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0000 - Initial Comments

Assisted Living

A second Revisit to 01/25/19 Complaint Investigation (Complaint Number: 2018017737) was conducted at Savannah Court of Lakeland Assisted Living Facility on 05/13/19. Deficiencies were identified at the time of survey.

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

Based on observation, record review, and interview, the Facility failed to ensure proper assistance with self-administration of medications according to the required steps in 429.256 Florida Statutes and failed to follow control standards for two Residents (#1 and #2) of two-sampled resident that required assistance with self-administration of medications.

Findings Included:

During a medication pass observation with Staff A, an unlicensed Medication Technician for Resident #1, conducted on at 10:15am, Staff A signed Resident #1's medications(meds) as given before the staff offered the meds to the resident. Staff A did not identify Resident #1 when the staff offered the resident the resident's prescribed meds, which included 10 milligrams (mg), 75mg, 125mg, Macu Health tablets, and 1000 micrograms (mcg). Staff A did not offer Resident #1's prescribed meds 325mg or laprat- 0.5mg-3 (2.5mg)/3milliliters (ML) Inhalant Solution to the resident. Staff A gave Resident #1 meds ordered for 07:00am and 08:00am at 10:15am, which was outside of the hour before and an hour after the med order as standard in med pass practice. Staff A did not read Resident #1's med labels to the resident when the staff gave the resident the meds.

During a med pass observation with Staff A, an unlicensed Medication Technician for Resident #2, conducted on at 10:15am, Staff A signed Resident #2's meds as given before the staff offered the meds to the resident. Staff placed Resident #2's med cards on Resident #2's recliner chair where the residents sits. Staff A did read Resident #2's med labels to the resident when offering the resident the resident's prescribed medications, which included 1000mcg, Fish Oil capsule, Tamulosin 0.4mg, 25mg, 20mg, 325mg, Acidophilus capsule, 10mg, 75mg, tablet, 100mg, and . Resident #2's meds were due to be given at 08:00am and Staff A offered the resident the meds at 10:25am, which was outside of the hour before and an hour after the med order as standard in

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med pass practice. When giving Resident #2 the prescribed , Staff A popped out one pill versus two as the med label stated. Staff A placed Resident #2's med packs in the central storage med cart.

During an interview with Staff A, an unlicensed Medication Technician, conducted on at 10:30am, Staff A stated, "Oh, it says two" when the Surveyor questioned the reason that the staff gave one , versus two pills as the med order stated for Resident #2. Staff A stated that the staff had three residents that still needed their 08:00am meds.

A review of the med cart audit performed by the Pharmacist Quality Assurance Registered Nurse (PQARN), conducted on , revealed the PQARN noted on the report dated that the Facility had "numerous med errors [and the unlicensed staff were] breaking non-scored pills in half".

During an interview with the Regional Director and the Resident Care Coordinator, conducted on at 01:15pm, the Regional Director agreed that it was required that unlicensed Medication Technicians identify the resident, read resident med labels to them, and give the ordered dose when assisting with self-administration of meds. The Regional Director and the Resident Care Coordinator both agreed that the standard of med pass practice was to give residents their meds up to an one hour before and one hour after a med was scheduled. The Resident Care Coordinator stated that it "is a big control issue" to place med packs where a resident sits and then put the meds into the central storage med cart.

Class III

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

Based on record review and interview, the Facility failed to ensure that Medication Observation Records (MORs) were free from errors, immediately updated each time medications (meds) were offered to residents and maintained with all required data for six Residents (#2, #3, #7, #11, #12, and #13) of six sampled residents who required assistance with self-administration of meds.

Findings Included:

A review of , MORs for Resident #2's, conducted on , revealed that Resident #2's prescribed meds were not documented as given or offered to the resident each time the meds were due which included:
- , 10 milligrams (mg) was not documented as given or offered to the resident

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on
- D3 50,000 units was not documented as given or offered to the resident from through .
- 20mg was not documented as given or offered to the resident on , , and at 08:00pm (See Photographic Evidence 2).

