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	AL11965678	**08/13/2018**
NAME OF PROVIDER OR SUPPLIER **SAVANNAH COURT OF LAKELAND**	STREET ADDRESS, CITY, STATE, ZIP CODE **6550 N SCORUM LOOP ROAD** **LAKELAND, FL 33809**	

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0000 - Initial Comments

Assisted Living Facility

A Complaint investigation (CCR #2018008961, 2018011046 and 2018011899) was conducted on .

The Savannah Court of Lakeland, Assisted Living Facility (License# 10024), had deficiencies at the time of this visit.

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

Based on record review and interview, the facility failed to properly maintain a daily medication observation record for 9 of 9 sampled residents (#1, 2, 5, 7, 11, 15, 16, 17 and 18) in facility with 31 in-house residents who receive assistance with self-administration of medications, immediately updating each time the medication is offered and recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors.

Findings included:

Review of Resident #2's , 2018 MOR revealed multiple medication providers' initials circled - many listed reason as refused medications; other times, medications not in cart/not available. Review of breathing medications revealed that Resident #2 was prescribed Sul 2.5mg/3ml with instructions to inhale 1 unit dose vial orally every 4 hours - The medication was written on the MOR to be provided at 8am, 12pm, 4pm, & 6pm - 6pm had been handwritten over the typed time. The medication was not provided every 4 hours as prescribed. Review of Resident #2's , 2018 MOR revealed medication provider initials circled 18 times that was not provided and only written on reverse of MOR that resident refused the medication 6 times.

Continued review of Resident #2's , 2018 Medication Observation Record (MOR) revealed that Resident #2 was prescribed 15mcg/2ml sol with instructions to inhale 1 unit dose vial via daily at 8am. This medication was not initialed as provided (blank spaces with no explanation on reverse) on 7/9, , , and . Medication Technician (Med Tech) initials were circled as not provided on , , , , , , , and . Written on reverse of MOR: treatment was not given on and because there was no mouthpiece.

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Record review revealed that Resident #2 was hospitalized on . Resident #2 was sent to the local Emergency Department via ambulance on and admitted to the . Hospital reports documented "active diagnosis: " and "at risk of ," and noted that the Resident #2 stated her machine was not working.

A review of sampled , and Medication Observation Records (MORs), including for Resident #2) was conducted at the facility on , and photographic evidence was obtained for further review of multiple concerns. Nine of 9 records reviewed contained errors and omissions, including the following examples:

Resident #2 was prescribed Dipttenist 25mg with physician orders to take 1 tab 2x daily at 8am and 8pm. Initials circled as not provided at 8am on through ; written on reverse of MOR as not provided at 8am on 8/9, , and . Initialed as provided at 8am on , but not initialed as provided on at 8pm. Initials circled as not provided at 8pm on 8/5, 8/6, 8/7, 8/9, , and ; written on reverse of MOR as not provided at 8pm on 8/5, 8/9, , and .

Resident #2 was prescribed 0.5mg/2ml Susp with physician orders to Inhale 1 unit dose vial via twice daily. There were no staff initials documenting provision of this medication on 8/4 at 8am, no staff initials documenting provision of this medication at 8pm on 8/4, 8/5, and , and no listing/reasons on reverse of MOR for the medication not being provided.

Resident #2 was prescribed , 25mg tab with physician orders to take 1 tablet by mouth twice daily 8am & 8pm. There were no staff initials documenting provision of this medication on 8/9 and at 8pm and no listing/reason on reverse of MOR for the medication not being provided.

Resident #2 was prescribed 20mg tablet with physician orders to take 1 tablet by mouth at bedtime 8pm. There were no staff initials documenting provision of this medication on 8/4, , and and no listing/reason on reverse of the MOR for the medication not being provided.

Resident #1 was prescribed PRN MAPAP ( ) initialed as provided 7/7, 7/8, , and 2 times on . No information was written on reverse of MOR for the time, reason, results on or for 2 times given on -- no time, reason, results, or provider initials 3 separate times.

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Resident #5 was prescribed 10mg tablet with physician orders to take 1 tablet by mouth at bedtime at 9pm. This medication was initialed as provided twice a day on 8/2, 8/3, and . There was no listing/explanation for this written on reverse of the MOR.

Resident #5 was prescribed 6.25mg tablet with physician orders to take 1 tablet by mouth twice daily 8am and 4pm. There were no staff initials documenting provision of this medication on at 8am and no listing/reason written on reverse of MOR for the medication not being provided.

