STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965383	**03/11/2019**
NAME OF PROVIDER OR SUPPLIER **SAVANNAH COTTAGE OF LAKELAND**	STREET ADDRESS, CITY, STATE, ZIP CODE **605 CARPENTERS WAY** **LAKELAND, FL 33809**	

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

0000 - Initial Comments

Assisted Living Facility

A complaint investigation (CCR 2019000380 and 2019000738) was conducted at Savannah Cottage of Lakeland on in conjunction with a biennial re-licensure survey. Savannah Cottage of Lakeland had deficiencies at the time of the investigation.

(License #9783)

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

Based on observation, record review, and interview, the Facility failed to provide the level of care and services required to meet the needs of residents accepted for admission; specifically, the facilityfailed to provide personal supervision as appropriate for each resident; failed to maintain a written record updated with residents' significan changes including , aggressive behaviors, and hospitalizations, and, failed to have documentation that residents' Primary Care Provider and Responsible Parties were notified of residents' incidents, significant changes for seven Residents (#2, #9, #14, #18, #22, and #23) of seven sampled residents admitted to the Facility.

Findings Included:

Observations of Resident #11 and #22, conducted on , revealed that the Facility did not utilize precautions with Resident's #11 and #22. At 11:00am, Resident #11 was observed with no shoes on and with regular socks with no grips on the bottom and Staff A approached the resident to assist them at the dining table. Staff A walked away without the residents' footwear. Resident #11 was further observed at 02:30pm and 04:00pm with no shoes on and regular socks with no grips on.

A record review for Resident #11, conducted on , revealed that Resident #11's Health Assessment Form dated stated that the resident had a diagnoses of 's and and required precautions and assistance with all Activities of Daily Living (ADLs). There were no services listed on page five of Resident #11's Health Assessment Form. Resident #11 had a facility Service Plan dated with no intervention or prevention measures or interventions that the resident required for taking the resident's shoes off repeatedly and stated that the resident required with . There were no interventions on the Service plan regarding Resident #11's combative behaviors and extensive , . Resident #11's progress notes stated that the resident had a to forehead with unknown cause. The Facility did not update the resident's

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965383	03/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH COTTAGE OF LAKELAND	**605 CARPENTERS WAY LAKELAND, FL 33809**

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

care plan, create an in-house incident report or investigate the incident. According to Facility incident reports, Resident #11 had a on and and had no action plans put in place mad no notifications to the resident's Primary Care Physician and Responsible Party, and did not update Resident #11's Service/Care Plan.

A record review for Resident #2, conducted on , revealed that Resident #2's undated Health Assessment stated that the resident had aggressive behavior and a diagnosis of Dependent . There were no care and services documented on page five of Resident #2's Health Assessment Form. There were no documented changes-in-condition or behaviors in the resident's record. There were no entries documented in the resident's record to meet the needs of the resident's behaviors and Dependency. According to a Hospital's Emergency Departments visit report, Resident #2 was sent for a low level on at 08:45am. There was no documentation of Resident #2's levels documented in the resident's record. There was no documentation of events, which led up to Resident #2's transport on . There was no in-house incident report documented as to what transpired during the event on . There were no services or referrals documented in Resident #2's record to meet the needs of the resident's aggressive behaviors. There was no documentation in Resident #2's record for the coordination of Third Party Services for administration or documented levels.

A record review for Resident # 9, conducted on , revealed that Resident #9's Health Assessment Form dated stated that the resident required precautions, had , and was forgetful. There were no care and services listed on page five of Resident #9's Health Assessment Form. Resident #9 did not have a facility Service or Care Plan the resident's precautions.. Resident #9's record had no documentation since .

A record review for Resident #14, conducted on , revealed that Resident #14's Health Assessment Form dated stated that the resident was a risk, required medication administration, and required assistance with all Activities of Daily Living except with eating, which was supervision only. Resident #14 had two Service Plans dated and . Both Service Plans included that the resident was a risk but did not include intervention or prevention measures to reduce the resident's risk of falling. Resident #14 had on and with no new Service Plan developed from the resident's . Resident #14 was in a Rehabilitation facility but there was no documentation in the resident record indicating for what reason. Resident #14's record had no documentation regarding the incident that led to the resident's transport to the hospital, then rehabilitation.

