.

(License # 10024)

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

Based on observation, records review and interview, the facility failed to ensure that medications of prescription drugs for assistance with self-administration were properly labeled and dispensed for 3 of 3 residents observed (#1, #12 and #13) and failed to make every reasonable effort to ensure that prescriptions for residents receiving assistance with self-administration were ordered or reordered in a timely manner for 3 of 3 residents whose records were reviewed (#8, #15 and #16).

Findings Included:

An observation of assistance with medication self-administration was conducted at 12:20pm on . The Resident Care Coordinator, who is a Medication Technician (Med Tech), was assisting residents to take their medications. Resident #12 was due to receive a pain medication at 12:00pm. The resident's medication observation record (MOR) said the resident was to receive a 5 milligram dose in the form of 1 tablet, by mouth, 4 times per day. A review of the medication label for the pain medication stated the resident was to receive a 5 milligram dose of the medication, 1 tablet by mouth 2 times per day. The Resident Care Coordinator was about to give the resident her medication when she was stopped and asked to review the resident's doctor's orders for the medication, which stated that the resident was to receive the medication as stated on the MOR, 4 times per day. The resident was given the pain medication.

Resident #1 was scheduled at 12:00pm to receive a medication for appetite improvement. Resident #1's MOR said that a 20 milligram dose of the medication, in the form of 1 tablet was to be taken by mouth 3 times per day. A review of the medication label for the resident's appetite improving medication stated the resident was to receive a 20 milligram dose, 1 tablet by mouth 4 times per day. The Resident Care

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Coordinator was about to give the resident the medication when she was stopped and asked to review the resident's doctor's orders for the medication, which stated the resident was to receive the medication as stated on the MOR, 3 times per day. The resident was given the appetite enhancing medication.

Resident #13 was scheduled to receive an inhaled medication at 12:00pm. A review of the resident's MOR said that the resident was to receive 1 vial of the medication, inhaled 4 times per day. A review of the medication label on the box of the resident's inhaled medication stated that the resident was to receive 1 vial of the medication 4 times per day "as needed." A review of the resident's MOR did not show that the medication was to be given "as needed", only 4 times per day. The Resident Care Coordinator was about to give the resident the medication when she was stopped and asked to review the resident's doctor's order for the medication, which stated the resident was to receive the inhaled medication 4 times per day on a routine basis and 4 times per day on an "as needed" basis. The resident was given the inhaled medication.

In an interview with the Resident Care Coordinator, she stated that the facility has a problems with ensuring that the resident's MORs and the filled prescriptions all match up to what the doctor's orders say. The Resident Care Coordinator, who is a Med Tech, stated that quite frequently she is the one who writes out the MORs, and that a facility doctor comes in periodically and reviews the residents' medications. The Resident Care Coordinator admitted that the facility had problems with their medication system and that it probably needed to be changed.

A focused records review of 3 resident's MOR was conducted on . Resident #15's MOR stated that the resident was to receive medication for pain each night a bedtime, 2 100-milligram tablets were to be taken each night. The MOR had and circled and on the back of the MOR it was noted that on "was a 30 day trial, needed new script" and on it was noted "not in cart, not given".
Resident #16's MOR stated that the resident was to receive medication for stomach pain every morning at 8:00am and every night at 8:00pm, 1 20-milligram tablet was to be taken twice daily. The MOR had both doses for circled and on the back of the MOR it was noted for both the morning and evening dose "not in cart, not given".
Resident #8's MOR stated that the resident was to receive a hormone medication every morning, 1 75-microgram tablet each day at 8:00am. The MOR had the dose for circled and noted on the back of the MOR it said "not on cart, not given".

Class III