A review of MORs for Resident #3, conducted on , revealed that Resident #3's prescribed meds 80mg and inhaler were not documented as given or offered to the resident on at 08:00pm (See Photographic Evidence 2). The second page of Resident #3's MORs did not include Resident #3's Health Care Provider's name and telephone number and the resident's as required.

A review of , , and MORs for Resident #7, conducted on , revealed that Resident #7's MORs had meds not documented as given or offered to the resident which included:
MORs
- 500mg was not documented as given or offered to the resident from through , and at 02:00pm and at 08:00pm
- 1gram was not documented as given or offered to the resident on at 08:00pm
- -S tablets was not documented as given or offered to the resident on at 08:00pm
(See Photographic Evidence6).
MORs
- 25mg tablets take one tablet by twice every day for , - not documented as given or offered to the resident on and at 08:00pm
- Sevelamar 800mg tablets take one tablet by twice every day - not documented as given or offered to the resident on and at 08:00pm and circled as not available on and at 08:00am and from at 08:00am through at 08:00am
- 500mg Chew tablets take three tablets by three times every day - not documented as given or offered to the resident on and at 02:00pm (See Photographic Evidence 5)
MORs
- -S was not documented as given or offered to the resident on at 08:00pm.
Resident #7's prescription 250mg started on for three months and should have been discontinued on and the med continued on the MORs as a scheduled med (See Photographic Evidence2).

A review of MORs for Resident #11, conducted on , revealed that Resident #11's prescribed med 25mg was not documented as given or offered to the resident from through at 08:00am and 04:00pm (See Photographic Evidence2).

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A review of , MORs for Resident #12's, conducted on , revealed that Resident #12's prescribed meds were not documented as given or offered to the resident each time the meds were due which included:
- , 81mg was not documented as given or offered to the resident on at 08:00am (See Photographic Evidnece2)
- 5mg was not documented as given or offered to the resident on , , , , and at 08:00pm and the prn (as needed) was marked out with a pen and scheduled as 08:00pm every day. There was no order found in Resident #12's record to change the med to a scheduled med
- , Succ ER 25mg was not documented as given or offered to the resident on and at 08:00am
- Sustained Release 20 milliequivalents was not documented as given or offered to the resident on through and through at 08:00am (See Photographic Evidence 3).

A review of , MORs for Resident #13, conducted on , revealed that Resident #13's prescribed meds were not documented as given or offered to the resident each time the meds were due which included:
- 20mg was not documented as given or offered to the resident from at 08:00am through at 08:00am and at 08:00pm through at 08:00am
- , 300mg was not documented as given or offered to the resident from at 08:00am through at 08:00am and at 08:00pm through at 08:00am
- 40mg was not documented as given or offered to the resident from through at 08:00pm and through at 08:00pm
- , 20mg was documented as given or offered to the resident from through at 08:00am and through at 08:00am
- , 40mg was not documented as given or offered to the resident from through at 08:00am and through at 08:00am
- 1000mg was not documented as given or offered to the resident from at 08:00am through at 08:00am and at 08:00pm through at 08:00am
- 50mg was not documented as given or offered to the resident from through at 08:00pm and through at 08:00pm
- Bypureonbise 2mg injection once every week was not documented as given or offered to the resident on any date from through
- Daily was not documented as given or offered to the resident from through , , and through at 08:00am

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- 10mg was not documented as given or offered to the resident from through and through at 08:00pm (See Photographic Evidence4).

A review of the med cart audit performed by the Pharmacist Quality Assurance Registered Nurse (PQARN), conducted on , revealed the PQARN noted on a report dated the unlicensed Medication Technicians did not have the "MORs for the month of , on [the med] cart, med assistants are using MORs for assisting with meds, and NO DOCUMENTATION is being done today" (See Photographic Evidence7).

During an interview with the Regional Director and the Resident Care Coordinator, conducted on at 01:15pm, the Regional Director and the Resident Care Coordinator agreed that unlicensed Medication Technicians were not documenting on the MORs as required each time meds were given or offered to residents. The RD agreed that each page of resident MORs were required to include residents', Health Care Provider's names, telephone numbers, and the residents'

Class III

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

Based on observation, record review, and interview, the Facility failed to:

(1) Provide medications as ordered; and,
(2) Fill or refill medications for residents that required assistance with self-administration of medications.

