STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965130	C 12/27/2018
NAME OF PROVIDER OR SUPPLIER **SPRINGS OF LADY LAKE (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **620 GRIFFIN AVE.** **LADY LAKE, FL 32159**	

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

0000 - Initial Comments

On , , an unannounced complaint investigation survey (CCR #2018017332) was conducted at Springs of Lady Lake Assisted Living Facility (License #9531), Lady Lake, FL. Deficient practice was identified at the time of the survey.

0008 - Admissions - Health Assessment - 429.26( ) FS; 58A-5.0181(2) FAC

Based on observation, record review and interview, the facility failed to ensure health assessments (AHCA Form 1823) were complete and accurate for 5 of 5 sampled residents, Residents #1, #2, #3, #4 & #6. The facility also failed to obtain an updated health assessment (AHCA Form 1823) which reflected a change in condition for 2 of 5 sampled residents, Resident #2 and Resident #6.

Findings:

Record review of Resident #1's health assessment (AHCA Form 1823) dated revealed omitted information on page 2. No comments were provided to indicate the type of assistance for ambulation, bathing and .

Record review of Resident #2's medical chart revealed a hospice plan of care with a hospice enrollment date of . Review of Resident #2's health assessment (AHCA Form 1823) dated revealed no indication of the resident's enrollment into hospice. No updated AHCA Form 1823 was found in the record for Resident #2 which reflected the hospice enrollment on .

On at 5:15 PM, Resident #6 was observed in a wheelchair on the 1st floor hallway, being assisted by Staff C, LPN (Licensed Practical Nurse) with self-administration of medication.

Record review of Resident #6's Medication Observation/Administration Record revealed a list of medications, which were completely different from those listed on the health assessment (AHCA Form 1823) dated . Further record review revealed the date of admission for Resident #6 as , while the health assessment was dated . Page 1 of Resident #6's health assessment was found to have stricken information on the header, which crossed out a previously printed facility name, address and administrator and handwritten above there was the name of the facility where Resident #6's currently resides along with the corresponding address to the current facility. Page 2 of the health assessment indicated Resident #6, who was observed using a wheelchair, is independent with all activities of daily living. Page 5 was signed by the administrator of the previous assisted living facility and not the Administrator of the current assisted living facility where Resident #6

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resides. No updated health assessment was found in Resident #6's record.

Record review of Resident #3's health assessment (AHCA Form 1823) dated revealed several omissions. Page 1 did not contain the facility's address, phone number and contact person. Page 2 revealed no comments on type of assistance required for activities of daily living.

Record review of Resident #4's health assessment (AHCA Form 1823) dated revealed no diet order and no comments on type of supervision required for transfer on page 2.

On at 5:15 PM, an interview was conducted with the Executive Director. He stated they had been reviewing and trying to bring everything up to date and they were still in the process. He confirmed the omissions and acknowledged the importance of having accurate and complete information on the resident health assessments.

Class III

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

Based on record review and interview, the facility failed to maintain a written record of an incident resulting in medical attention and failed to contact the resident's family to report a significant change in condition for 1 of 3 sampled residents, Resident #1.

Findings:

On at 10:29 AM, a telephonic interview was conducted with the daughter of Resident #1. She stated her mother (Resident #1) informed her that she had when she spoke to her by telephone around 9:00 AM on . Resident #1's daughter stated she received no call from the facility informing her of her mother's . She also stated she saw her mother's covered with a bandage when she arrived at the facility on around 10:30 AM. She stated, after seeing her mother, she immediately decided to take her to the hospital to have her checked out.

Record review of the facility's sign-out log revealed that Resident #1's daughter signed her mother out of the facility on at 10:45 AM.

Record review of the facility's "Found on Floor Report" revealed no mention of Resident #1. She was not listed on the report reviewed for the months of and .

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Record review of documentation in Point Click Care electronic record revealed a reference related to Resident #1's . The reference provided no details of Resident #1's . The reference was a late entry on at 20:48 in Point Click Care record, reading as follows: "Effective date at 11:39 AM- writer received phone call from daughter about resident having in the early morning of . Writer explained to daughter the need to investigate the incident as it was not yet reported to Administration." The documentation reviewed only referenced that the would be investigated, but no record of the findings of an investigation were found.

On at 2:15 PM, an interview was conducted with the Executive Director. He stated, to the best of his recollection, Resident #1 was found in a chair by the Medication Technician on 11/17/2018 at about 6:30 AM. The Medication Technician then called the nurse, who asked the resident if she was in . Resident denied , nurse put steri-strips on the residents' forehead. The Executive Director confirmed no notation was put into a progress note at the time of the incident. He stated the Medication Technicians do not have access to the progress note section and therefore they cannot write a progress note. The Executive Director confirmed that the resident's daughter was not called at the time of the incident. The Executive Director stated he was not informed of the incident until he received a call from the resident's daughter asking about her mother's and that she was taking the Resident #1 to the hospital.