Resident #7 was prescribed 20mg tablet with physician orders to take ½ tablet=10mg by mouth once daily 8am. There were no staff initials documenting provision of this medication on and no listing/reason on reverse of MOR for the medication not being provided.

Resident #7 was prescribed Immediate 5mg tab with physician orders to take 1 tablet by mouth 4 times daily 8am, 12pm, 4pm, 8pm. There were no staff initials documenting provision of this medication on at 8pm and no listing/reason on reverse of MOR for the medication not being provided.

Resident #11 was prescribed 81mg with physician orders to take 1 tablet by mouth daily 8am - Initials circled as not provided on 8/4, 8/8, 8/9, and , written on reverse of MOR as not provided at 8am on 8/3, 8/4, 8/8, 8/9, , and because medication was not in the cart. The medication was initialed as provided on 8/3 and .

Resident #11 was prescribed "Amox-Clav 500-125mg" with physician orders to take 1 tab by mouth 3 times daily 8am, 12pm, 8pm. This medication was not initialed as provided at 8am on 8/1, 8/2, and 8/9; Not initialed as provided at 12pm on 8/1, 8/2, and 8/9; Not initialed as provided at 8pm on 8/2, 8/7, and 8/9. There was no listing/reasons for the medication not being provided on reverse of the MOR.

Resident #11 was prescribed 125mg with physician orders to take 1 tab by mouth every morning at 8am. As of 11:30am review on , this medication was initialed as provided on only. There was no listing/reasons for the medication not being provided on reverse of the MOR.

Resident #15 was prescribed with physician orders to take daily at 8am - circled as not provided on 8/9 and ; written on reverse of MOR: "8/9 found in cart, given 8am." There was no listing/reason for the medication not being provided at 8am.

Resident #15 was prescribed , with physician orders to take 4 times daily, written on MOR to be provided daily at 8am, 11am, 4pm, 8pm. There were no staff initials documenting provision

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of this medication on at 8pm and no listing/reason on reverse of MOR for the medication not being provided.

Resident #16 was prescribed Bumer 0.5mg with physician orders to take 1 tab by mouth daily - circled as not provided on 8/9, , & ; written on reverse of MOR as not taken on only ("not in cart").

Resident #16 was prescribed , 125mg with physician orders to take 1 tab every 6 hours: 8am, 11am, 3pm - Initialed as provided at 8am and 11am on 8/1 through 8/9 and at 3pm on 8/3 through 8/9 - "Completed." This medication was not documented as given every 6 hours as prescribed.

Resident #17 was prescribed , 100mcg tablet with physician orders to take 1 tablet by mouth once daily 8am - Initials circled as not provided on 8/9, , , & ; written on reverse of MOR as not provided on and because it was not in the cart. There were no times, reasons, results, or initials on reverse of the MOR regarding the medication not having been provided on 8/9, , and .

Resident #18 was prescribed 0.4mg capsule with physician orders to take 1 capsule by mouth at bedtime -- not initialed as provided on 8/4 and . There was no listing/reasons for the medication not being provided on reverse of the MOR.

Resident #18 was prescribed , , 10mg tab with physician orders to take 1 tablet by mouth once daily 8am -- not initialed as provided on . There was no listing/reasons for the medication not being provided on reverse of the MOR.

Resident #18 was prescribed 15 mg tablet with physician orders to take 1 tablet by mouth once daily 8am -- not initialed as provided on . There was no listing/reasons for the medication not being provided on reverse of the MOR.

2 current MOR books and MORs of closed Record Reviews had sticky notes with directions written: "Please fill holes in the MOR Thank you." <photographic evidence obtained>

On , the Administrator was informed of findings of multiple medication errors. The Administrator stated at 1:25pm that she "skims MORs for holes in the MORs and the employee responsible is counseled. It has been a struggle since I started here."

Class II

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

Based on record review and interview, the facility failed to contact residents' health care providers for revised instructions for medications prescribed for use "as needed" without circumstances under which it would be appropriate for the resident to request the medication and any limitations specified for four sampled residents (#2, #5, # 11 and #17). The facility also failed to ensure that any change in directions for use of a medication is accompanied by a written, faxed, or electronic copy of a medication order issued and signed by the resident's health care provider and recorded in the resident's Medication Observation Record (Resident #15).