During an interview with Staff A, conducted on at 01:30pm, Staff A stated that Resident #14

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965383	03/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH COTTAGE OF LAKELAND	**605 CARPENTERS WAY LAKELAND, FL 33809**

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

went to the Hospital and then to Rehabilitation due to a .

A record review for Resident #18, conducted on , revealed that Resident #18's record had no documentation of what transpired to send the resident to the Hospital on and . Resident #18's record had no facility Service Plan in place to meet the resident's needs. Resident #18 had diagnoses of , , and .

A record review for Resident #22, conducted on , revealed that Resident #22's Health Assessment Form dated stated that the Resident had diagnoses of and 's and multiple to the , left , and left fold (See Photographic Evidence2). Resident #22 was weak and required assistance with all ADLs, had a communicable of in the , and required 24-hour nursing care, and medication administration. There were no services offered or arranged by the Facility listed on page five of Resident #22's Health Assessment Form. According to Resident #22's progress notes, the resident incurred a on at 07:00pm. Resident #22 had sustained on and as well with no documentation in the resident's record regarding the event. There were no documented facility interventions or facility service plans with these .

At 12:10pm, 02:28pm, and 04:02pm, Resident #22 was observed with no shoes on and only regular socks with no grips to the bottom of the socks around the Facility in the resident's high- wheelchair.

A record review for Former Resident #23, conducted on , revealed that Resident #23's Health Assessment Form dated stated that the resident had a diagnoses of 's and and was independent with all ADLs except toileting, which was supervision. Resident #23 did not have documentation in the resident's record to meet the resident's needs for , aggressive behaviors, refusals of care needs (shower), and forgetting to use prescribed walker. According to the Resident #23's record, the resident had aggressive behaviors and refusals of showers on and around and on , , and . The Facility's in-house incident reports and Resident #23's progress/observation notes did not include notifications to Resident 23's Primary Care Provider with each incident. The Facility did not update in created a Service or Care Plan in order to meet Resident #23's needs.

A review of the Facility's Third Party Agreement Policy, found in the Residency Agreement, conducted on , revealed that the "Facility shall take action to assist in facilitating the provision of required services and coordinate with the Third Party Provider to meet the specific service goals [of the resident]".

During an interview with the Administrator, conducted on at 05:53pm, the Administrator

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965383	03/11/2019
NAME OF PROVIDER OR SUPPLIER **SAVANNAH COTTAGE OF LAKELAND**	STREET ADDRESS, CITY, STATE, ZIP CODE **605 CARPENTERS WAY LAKELAND, FL 33809**	

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

acknowledged and confirmed that the Facility did not update Residents #2, #9, #11, #14, #18, #22, and #23' Service/Care Plans to meet the residents' needs for and behavior interventions/prevention measures. The Administrator verified that Resident #2 had no documentation in the resident's record regarding Third Party Services of a Home Health Agency (HHA) and documented communication between the HHA and the Facility regarding the provision of care for Resident #2, which included documentation of administrations and levels. The Administrator confirmed that both Resident #11 and Resident #22 both take their shoes off and staff leave them off. The Administrator confirmed that documentation of incident reports and the documentation in resident records were not consistent and verified the lack of notifications to residents' Primary Care Physicians and Responsible Parties.

Class III

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

Based on record review and interview, the Facility failed to update Medication Observation Records (MORs) immediately each time medications (meds) were offered to four Residents (#10, #12, #13, and #17) of four sampled residents; and, failed to maintain MORs with all required data for one Resident (#12) of four sampled residents.

Finding Included:

A record review for Resident #10, conducted on , revealed that Resident #10's MORs had medications not documented as given and meds circled as not given to the resident. Resident #10's prescribed 250mg was not documented as given on at 05:00pm and at 09:00am and 05:00pm. Resident #10's prescribed 1mg was not documented as given on at 08:00am and circled as not given on at 08:00am. There were no reasons on the of Resident #10's MORs explaining why the resident did not receive the aforementioned meds on the dates and times described. There were no orders to hold the aforementioned medications on the dates and times described in Resident #10's record. There was no documented evidence that the Facility notified Resident #10's Primary Care Physician and Responsible Party that the resident did not received the medications.