These failures placed nineteen residents of twenty-five in-house residents at risk for of medical side effects such as increased signs and symptoms including but not limited to:
- (high) which could lead to a , or silent (www.helloheart.com)
- (high levels) which could become severe and lead to serious complications such as a or and long term effects of the , and (www.drugs.com)
- (low hormone levels) which could lead to long term effects of Hashimoto's Greaves' irregularities, / / , and increased size (www.verywellhealth.com)
- Increased risk of due to not receiving prescribed meds
- Increased risk of reoccurrence due to not receiving prescribed

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Findings Included:

During an observation of the medication (med) pass with Staff A (an unlicensed Medication Technician) for Resident #1, conducted on , Staff A provided assistance with the resident's prescribed 07:00am and 08:00am meds at 10:15am. The meds included Resident #1's , 125micrograms (mcg) (due at 07:00am), ( ) 10millagrams (mg), , 75mg, Macu-Health tablets, and 1000mcg (all due at 8:00am, other than the).
Resident #1's next scheduled dose of was at 12:00pm. Staff A did not provide Resident #1's prescribed med 325mg as it was not available to offer to the resident. Staff A did not provide or offer Resident #1's prescribed med , - 0.5mg-3 (2.5mg)/3 milliliters (ml) Inhalant Solution and circled the med and documented it as refused by the resident on the resident's Medication Observation Records (MORs). The , - 0.5mg-3 (2.5mg)/3ML Inhalant Solution was circled as not given due to the resident's refusals from through .
Resident #1's , order changed for 125mcg to 137mcg on .

During an observation of the med pass with Staff A (an unlicensed Medication Technician) for Resident #2, conducted on , Staff A provided assistance with the resident's prescribed 08:00am meds at 10:25am. The meds included Resident #1's 1000mcg, Fish Oil capsules, Tamulosin 0.4mg, 25mg, 20mg, , 325mg, Acidophilus capsules, 10mg, , 75mg, Daily tablets, 100mg tablets, and , 10mg. Staff A offered Resident #2 , 325mg one tablet versus the two tablets that were ordered.

During an interview with Staff A (an unlicensed Medication Technician), conducted on at 10:30am, Staff A stated, "Oh, it says two" when questioned why the staff only gave one pill of the , to Resident #2 versus two pills of the med. Staff A then stated that at that time, there were three residents remaining to receive their 08:00am meds.

A review of the , MORs for Residents #2, #3, #6, #7, #8 and #12, conducted on , revealed that the residents had meds circled as not available on their MORs (See Photographic Evidence 2 through 6).
- Resident #2 had prescribed meds circled as not given. The reason given on the of the MORs for dates and times that the meds were not given stated "Code 2" and Code 2 indicated that the med was not available according to the Code index. Each date and time circled did not include a reason that the meds were not given on the of Resident #2's MORs, which included:
o Fish Oil 1000mg circled as not available from through at 08:00am
o 20mg circled as not available from through at 08:00pm

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- Resident #3 had the prescribed med CL 20mg circled as not available from through at 08:00am. The reason given on the of the MORs for some of the dates and times that the med was not given stated "Code 2" and Code 2 indicated that the med was not available according to the Code index. Not all dates and times circled did not include a reason that the med was not given on the of Resident #3's MORs.

- Resident #6 had the prescribed med Sevelamar 800mg circled as not available or 'Code 2' from at 08:00am through at 08:00am. The reason given on the of the MORs for some dates and times that the meds were not given stated "Code 2" and Code 2 indicated that the med was not available according to the Code index. Each date and time circled did not include a reason that the meds were not given on the of Resident #6's MORs.