Findings included:

A review of sampled , and Medication Observation Records (MORs) was conducted at the facility on .

Review of Resident #2's Medication Observation Records (MOR) revealed 5 of 6 "as needed-PRNs" listed with no parameters for provision: Powder - "Take 17 grams (1 capful) by mouth once daily as needed." MAPAP 500mg tablet - "Take 1 tablet twice daily as needed." Sul 2.5mg/ 3ml - "Inhale 1 unit dose vial orally every 6 hours as needed." 4mg tablet - "Take 1 tablet by mouth every 6 hours as needed." Ibpratropium BR 0.02% Soln - "Inhale 2.5ml via every 6 hours as needed."

Review of Resident #5's Medication Observation Records (MOR) revealed 2 of 2 "as needed-PRNs" listed with no parameters for provision: Milk of Magnesia 30ml PRN - There were no instructions written next to this medication; ( ) 5-325mg - "Take 1 tablet by mouth every 6 hours PRN."

Review of Resident #11's Medication Observation Records (MOR) revealed 2 of 2 "as needed-PRNs" listed with no parameters for provision: 50mg -Take 1 tablet by mouth 2 times daily PRN; " Powder - Take 1 capful with H2O once daily as needed PRN."

Review of Resident #17's Medication Observation Records (MOR) revealed 1 of 1 "as needed-PRN" listed with no parameters for provision: 50mg -"Take ½ tab by mouth daily (PRN)."

Upon review of Resident #15's MOR on at 10:50am, Staff B was interviewed regarding why the Community Relations Director initialed provision of Resident #15's 8am medication when Staff B had stated she provided 8am meds and MORs indicated Staff B documented provision of other 8am meds. Staff B stated the medication listed as to be provided at 8am should be 8pm because

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that medication is taken at night. Staff B stated Resident #15's son said Resident #15 needs to take the medication at night because it's making the resident tired. Staff B stated the Resident Care Coordinator changed the medication to 8pm because it shouldn't be taken in the morning. Staff B was asked if the facility got a new order from Resident #15's doctor. Staff B stated she did not know, and stated the Resident Care Coordinator would get new order, stated both Resident's daughter and son said to give the medication at night. Staff B stated: " is just a and they don't have a primary doctor, so it was just the daughter who said to change it." "P" was observed handwritten over the "AM" in the MOR. No revised medication order was issued and signed by the resident's health care provider or recorded in the resident's Medication Observation Record or made available during facility visit.

On at 5:45pm, the Administrator was informed of the need for parameters for "as needed-PRN" medications; the Administrator acknowledged understanding.

Class III

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

Based on observation, interview and record review, the facility was cited for a Class II deficiency for failing to maintain accurate Medication Observation Records (MORs) for nine of nine sampled residents. Resident #2 required hospitalization after failing to receive prescribed medication. Due to receiving a Class II medication deficiency, the facility must now contract with a registered nurse or licensed pharmacist.

Findings included:

Review of Resident #2's , 2018 MOR revealed multiple medication providers' initials circled - many listed reason as refused medications; other times, medications not in cart/not available. Review of breathing medications revealed that Resident #2 was prescribed Sul 2.5mg/3ml with instructions to inhale 1 unit dose vial orally every 4 hours - The medication was written on the MOR to be provided at 8 am, 1, PM, & PM - PM had been handwritten over the typed time. The medication was not provided every 4 hours as prescribed. Review of Resident #2's , 2018 MOR revealed medication provider initials circled 18 times that was not provided and only written on reverse of MOR that resident refused the medication 6 times.

Continued review of Resident #2's , 2018 Medication Observation Record (MOR) revealed that Resident #2 was prescribed 15 mcg/2 ml sol with instructions to inhale 1 unit dose vial via daily at 8 am. This medication was not initialed as provided (blank spaces with no explanation

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on reverse) on 7/9, , , and . Medication Technician (Med Tech) initials were circled as not provided on , , , , , , and . Written on reverse of MOR: treatment was not given on and because there was no mouthpiece.

The facility had incomplete or inaccurate MORs for additional residents.

The facility must now contract with a registered nurse or licensed pharmacist.

This serves as the notification.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on record review and interview, the facility failed to ensure that 1 of 3 unlicensed staff who provide residents assistance with self-administration of medications in a facility with 31 in-house residents has completed the required initial 4-hour training on providing assistance with self-administration of medications and safe medication practices in an assisted living facility.