A record review for Resident #12, conducted on , revealed that Resident #12's MORs had medications not documented as given to the resident. Resident #12's prescribed 0.5mg was not documented as given on at 08:00pm. Resident #12's prescribed 25-100mg was not documented as given on at

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965383	03/11/2019
NAME OF PROVIDER OR SUPPLIER **SAVANNAH COTTAGE OF LAKELAND**	STREET ADDRESS, CITY, STATE, ZIP CODE **605 CARPENTERS WAY LAKELAND, FL 33809**	

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

12:00pm; and at 10:00pm. Resident #12's MORs did not include the resident's Primary Care Physician or telephone number, the resident's and diagnosis, or the charting period timeframe. There were no reasons on the of Resident #12's MORs explaining why the resident did not received the aforementioned meds on the dates and times described. There were no orders to hold the aforementioned medications on the dates and times described in Resident #12's record. There was no documented evidence that the Facility notified Resident #12's Primary Care Physician and Responsible Party that the resident did not received the medications.

A record review for Resident #13, conducted on , revealed that Resident #13's MORs had medications not documented as given and meds circled as not given to the resident. Resident #13's prescribed , 125mg was not documented as given on at 05:00pm and at 09:00am and was circled as not given on at 05:00pm. Resident #13's prescribed , 5mg was not documented as given on , , , , and at 08:00pm. Resident #13's prescribed , 5mg was not documented as given on , /19, & at 08:00am and 08:00pm and through at 08:00pm and was circled as not given on through at 08:00am. Resident #13's prescribed , 500mg was not documented as given on at 09:00pm. There were no reason on the of Resident #13's MORs explaining why the resident did not given the aforementioned meds on the dates and times described. There were no orders to hold the aforementioned medications on the dates and times described in Resident #13's record. There was no documented evidence that the Facility notified Resident #13's Primary Care Physician and Responsible Party that the resident did not received the medications.

A record review for Resident #17, conducted on , revealed that Resident #17's MORs had medications not documented as given and meds circled as not given to the resident. Resident #17's prescribed 10mg was not documented as given on and at 08:00am and circled as not given from through at 08:00am. Resident #17's prescribed , 25mg tablets was not documented as given on and at 08:00am and , through at 08:00pm. Resident #17's , 25mg was circled as not given on at 08:00am and through at 08:00am and , , /19, at 08:00pm. Resident #17's prescribed 50mg was not documented as given on , , , , and at 08:00pm and circled as not given on , , , , and at 08:00pm. The reasons that Resident #17 did not received the aforementioned meds were documented as a "Code 2" for some of the dates and times described and did not include all of the dates and times described. There were no orders to hold the aforementioned medications on the dates and times described in Resident #17's record. There was no documented evidence that the Facility notified Resident #17's Primary Care

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965383	03/11/2019
NAME OF PROVIDER OR SUPPLIER **SAVANNAH COTTAGE OF LAKELAND**	STREET ADDRESS, CITY, STATE, ZIP CODE **605 CARPENTERS WAY** **LAKELAND, FL 33809**	

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

Physician and Responsible Party that the resident did not received the medications.

During an interview with the Administrator, conducted on at 11:45am, the Administrator acknowledged and confirmed that Residents #10, #12, #13, and #17 had MORs that were not updated each time a medication dose was offered to the residents and that Resident #12's MORs had missing required data.

Class III

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

Based on observation, record review, and interview, the Facility failed to keep centrally stored medication in a locked cabinet or cart secured at all times. The Facility failed to notify a discharged resident or the resident's responsible party and wait fifteen days before disposing of medications for three Residents (#9, #23, and #24) of three sampled discharged residents.

Findings Included:

During an observation of the facility's medication carts, conducted on at 11:02am, one of the two medication carts was found unlocked with the key left in the key lock and no staff in attendance (See Photographic Evidence1). The two medication carts were filled with residents' medications. While the medication cart was unlocked, Staff A walked from around the corner up to the medication cart for approximately fifteen seconds and then walked down the hall and around the corner without locking the medication cart or removing the keys.

