STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965678	R 03/14/2018
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

A revisit to complaint (CCR 2017014220, 2017014011,and 2017013945) was conducted at Savannah Court of Lakeland on in conjunction with a complaint investigation (CCR 2018002526) and a revisit to biennial survey. Savannah Court of Lakeland had deficiencies at the time of the visit.

(License #10024)

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record review and interview, the facility failed to ensure that medication observation records (MORs) were immediately updated each time medication was offered for three (Resident #1, Resident #4, and Resident #5) of six MORs reviewed.

Findings included:

A review of MORs was conducted on . The review revealed that Resident #1's MORs had a blank space for the medication 625 MG that was to be given on at 8pm and at 8am.

A review of Resident #4's MORS showed the medication 10 MG circled on 8am on and and a blank for at 8am. There were blank sections for the 8am dosages on for the medications 75 MG, 20 MG, 75 MG, 25 MG, Preservision Areds, and 625 MG. There was also a blank section for 625 MG for the 8 pm dosage on . There were blank sections for Barrier Cream on and for 3pm-11pm. There was no documentation on the back of the MORs as to why these sections were not completed.

A review of Resident #5's MORs showed blank sections for for dosages of 75 MG (8am dosage), Daily Vite tablet (8am dosage), 100 Mg (8am dosage), Fish Oil 1000MG capsule (8am dosage), Klor-Com 10 MEQ tablet (8am dosage), 0.4 MG capsule (8pm dosage), Atemelol 25 MG tablet (8am dosage), DR 20 MG Tablet (8am dosage), 1000 MCG, and 500 MG (8am and 8pm dosages). Additionally, there were blanks for the medication Daza 2% cream on (8am and 12 pm applications) as well as

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, , , - (12 PM applications) and the medication 10 MG tablet on (8am & 8pm dosages). There was no documentation on the back of the MORs as to why these sections were not completed (photographic evidence obtained).

The Resident Care Coordinator was interviewed at 11:30 AM on concerning the blank sections on Resident # 1's, Resident #4's, and Resident #5's MORs. The Resident Care Coordinator stated that they did not know why these sections were blank.

Class III

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

Based on observation, record review, and interview, the facility failed to ensure that prescriptions for residents who received assistance with self-administration of medications were refilled in a timely manner for one (Resident #2) of three residents' medications observed. Additionally, the facility failed to ensure that medications for assistance with self-administration were properly labeled for one (Resident #1) of six residents' medication observation records reviewed.

Findings included:

A review of residents' medications and medication observation records (MORs) was conducted on . This medication reconciliation showed that Resident #2's medication 10GM/15 ML solution was not present. The Resident Care Coordinator was asked to locate this medication.

The Resident Care Coordinator was interviewed at 11:23 AM on and they stated that they did not see Resident #2's 10GM/15 ML solution on the medication cart. There was no evidence presented that the medication was in the facility.

A review of Resident #1's MORs and medication labels showed inconsistencies as follows: The MORs showed the medications Levothydoxine 75 MG- the medication label read 75 MCG; , 50 MG- the medication label read 5MG; Megestrol 20MG- Take 1 tablet by mouth 3 times daily- the label read take 4 times daily.

The Resident Care Coordinator was interviewed at 11:27 AM on concerning the inconsistencies between the MORs and medication labels for Resident #1. The Resident Care Coordinator acknowledged the inconsistencies for three of the resident's medications. The Resident Care Coordinator was asked to produce doctor's orders for the medications which showed the following:

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MORs showed Levothydoxine 75 MG- the doctor's order: 75mcg, MORs: , 50 MG- The doctor's order: 5 MG; MORs: Megestrol 20MG- Take 1 tablet by mouth 3 times daily, medication label: take 4 times daily- The doctor's orders stated take 3 times daily.

Class III

0058 - Pharmacy & Dietary; Uncorrected Deficiencies - 429.42(1-2) FS; 58A-5.033(3)(a) FAC

Based on observation, record review, and interview, the facility failed to ensure that prescriptions for residents who received assistance with self-administration of medications were refilled in a timely manner for one (Resident #2) of three residents' medications observed. The facility also failed to ensure that medications for assistance with self-administration were properly labeled for one (Resident #1) of six residents' medication observation records reviewed. Additionally, based on record review and interview, the facility failed to utilize a registered dietitian approved menu that included portion sizes.

Findings included:

A review of residents' medications and medication observation records (MORs) was conducted on . This medication reconciliation showed that Resident #2's medication 10GM/15 ML solution was not present. The Resident Care Coordinator was asked to locate this medication.

The Resident Care Coordinator was interviewed at 11:23 AM on and they stated that they did not see Resident #2's 10GM/15 ML solution on the medication cart. There was no proof presented that the medication was in the facility.

A review of Resident #1's MORs and medication labels showed inconsistencies as follows: The MORs showed the medications Levothydoxine 75 MG- the medication label read 75 MCG; , 50 MG- the medication label read 5MG; Megestrol 20MG- Take 1 tablet by mouth 3 times daily- the label read take 4 times daily.

The Resident Care Coordinator was interviewed at 11:27 AM on concerning the inconsistencies between the MORs and medication labels for Resident #1. The Resident Care Coordinator acknowledged the inconsistencies for three of the resident's medications. The Resident Care Coordinator was asked to produce doctor's orders for the medications which showed the following: MORs showed Levothydoxine 75 MG- The doctor's order: 75mcg), MORs: , 50 MG- The doctor's order: 5 MG; MORs: Megestrol 20MG- Take 1 tablet by mouth 3 times daily, medication label:

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take 4 times daily- The doctor's orders stated take 3 times daily.

A review of the facility's menu for the lunch meal served on indicated salad of the day, beef stew w/vegetables, Brussels sprouts, dinner roll, butter, dessert or fruit of the day, milk, coffee, tea, decaf. The menu showed no portion sizes (photographic evidence obtained).
The Administrator was interviewed at 11:47 AM on concerning food portion sizes on the menu. The Administrator stated that the approved menu they had with portion sizes was not consistent with the day's menu (it read cottage pie, mashed potatoes, squash, dinner roll, butter, dessert or fruit, milk, coffee, tea, decaf (photographic evidence obtained).

As a result of uncorrected Class III deficiencies regarding medicinal drugs for residents that received assistance with self-administered medications and an uncorrected deficiency regarding dietary services, the facility will be required to employ the consultant services of a licensed pharmacist or a licensed registered nurse and a registered or licensed dietitian. The consultants shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required.

This serves as a written notification of the requirement for the above described consultation services.

Class III