- Resident #7 had prescribed meds circled as not given. The reason given on the of the MORs for some dates and times that the meds were not given stated "Code 2" and Code 2 indicated that the med was not available according to the Code index. Each date and time circled did not include a reason that the meds were not given on the of Resident #7's MORs, which included:
o 24-hour Extended Release 120mg circled as not available from through at 08:00am
o 250mg capsules take one capsule by every day for three months and was circled as not available from through . The started on and should have ended on . Resident #7 missed seven does of the med in . A further review of Resident #7's MORs revealed that on and the med was circled as not give to Resident #7. A further review of Resident #7's MORs revealed that the resident received the as ordered. A further review of Resident #7's MORs revealed that the was circled as not available from through . Resident #7 missed twenty-five doses of the prescribed in . Resident #7's prescribed med Centrum Silver tablets was also circled as not available from through .

- Resident #8 had the prescribed med Centrum Silver tablets circled as not given from through and the med was not in the med cart. The reason given on the of the MORs for some dates and times that the med was not given stated "Code 2" and Code 2 indicated that the med was not available according to the Code index. Each date and time circled did not include a reason that the med was not given on the of Resident #8's MORs.

- Resident #12 had prescribed meds circled as not given. The reason given on the of the MORs for some dates and times that the meds were not given stated "Code 2" and Code 2 indicated that the

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meds were not available according to the Code index. Each date and time circled did not include a reason that the med was not given on the of Resident #12's MORs, which included:
o Fish Oil 1000mg circled as not available from through at 08:00am
o D3 1000 unit circled as not available from through
o Refresh Tears 0.5% , , circled as not available from through

- Resident #12 had the prescribed med changed from prn (as needed) to a scheduled time for every night at 08:00pm on . Resident #12 did not have an order from the resident's Health Care Provider to make the change.

A review of a med cart audit performed by the Facility's Pharmacy Registered Nurse on , conducted on , revealed that Residents #1, #2, #3, #4, #7, #8, #11, #12, #14, #15, #16, #17, #18, #19, #20, #21, #22, and #23 were out of prescribed medications on the day of the audit (See Photographic Evidence).

- Resident #1 was missing the prescribed meds 325mg, Macu-Health, , 137mcg, ProAir Inhaler, and 50mg. Resident #1's , 137mcg and Macu-Health continued as not available through .

- Resident #2 was missing the prescribed meds tablets and 10milliequivalent.

- Resident #4 was missing the prescribed meds 0.4mg, , 81mg, and Gel.

- Resident #7 was missing the prescribed meds Extended Release 120mg, , 20mg, , 40mg, and (,) 250mg. Resident #7's continued as not available through .

- Resident #8 was missing the prescribed med , 50mg and the residents 25mg dose remained in the med cart.

- Resident #11 was missing the prescribed meds 25mg and .

- Resident #12 was missing the prescribed meds Fish Oil 1000mg, Refresh Tear , , , and D3 1000 units. Resident #12's Fish Oil, Refresh Tears, and D3 continued as not available through .

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- Resident #14 was missing the prescribed meds 10mg, Zytenz, D3 50,000 units, and 1.5mg.

- Resident #15 was missing the prescribed meds 50mg and .

- Resident #16 was missing the prescribed meds 325mg, 0.5mg, 0.25mg, and / 5/325mg.

- Resident #17 was missing the prescribed med Patch 25mcg.

- Resident #18 was missing the prescribed meds Extended Release 600mg and .

- Resident #19 was missing the prescribed med Dorzol/ .

- Resident #20 was missing the prescribed meds 40mg, 50mg, 10mg, and SM .

- Resident #21 was missing the prescribed meds 100mg, D3 50,000 units, Buproprion 100mg, Olanzipine 10mg, and Performist Inhaler.

- Resident #22 was missing the prescribed meds Cream, 500mg, Flex Touch , and Flex .

- Resident #23 was missing the prescribed meds 5mg and .

There was no documented evidence provided that residents', Health Care Providers or Responsible Parties were notified of any of the missing medication.

The Facility's Pharmacy Registered Nurse noted in her audit that the Facility had multiple medication issues, which included: loose pills in both the 100 & 200 hall med carts; internal and external meds stored together in both the 100 & 200 hall med carts; "numerous med errors"; MORs not on [the med] cart [and unlicensed Medication Technicians] using MORs [and] "no documentation being done"; and, [unlicensed Medication Technicians] breaking non-scored pill in half.