A record review for Resident #9, conducted on , revealed that there were no documentation of the disposal of resident's medications upon discharge. There was no documentation of notifications to the Resident's Responsible Party to pick up Resident #9's medications upon discharge. Resident #9 was discharged from the Facility on .

A record review for Resident #23, conducted on , revealed that there were no documentation of the disposal of the resident's medications upon discharge. There was no documentation of notifications to the Resident's Responsible Party to pick up the Resident #23's medications upon discharge. Resident #23 was discharged from the Facility on .

A record review for Resident #24, conducted on , revealed that there was no documentation of

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965383	03/11/2019
NAME OF PROVIDER OR SUPPLIER SAVANNAH COTTAGE OF LAKELAND	STREET ADDRESS, CITY, STATE, ZIP CODE 605 CARPENTERS WAY LAKELAND, FL 33809	

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

the disposal of the resident's medications upon discharge. There were no notifications to the Resident's Responsible Party to pick up the Resident 24's medications upon discharge and there was no specific date noted in the resident's record or on the Admission and Dishcarge Log as to when the resident was discharged.

During an interview with the Administrator, conducted on 11:45am, the administrator verified, through Photographic Evidence1, that one of the medication cart was left unlocked with the keys left in the key lock, which left residents access to medication in the secured Memory Care Facility. The Administrator confirmed that medications should be locked at all times and that this was not following the Facility's protocol. Requested Residents #9, #23, and #24's medication disposition records for the residents upon discharge from the Facility. At 03:30pm, requested the medication disposition records for Residents #9, #23, and #24 and the Facility's medication disposition policy and procedure. By 05:53pm, the Administrator had not produced the medication disposition records for Resident #9, #23, and #24 or the Facility's medication dispostion policy and procedure.

Class III

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

Based on observation, record review, and interview, the Facility failed to provide medications as ordered to four Residents (#1, #12, #13, and #20) of four sampled residents and failed to ensure that prescriptions were filled or refilled in a timely fashion for three Residents (#1, #9, and #17) of three sampled residents.

Finding Included:

During an observation of the Medication Observation Records (MORs) for the 12:00pm medication (med) pass and interview with Staff A, conducted on [redacted] at 10:40am, Resident #1, #12, #13, #15, #16, and #19's were flagged. Staff A stated that the MORs that were flagged, "are the residents that I give meds to at the noon med pass [and] I get started at 11am". At 11:05am, Staff A assisted Resident #12 with the resident's prescribed [redacted] 100mg medication. Resident #12 [redacted] was not due until 01:00pm. At 11:15am, Staff A started to give Resident #15 a med and stopped during the assistance and told the resident, "oh wait, I don't give yours now [and] it's not due until one o' clock".

A review of Resident #1, #12, #13, #15, #16, and #19's MORs, conducted on [redacted], revealed that #1, #13, #15, #16, and #19 MORs stated that their next med due was at 01:00pm. Resident #12 was the only resident that had meds due at 12:00pm.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965383	03/11/2019
NAME OF PROVIDER OR SUPPLIER **SAVANNAH COTTAGE OF LAKELAND**	STREET ADDRESS, CITY, STATE, ZIP CODE **605 CARPENTERS WAY** **LAKELAND, FL 33809**	

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

During an interview with Staff A, conducted on at 11:15am, Staff A stated that the staff, "always starts the med pass at 11am".

A record review for Resident #1, conducted on , revealed Resident #1's MORs had the med , circled as not given to the resident through . The reason given on the of Resident #1's for not receiving this med was due to "Code 2" which indicated that the med was not available. Not all of the dates and times that the med was not available for Resident #1 was included with the reasons on the of the resident's MORs. There was no documented evidence that the Facility attempted to obtain this med for Resident #1. There was no documented evidence that the Facility notified Resident #1's Primary Health Care Provider and the resident's Responsible Party that the resident was not receiving this med.

