STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965678	**01/25/2019**
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 Complaint Survey (CCR#: 2018017737) was conducted at Savannah Court of Lakeland Assisted Living Facility on . Savannah Court of Lakeland Assisted Living Facility had deficient practice identified at the time of the survey.

(License#: 10024)

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

Based on record review and interview, the Facility failed to obtain a -to- health examination within thirty day of admission that addressed assistance needed for medication administration for two Residents (#3 and #8) of seven sampled residents.

Findings Included:

A record review for Resident #3, conducted on , revealed that Resident #3's most recent Health Assessment Form dated did not include the type of assistance that the resident required for medication administration. Resident #3 was admitted in to the Facility on .

A record review for Resident #8, conducted on , revealed that Resident #8's most recent Health Assessment Form dated did not include they type of assistance that the resident required for medication administration. Resident #8 was admitted in to the Facility on .

During an interview with the Administrator, conducted on at 04:30pm, the Administrator acknowledged and confirmed that Residents #3 and #8's Health Assessment Forms did not include the required data regarding the type of assistance that each resident required for medication administration.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on observation, record review, and interview, the Facility failed to honor resident right by failing to provide a safe and clean living environment, free of environmental hazards and following standards of

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control.

Findings Included:

A tour of the Facility, conducted on at 10:40am, revealed that Resident #1 and #2 rooms and bathrooms had a strong odor of . Resident #1's toilet had standing in it and there was a black ring around the toilet bowl consistent with mold at the water line. Resident #1's floor was sticky and visibly dirty. Resident #2's bathroom had a piece of toilet paper with a brown discoloration on the floor between the wall and the toilet and the floor was sticky. Resident #6 and #7's room had five freestanding small portable tanks, an lying on the floor, and a large portable tank not securely in the wheeled rack (See Photographic Evidence1). Resident #6 had a machine with the mouthpiece lying out on the resident's bedside table. Resident #7 had a machine with the mouthpiece lying out on the resident's bedside table covered with other items on the resident's table. Resident #9 had a prescribed medication, Spray, on the table next to the resident's chair in the shared room.

During an interview with Resident #1, conducted on at 11:15am, Resident #1 stated that the resident's room and bathroom were "not clean now" and that some staff "don't check on me" and "I have no energy".

During an observation of Staff B with Resident #3, conducted on at 11:34am, Staff B was observed pushing Resident #3 in a wheelchair to the dining room. Resident #3 had a bag hanging from the left armrest of the resident's wheelchair with visibly contained one-fourth of the bag. Staff B pushed Resident #3 up to the dining table and the bag was near tabletop level. There was one male resident sitting to Resident #3's left side during the lunch meal.

During an interview with Staff A, conducted on at 12:10pm, Staff A stated that Resident #1, #2, #3, and #11 had frequent odors in their rooms. Staff A hired as the Facility's Licensed Practical Nurse.

During an interview with Staff E, conducted on at 12:23pm, Staff E stated that Resident #2 and #11 had frequent odors in their rooms and Resident #1 usually had none. Staff E is employed as the Facility's Housekeeper.

During an interview with Staff B, conducted on at 12:35pm, Staff B stated that Resident #2's room sometimes smells of .

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During an observation of the medication pass with Staff B for Resident #6, conducted on at 12:44pm, Staff B assisted Resident #6 with the prescribed medication 0.5mg/3ml Solution treatment. After the treatment, Staff B rinsed the chamber and mouthpiece. Staff B then placed the chamber and mouthpiece on Resident #6's bedside table. The mouthpiece touch the tabletop. Staff B did not provide a barrier or wash the area prior to lying the mouthpiece on the tabletop. Staff B exited Resident #6's room and left the lying on the floor. The aforementioned portable tanks continued as unsafely stored. At 12:58pm, Staff B assisted Resident #9 with the prescribed medication 500mg. Staff B exited Resident #9's room and left the prescribed medication on the resident's chairside table.

During an interview with Staff A and Resident #7, conducted on at 02:55pm, Staff A picked up Resident #7's , off the floor, and placed it in the resident's nares/ and stated that resident #7, "just throws the on the floor". Staff A stated that the " company" [vendor]" bring the and store them in the resident's room.

During an observation of Resident #1 and #2's rooms, conducted on at 03:10pm, revealed that both resident's bathrooms had no change in condition or odors from earlier on the date of survey.

A review of The National Fire and Protection Association (NFPA) and Occupational Safety and Health Administration standard for safe cylinder storage, conducted on , revealed that both Agencies recommended that that "all freestanding cylinders must be stored in a rack, a cart, or another enclosure to protect them. Unsecured cylinders could , breaking the valve and possibly resulting in a rapid release of the gas, propelling the cylinder and turning it into a dangerous projectile."