Findings included:

Review of the facility's Medication Observation Records and interview with the facility Administrator on confirmed that Staff A, B, and C are unlicensed Resident Aides who assist residents with self-administration of medications. A focused review of 3 employee files was conducted at the facility on at 3:00pm.

Record review revealed that Staff A, hired , completed a 2-hour training update in providing assistance with self-administration of medications on . There was no documentation of Staff A having completed an initial 4-hour training in assisting residents with self-administration of medications in an Assisted Living Facility.

On at 5:30pm, the Administrator was informed that there was no documentation of Staff A having completed an initial 4-hour training. The Administrator stated she had reviewed employee records for medication training and was not aware of Staff A's file missing the required documentation.

Class III

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

Based on record review and interview, the facility failed to maintain an Interdisciplinary Care Plan for 3 of 3 residents receiving hospice services at the facility.

Findings included:

On beginning at 1:25pm, focused record reviews of 3 residents receiving hospice services at the facility from 3 different hospice providers were conducted.

Resident #1's file contained 3 Hospice Alert forms regarding medications and a Hospice Notification slip; no other hospice information was found in the file. There was no Interdisciplinary Care Plan. When the Interdisciplinary Care Plans were requested from the Administrator, the Administrator provided the Hospice agency's Healthcare notebook, which contained sign-in sheets, visit summaries, and an agency form entitled "Interdisciplinary Care Plan." The agency form did not indicate hospice and facility responsibilities, and no information was found in the book regarding Resident #1.

Resident #4's file contained a Patient Info sheet with the hospice team listed and a blank "Service Pan for ALF Patient." The Administrator provided the Hospice agency's notebook, which contained information regarding hospice and nothing regarding the facility's role. There was no Interdisciplinary Care Plan.

Resident #5's file contained an agency Hospice Team Care Plan, Hospice Clinical Notes, and Visit Reports, including facility contacts and communication with resident's family. There was no Interdisciplinary Care Plan. On at 3:22pm, the Resident Care Coordinator provided a Hospice Patient Info and Team notes faxed to the facility on the day of visit (at 3:06pm). There was no Interdisciplinary Care Plan.

The purpose and requirements of Interdisciplinary Care Plans was reviewed with the Administrator and the Resident Care Coordinator during exit conference conducted on at 5:45pm.

Class III

0163 - Records - Resident, Penalties for Alteration - 429.49 FS

Based on record reviews and interviews, the facility fraudulently altered and falsified medical records in an Assisted Living Facility with 31 in-house residents. The facility failed to ensure that Medication

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Observation Records (MORs) were accurately updated and had staff sign them after the fact and for medications they did not provide assistance for. This falsification placed all residents in the facility receiving assistance with self-administration of medication at risk.

Findings included:

Review of Medication Observation Records (MORs) was conducted at the facility on and photographic evidence obtained.

A sticky note was observed on the back page of Resident #1's MOR: " 8am Please fill the MOR Thank you." <photographic evidence obtained>
Review of the MOR on revealed most medication spaces initialed as provided; there was no indication that medication was provided in accordance with physician orders and documented by the person providing the medication at the time of provision.

A sticky note was observed on Resident #2's MOR: "Please fill holes in the MOR Thank you." <photographic evidence obtained>

Review of Resident #2's 2018 MOR revealed multiple medication providers' initials circled - many listed reason as refused medications; other times, medications not in cart/not available. Review of breathing medications revealed that Resident #2 was prescribed Sul 2.5mg/3ml with instructions to inhale 1 unit dose vial orally every 4 hours. The medication was written on the MOR to be provided at 8am, 12pm, 4pm, and 6pm. 6pm had been handwritten over the typed time on the MOR. The medication was not provided every 4 hours as prescribed. Review of Resident #2's 2018 MOR revealed medication provider initials circled 18 times that was not provided and only written on reverse of MOR that resident refused the medication 6 times. No other reasons for missed dosages were documented

Record review revealed that Resident #2 was hospitalized on . Resident #2 was sent to Emergency Department Urgent Triage via ambulance on and admitted to the . Hospital reports documented "active diagnosis: " and "at risk of ," and noted that the Resident stated her machine was not working.