Record review of the facility's Emergency Care Procedures for Residents was completed. Clauses 5 and 6 read: "An incident will be documented" and "facility administration staff is responsible for medical care coordination. The families of seriously injured or ill person requiring higher level of care should be contacted by the on duty staff member."

On at 5:46 PM, during an interview, the Executive Director stated Resident #1 only experienced a on her forehead and the nurse bandaged it with a steri-strip. He confirmed he had not followed up on the incident concerning Resident #1.

A record review of the Emergency Department Clinical Summary Report for Resident #1 indicated the emergency room visit on . Review of Resident #1's diagnosis tests from the hospital revealed closed injury; concussion; of right ; elderly ; of right ; and right , hematoma.

Class III

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

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Based on observation and interview, the facility failed to ensure the assistance with self-administration of medication was observed by the Medication Technician who prepared the medications, failed to ensure the Medication Observation/Administration Record was accurately documented by the licensed practical nurse who administered the medication for 1 of 2 sampled residents, Resident #6, and failed to ensure the label was read to a resident prior to assistance with self administration for 1 of 2 sampled residents, Resident #7.

Findings:

On at 5:15 PM, unlicensed Staff C, Medication Technician, was observed providing assistance with self-administration of medications for Resident #6. Staff C removed Lacto Capsule, Metropolol 12.5 mg Tablet, 18 mg tablet, and CL 20 meq tablet from the cart and placed the medications into a small plastic cup. Staff C then locked the computer and carried the small plastic cup and a small plastic container of applesauce to Staff B, LPN (Licensed Practical Nurse) who was at a second medication cart located within 10 in the 1st floor hallway. Staff B was observed crushing the medications, mixing them with applesauce in the small plastic cup and handing the crushed medications to Resident #6. Staff B and Resident #6 then left the area to return to the resident's room on the second floor for the resident to take the medications. Staff C was observed returning to her medication cart and marking the electronic Medication Observation/Administration Record with her initials.

Record review of the Medication Observation/Administration Record for resident #6 revealed the medication dosages given on at 5:15 PM were initialed by Staff C and not by Staff B who administered the medications.

On at 5:25 PM, an interview was conducted with the Executive Director. He confirmed the Medication Technicians remove the medications from the medication cart and give the medications to a nurse when the resident requires administration of medications, and then, the Medication Technicians sign the Medication Observation/Administration Record.

On at 5:34 PM, Staff C, Medication Technician, was observed providing assistance with self-administration of medications for Resident #7. Staff C compared the label of 1000 mg Tablet to the electronic Medication Observation/Administration Record and placed the medication into a medication cup. She then handed the medication cup to the resident, and offered the resident a cup of water, without reading the label of medication to the resident.

On at 5:39 PM, an interview was conducted with Staff C. When asked if it was the usual and

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customary manner in which she assists residents with their medications, she responded "Yes." When asked if she reads the labels of the medications to the residents before handing them the medications, she responded "No, usually not."

Class III

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

Based on observation, record review and interview, the facility failed to ensure the nurse initialed the Medication Administration Record for 1 of 2 sampled residents, Resident #6.

Findings:

On at 5:15 PM, unlicensed Staff C, Medication Technician, was observed providing assistance with self-administration of medications for Resident #6. Staff C removed Lacto Capsule, Metropolol 12.5 mg Tablet, 18 mg tablet, and CL 20 meq tablet from the cart and placed the medications into a small plastic cup. Staff C then locked the computer and carried the small plastic cup and a small plastic container of applesauce to Staff B, LPN (Licensed Practical Nurse) who was at a second medication cart located within 10 in the 1st floor hallway. Staff B was observed crushing the medications, mixing them with applesauce in the small plastic cup and handing the crushed medications to Resident #6. Staff B and Resident #6 then left the area to return to the resident's room on the second floor for the resident to take the medications. Staff C was observed returning to her medication cart and marking the electronic Medication Observation/Administration Record with her initials.

Record review of the Medication Observation/Administration Record for resident #6 revealed the medication dosages given on at 5:15 PM were initialed by Staff C and not by Staff B who administered the medications.

On at 5:25 PM, an interview was conducted with the Executive Director. He confirmed the Medication Technicians remove the medications from the medication cart and give the medications to a nurse when the resident requires administration of medications, and then, the Medication Technicians sign the Medication Observation/Administration Record. He confirmed it was the facility's standard of practice for a Medication Technician to sign the Medication Observation/Administration Record when a nurse administers the medications to a resident whose medications are in the Medication Technician's assigned cart for the day.

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