STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965383	R 05/03/2019

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)

0000 - Initial Comments

Assisted Living

A Revisit to 03/11/19 Complaint Investigation (Complaint Numbers: 2019000768 and 2019000380), a Complaint Investigation (Complaint Number: 2019004855), and a Revisit to 03/11/19 Biennial Survey were conducted at Savannah Cottages of Lakeland Assisted Living Facility on 05/03/19. Deficiencies were identified at the time of survey.

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 for for one Resident (#2) of three sampled residents who were risks.

Findings Included:

During observations of Resident #2, conducted on at 08:12am, 11:35am, and 02:23pm, Resident #2 had on regular socks and no shoes.

A review of staff in-service, conducted on , revealed that "non-skid socks obtained for resident who do not wear shoes".

A review of a letter dated , conducted on , revealed that the Facility sent a letter to all residents' responsible parties and stated that, "some resident prefer not to wear shoes [and] that these residents will have to purchase non-skid socks to enhance safety".

A review of Resident #2's record, conducted on , revealed that Resident #2's Health Assessment Form dated stated that the resident required " precautions" and "supervision with ambulation".

During an interview with the Administrator, conducted on at 02:23pm, the Administrator observed Resident #2 with regular socks on and no shoes. The Administrator stated that Resident #2 "should have grippy socks or shoes on" and "I purchased the grippy socks for [the resident] myself because the family won't".
Class III

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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 six Residents (#1, #2, #6, #7, #8, and #9) of eight sampled residents; and, failed to maintain MORs with all required data for two Residents (#7 and #8) of eight sampled residents.

Finding Included:

A review of Resident #1's MORs, conducted on , revealed that Resident #1's MORs had meds that were not documented as given, which included Resident #1's prescribed meds:
- Packet take 1 powder pack (4gm) mix with 6oz water and drink by twice daily was not document as given on at 05:00pm and at 09:00am
- 100mg tablets take one tablet by every day was not documented as given on and at 09:00am

A review of Resident #2's MORs, conducted on , revealed that Resident #2's MORs had meds that were not documented as given, which included Resident #2's prescribed meds:
- Acidophilus capsules take one capsule by every day was not documented as given from through
- 0.5mg tablets take a half tablet by every day was not documented as given on at 09:00pm
- 75mg tablets take one tablet by every day was not documented as given on at 09:00am
- 400mg tablets take one table by every day was not documented as given on at 09:00am
- 20mg tablets take one tablet by once every day was not documented as given on at 09:00am

A review of Resident #6's MORs, conducted on , revealed that Resident #6's MORs had meds that were not documented as given, which included Resident #6's prescribed meds:
- 1mg tablets take one tablet by every day was not documented as given on at 08:00am
- DR 25mg tablets take one tablet by twice every day was not documented as given on at 08:00am
- 2% Cream apply to and three time every day was not documented as given on and at 06:00pm and at 08:00am

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- , 500mg capsules take one capsule by every day was not documented as given on 08:00am and did not include the length of time that this was ordered for.
A review of Resident #6's , 500mg revealed that the med was ordered for nine days.

A review of Resident #7's , MORs, conducted on , revealed that Resident #7's MORs had meds that were not documented as given, which included Resident #7's prescribed meds:
- 2mg tablets take one tablet by twice every day was not documented on at 09:00am
- 10MEQ tablets take one tablet by twice every day was not documented on 0/30/19 at 08:00am and 05:00pm
Page two of Resident #7's MORs revealed that there was no information pertaining to the residents , Physician, the Physician's telephone number, or the date range for the resident's MORs documentation period as required.

A review of Resident #8's , MORs, conducted on , revealed that Resident #8's MORs had meds that were not documented as given, which included Resident #8's prescribed meds:
- , 0.25mg tablets take one table by at bedtime was not documented on at 08:00pm
Resident #8's MORs did not include information pertaining to the resident's , Physician, the Physician's telephone number, or the date range for the resident's MORs documentation perioid as required.