A record review for Resident #9, conducted on , revealed Resident #9's MORs had the med C 500mg, circled as not given to the resident through . The reason given on the of Resident #9's MORs for not receiving this med was due to "Code 2" which indicated that the med was not available. Not all of the dates and times that the med was not available for Resident #9 were included with the reasons on the of the resident's MORs. There was no documented evidence that the Facility attempted to obtain this med for Resident #9. There was no documented evidence that the Facility notified Resident #9's Primary Health Care Provider and the resident's Responsible Party that the resident was not receiving this med.

A record review for Resident #17, conducted on , revealed Resident #17's MORs had the meds 10mg, , 25mg, and 50mg, circled as not given to the resident through . The reason given on the of Resident #17's MORs for not receiving these meds were due to "Code 2" which indicated that the meds were not available. Not all of the dates and times that the meds were not available for Resident #17 were included with the reasons on the of the resident's MORs. There was no documented evidence that the Facility attempted to obtain these meds for Resident #17. There was no documented evidence that the Facility notified Resident #17's Primary Health Care Provider and the resident's Responsible Party that the resident was not receiving these med.

An audit of the med cart, conducted on at 11:45am, revealed that Resident #1's continued as not on the med cart/unavailable to the resident. Resident #13 had a ordered for fourteen days. Resident #13 had five doses remaining on the prescription and the resident med card had six doses remaining, which indicated that the resident missed one dose of the . Resident #13's was not available for the resident

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965383	03/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH COTTAGE OF LAKELAND	**605 CARPENTERS WAY LAKELAND, FL 33809**

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

on the med cart. Resident #20 had a ordered for fourteen days. Resident #20 had one dose remaining of on the prescription and the resident's med card had two doses remaining, which indicated that the resident missed on dose of the .

During an interview with the Administrator during the med audit, conducted on at 11:45am, the Administrator acknowledged and confirmed that Resident #1's and Resident #13's were not available in the med cart. The Administrator acknowledged and confirmed that Resident #13 and #20 missed one dose each of their prescribed treatment. The Administrator verified that medications given to resident's must be given within one hour prior to or one hour after the prescribed time. The Administrator acknowledged and confirmed that Residents #1, #9, #17 had meds circled on their MORs due to the unavailability of the residents' meds.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the facility failed to maintain a safe living environment, free of hazards for one (Resident #19) of one resident sampled.

Findings included:

A tour of the facility was conducted at 10:27 AM on and Staff E was observed cleaning stained furniture cushions in the northeast corridor. Resident #19 was observed sitting on a sofa in this area with a fire extinguisher behind them, laying across their . Staff E was asked why Resident #19 was sitting on a fire extinguisher and they stated that they did not know it was there.

Class III

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

Based on record review and interview, the Facility failed to maintain one Resident (#23) of one, discharged resident's record for two years, which included Physician orders, care and services provision, Medication Observation Records (MORs), Observation Logs, and Record.

Findings Included:

A review of the Admission and Discharge Log, conducted on , revealed that Resident #23 was

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965383	**03/11/2019**
NAME OF PROVIDER OR SUPPLIER **SAVANNAH COTTAGE OF LAKELAND**	STREET ADDRESS, CITY, STATE, ZIP CODE **605 CARPENTERS WAY** **LAKELAND, FL 33809**	

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

admitted in to the Facility on . Resident #23 discharged from the Facility on with no reason for the discharge noted.

A record review for Resident #23, conducted on , revealed that there was no Health Assessment Form, Residency Agreement, Physician Orders, care and services provision, MORs, Observation Logs, and Record in the resident's record.

During an interview with the Administrator, conducted on at 02:15pm, the Administrator confirmed and acknowledged that Resident #23 had no Health Assessment Form, Residency Agreement, Physician Orders, care and services provision, MORs, Observation Logs, and Record in the resident's record. The Administrator produced Resident #23's Health Assessment Form dated and Residency Agreement at 02:45pm but did not provide any other requested documents. At 03:30pm, rerequested Resident #23's record from the Administrator. At 05:53pm, the Administrator acknowledged and confirmed that Resident #23 had no Physician Orders, care and services provision, MORs, Observation Logs, and Record in the resident's record as required for two years post-discharge.
Class III