A review of the Centers for Control (-associated), conducted on , revealed that patients with to "check the position of the bag [and] always [keep the bag] below the level of the ". Keeping the bag below the level of the prevents caused by the inability of the to flow freely out of the (cdc.gov).

During an interview with the Administrator, conducted on at 11:00am, the Administrator denied that the Facility had a Housekeeping Cleaning Schedule and verbally described the housekeeper's daily and weekly cleaning duties. At 04:00pm, the Administrator acknowledged and confirmed that Resident #1 and #2's rooms and bathrooms had strong odors and needed cleaning. The Administrator acknowledged and confirmed that the portable tanks in Residents #6 and #7's rooms stored unsafely and that lying the mouthpieces on the bedside stand were not stored in a fashion that

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maintained good control standards. The Administrator denied that the Facility had a policy and procedure for the storage of medications and and stated that the, "Third Party Provider takes care of everything with and tubing".

At 04:30pm, the Administrator agreed that placing Resident #3 at the dining room table with an exposed bag at tabletop level was a dignity concern and a violation of control standards. The Administrator denied that the Facility had a policy and procedure for . There was no documentation that Resident #3's Third Party Provider informed of the inability to maintain appropriately. The Administrator stated that residents, who keep medications in their room, must have a locked box to keep the medications in.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation, record review, and interview, the Facility failed to keep medications centrally stored in a locked cart at all times for one Resident (#9) of one sampled who required assistance with self-administration of medications (meds).

Findings Included:

During an observation of Resident #9's room, conducted on at 10:40am, Resident #9 had a prescribed Spray on a table next to the resident's chair in a shared room with Resident #8.

During a medication review of Staff B for Resident #9, conducted on at 12:58pm, Staff B assisted Resident #9 with the resident's prescribed 500mg in the resident's room. Staff B did not remove the Spray from Resident #9's shared room.

A record review for Resident #9, conducted on , revealed that Resident #9's most recent Health Assessment Form dated stated that the resident needed assistance with self-administration of meds. There were no Physician orders in Resident #9's record that stated that the resident could keep the prescribed Spray in the resident's room. There was no documentation that Resident #9 was able to self-administer the prescribed Spray. Resident #9's Medication Observation Records (MORs) stated that the resident 'self-administered' the prescribed Spray.

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During an interview with the Administrator, conducted on at 04:30pm, the Administrator acknowledged and confirmed that Resident #9 should not be self-administering the prescribed Spray. The Administrator stated that, "if the residents' 1823 (referring to the Agency for Health Care Administration Form 1823) states 'needs assistance', then we need to provide the assistance and any resident that keep meds in their rooms should have a locked box to keep the meds in".

Class III

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

Based on observation, record review, and interview, the Facility failed to assure that all centrally stored medications had proper medication labels on them, which included all required data for one Resident (#6) of three-sampled resident who required assistance with self-administration of medication.

Findings Included:

During an observation of the medication pass with Staff B for Resident #6, conducted on at 12:44pm, Staff B pulled out a vial of 0.5mg/3ml Solution from a foil pack that did not have a medication label on it. The foil pack only had the resident's first and last name handwritten on it in black ink. Staff B stated that, "the medication label for the solution was on the box it came in and I'm not sure where the box is".

A record review for Resident #6, conducted on , revealed that Resident #6's most recent Health Assessment Form dated stated that the resident needed assistance with self-administration of medication.

During an interview with the Administrator, conducted on at 04:00pm, the Administrator acknowledged and confirmed that, "all medications should have a medication label from Pharmacy".

Class III

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c); 59A-35.090(2)(d)-(3)

Based on record review and interview, the Facility failed to ensure that an Attestation of Compliance was signed and included in two employee records Staff (A and B) of three sampled employee records.

Findings Included:

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An employee record review for Staff A, conducted on [redacted], revealed that Staff's record did not include a signed Attestation of Compliance accompanying the employee's background screening eligibility dated [redacted]. Staff A's date of hire was on [redacted].

An employee record review for Staff B, conducted on [redacted], revealed that Staff B's record did not include a signed Attestation of Compliance accompanying the employee's background screening eligibility dated [redacted]. Staff B's date of hire was on [redacted].

During an interview with the Administrator, conducted on [redacted] at 04:30pm, the Administrator acknowledged and confirmed that both Staff A and B's employee records did not include a signed Attestation of Compliance and stated that, "this is in our new hire packet and should have been in their records".

Unclassified