A review of Resident #9's , MORs, conducted on , revealed that Resident #9's MORs had meds that were not documented as given, which included Resident #9's prescribed meds:
- 5mg tablets take one tablet by every day was not documented as given on at 9am and at 09:00am
- 30mg tablets take one tablet by three times every day was not documented as given on at 09:00am
- , 0.5mg tablets take one tablet by twice daily was not documented as given on at 08:00am
- 550mg tablets take one tablet by twice every day was not documented as given on & at 09:00am

During an interview with the Regional Director and the Administrator, conducted on at 03:20pm, both the Regional Director and the Administrator agreed that Resident #1, #2, #6, #7, and #9's MORs did not include documentation each time the residents were offered meds for the aforementioned meds with the described dates and times. The Regional Director agreed that Resident #7 and #8's

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MORs were missing required data.

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 and ensure that medications were filled, or refilled, in a timely fashion for five Residents (#1, #2, #7, #9, and #10) of eight sampled residents that require assistance with self-administration of medications.

Finding Included:

During an observation of the medication pass with Staff A for Resident #1, conducted on at 09:52am, Staff A observed providing Resident #1 with the residents prescribed 09:00am medications, which included:
- 10mg
- 10mg
- 1mg
- 10mg
- 25mg
- 100mg
- ER 75mg
- 50mg
- 0.5mg
- D-3 2000units
- 500mg

Resident #1 had two prescribed medications due at 08:00am that Staff A did not provide to the resident which included, Packet 4grams to mix with six ounces of water and drink by twice every day and Muprocin 2% Cream to apply to the right lower twice a day.

During a review of Resident #2's Medication Observation Records (MORs), conducted on , revealed that Resident #2 had the prescribed medication 0.5mg tablets to take a half a tablet by every day circled as not given to the resident due to the medication was not available.

During an observation of the medication pass with Staff A for Resident #7, conducted on at 09:57am, Staff A did not offer Resident #7 the resident's prescribed medication 10mg

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and circled the medication on the resident's MORs as not available. Resident #7's , MORs had the medication circled as not given from through due to the medication was not available. Staff A stated that, "this hasn't been available.

A review of Resident #9's , MORs, conducted on , revealed that Resident had two prescribed medications circled as not given due to the medication was not available which included the residents , 0.5mg and 550mg.

During an observation of the medication pass with Staff A for Resident #10, conducted on at 10:05am, Staff observed that Resident #10 was not in the dining room and stated that the resident "might be in her bed". Staff A went on to assist Resident #8 with medications without seeking for Resident #10. At 10:15am, after Staff A assisted Resident #8 with medications, the staff parked the medication cart and began cleaning up for the medication pass. Staff A responded "I'm done with the med (medication) pass" when Surveyor asked. Staff A did not provide Resident #10 with the resident prescribed medications 500mg, 100mg, and 20 MEQ. A review of Resident #7's MORs revealed that these medications were not documented as given.

During an interview with the Regional Director, conducted on at 11:40am, the Regional Director agreed that the Staff A did not follow proper assistance with self-administration of medication when the Surveyor described that Staff A did not provide medication to Resident #1 or #10. At 03:20pm, the Administrator was unable to provide evidence that the Facility attempted to obtain missing medications for Residents #2, #7, or #9. The Administrator was unable to provide evidence that the Facility notified Resident #2, #7, or #9's Primary Health Care Providers or Responsible Parties that the residents were not receiving the aforementioned medications as ordered.
Class III

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

Based on record review, observation, and interview the facility failed to ensure documented class III deficiencies regarding medicinal drugs were corrected as required.

Findings Included:

During a Revisit to 03/11/19 Complaint Investigation (Complaint Number: 2019000768 and 2019000383), a Revisit to 03/11/19 Re-Licensure Survey, and a Complaint Investigation (Complaint Number: 2019004855), conducted at the Facility on 05/03/19, revealed that the Facility continued with uncorrected and recited Class III medication deficiencies.

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During the Exit Conference with the Regional Director, conducted on . . . . . at 003:30pm, the Regional Director verbalized understanding of the requirement to obtain the Facility must employ or contract with consultant services of a licensed Pharmacist or a licensed Registered Nurse. The consultant services at a minimum provide for onsite quarterly consultation until the Inspection Team from the Agency determines that such consultation services are no longer required and stated that , "we will contact them today".
Class III