Review of Resident #2's 2018 MOR revealed multiple inconsistencies: "H" <Hospital> was

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written every day in 16 of 21 medication initials spaces (5 blank) for , with no explanation on reverse. H was written in 15 of 21 medication initials spaces (6 blank) for , with no explanation on reverse. On , medications were initialed as provided 5 times; H was written 10 times, and 6 spaces were observed blank, with no explanation on reverse. On another page of the MOR, 2 medications were initialed as provided at 8am on (1 blank), 1 medication initialed as provided at 5pm, and 2 medications initialed as provided at 8pm.
The 8am and 5pm medications contained the Community Relations Director's initials as having provided; Staff schedule indicated Staff B and Staff G were the assigned Med Techs during those times , and Staff D initialed on another page as having provided medications during those times. On , 2 of 3 medications were initialed as provided by the Community Relations Director at 8am on (1 blank with no explanation).
Staff schedule indicated Staff E was the assigned Med Tech for provision of 8am medications; other resident MORs contained Staff E's initials for provision of 8am medications on . Three medications were initialed as provided at 4pm by Staff D, who also initialed provision of another medication during 3-11pm shift and initialed provision of a 5pm medication. An H <Hospital> was written next to 3 medications scheduled for 8pm on ; Staff D initialed provision of one 8pm medication.

Upon review of Resident #15's MOR on at 10:50am, Staff B was interviewed regarding why the Community Relations Director initialed provision of Resident #15's 8am medication when Staff B had stated she provided 8am meds and MORs indicated Staff B documented provision of other 8am meds. Staff B stated the medication listed as to be provided at 8am should be 8pm because that medication is taken at night. Staff B stated Resident #15's son said Resident needs to take the medication at night because it's making the resident tired. Staff B stated the Resident Care Coordinator changed the medication to 8pm because it shouldn't be taken in the morning. Surveyor asked if the facility got a new order from Resident #15's doctor. Staff B stated she did not know, stated the Resident Care Coordinator would get new order, stated both Resident's daughter and son said to give the medication at night. Staff B stated: " is just a and they don't have a primary doctor, so it was just the daughter who said to change it." "P" was observed handwritten over the "AM" in the MOR.

Review of Medication Observation Records revealed that the Community Relations Director also initialed, but did not provide signature and initials on reverse of any MOR reviewed, as having provided Resident #16 all 8am medications on and and 8pm medication (,) on 8/2 and . Other medications were initialed as provided by Staff D at 8pm on . Review of facility staff schedules indicated that Staff D worked as the designated Med Tech from 3-11pm on and .

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Review of Medication Observation Records revealed that the Community Relations Director also initialed provision of Resident #7's 8pm medication on . Staff D initialed provision of Resident #7's 8pm medication on . Review of facility staff schedules indicated that Staff D worked as the designated Med Tech from 3-11pm on . In spaces for initialing for a 3rd medication on the same page ( ), the MOR indicates that Resident #7 was in the hospital from 8/1- . On reverse of another page of Resident #7's 2018 MOR was written that Resident #7 was in the hospital on . Staff initials indicate that Resident #7 was provided on at 8pm and 4 times per day as prescribed from to present (noon) except at 8pm was not initialed as having been provided.

Review of Medication Observation Records revealed that the Community Relations Director also initialed provision of all (13) of Resident #16's 8am medications on . Other residents' 8am medications on were initialed as provided by Staff E. Review of facility staff schedules indicated that Staff E worked as the designated Med Tech 7am-3pm on . The Community Relations Director also initialed provision of all but 2 of Resident #16's 8am medications on ; the other 2 medications were initialed as provided by Staff B. Review of facility staff schedules indicated that Staff E worked as the designated Med Tech 7am-3pm on .

Interviews were conducted with family members of facility residents on beginning at 2:20pm. One family member stated that the resident was "not given his medications, went without pain relief for a week because the MORs weren't written correctly, no pain meds for 7 days. The last day of <the resident> was out of medications for 2 days; the medications were not ordered. Meds not there and meds not labeled. They do a lot of altering of records."

Another family member stated: "Morning medications were not provided <the resident> until 1:30pm. They are very neglectful, then they just write down that they gave them on time."

On , the Administrator was informed of findings of multiple medication errors. The Administrator stated at 1:25pm that she "skims MORs for holes in the MORs and the employee responsible is counseled. It has been a struggle since I started here." The Administrator further stated that the sticky notes attached to resident MORs must have been put there by the former Resident Care Coordinator.

Class II