During an interview with the Regional Director (RD) and the Resident Care Coordinator (RCC), conducted on at 01:15pm, the RCC stated, "that's what they (referring to unlicensed Medication Technicians) do" (referring to issues/concerns with meds not available and not documented

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as given). The RCC indicated that the RCC was working with the Medication Technicians to inform the RCC when meds were missing. The RD and RCC both agreed that the med pass went outside of the standard of practice window of one hour before and one hour after a med is due. The RD stated that, "I would have to say no" when questioned whether residents' Health Care Providers and Responsible Parties were notified that the residents were not receiving their meds.

Class III

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

Based on observation, record review, and interview, the Facility failed to ensure documented class III deficiencies regarding assisting with self-administration, medication records, and medication labeling and orders were corrected as required. Additionally, the Facility failed to employ or contract with the consultant services of a Pharmacist or Registered Nurse as previously required for medication deficiencies.

Findings Included:

The facility failed to correct medication deficient practices which required the facilty to employ or contract with the consultant services of a licensed Pharmacist or a licensed Registered Nurse. During a second revisit, conducted on , revealed that the Facility failed to employ or contract with a licensed Pharmacist or licensed Registered Nurse as required; and, failed to correct Class III medication deficiencies. The Facility provided no evidence of staffing education, the employment or contract with a Pharmacist or Registered Nurse, or the consultant services assessments, plan, and recommendations to remedy the medication deficient practice. On , the Facility had their Pharmacy send a Registered Nurse Consultant to audit the medication carts which was already a provision under their current Pharmacy Contract.

During the medication pass observation with Staff A (an unlicensed Medication Technician) for Residents #1 and #2, conducted on , Staff A failed to provide Resident #1 with two prescribed medication and gave Resident #2 an incorrect dose of one of the resident's medications. Staff A failed to identify Resident #1. Staff A signed medications out as given before offering Resident #1 and #2 their medications. Staff A signed one of the medications that was not offered to Resident #1 as the resident refused. Staff A gave both Resident #1 and #2 their medications outside of the one hour before and one hour after the medication-scheduled timeframe according to the standard in practice. Staff A did not read Residents #1 and #2's medication labels to the residents. Staff A did not follow control standards when the staff place Resident #2's medication pill packs in the residents recliner chair where

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the resident sits and then placed the medication pill packs in the central storage medication cart.

During a review of Medication Observation Records (MORs) and the Facility's Pharmacy Registered Nurse medication cart audit for Residents #2, #3, #7, #11, #12, and #13, conducted on , revealed that unlicensed Medication Technicians were not immediately updating the residents or documenting that medications were given or offered to residents as required. The MORs were not maintained with all required data such as Health Care Provider's name, telephone number and resident's . The Facility failed to fill or refill medications for 18 (Residents #1, #2, #3, #4, #7, #8, #11, #12, #14, #15, #16, #17, #18, #19, #20, #21, #22, and #23) of twenty-five (25) in-house residents, which placed the residents at risk for exacerbation (or) of medical side effects such as increased signs and symptoms which included (but not limited to):

- (high ,) which could lead to a , , or silent (www.helloheart.com)
- (high levels) which could become severe and lead to serious complications such as a or and long term effects of the , , , , and (www.drugs.com)
- (low hormone levels) which could lead to long term effects of Hashimoto's Greaves' , , irregularities, , , , , , , / / , and increased size (www.verywellhealth.com)
- Increased risk of , due to not receiving prescribed , meds
- Increased risk of reoccurrence due to not receiving prescribed

The Facility's Pharmacy Registered Nurse noted that the Facility had multiple medication issues, which included: loose pills in both the 100 & 200 hall med carts; internal and external meds stored together in both the 100 & 200 hall med carts; "numerous med errors"; , MORs not on [the med] cart [and unlicensed Medication Technicians] using MORs [and] no documentation being done"; and, [unlicensed Medication Technicians] breaking non-scored pill in half (See Photographic Evidences 2 through 7).

During an interview with the Regional Director (RD) and the Resident Care Coordinator (RCC), conducted on at 01:15pm, the RD was unable to provide evidence of employment or contract with a licensed Pharmacist or licensed Registered Nurse Consultant. The RD and the RCC agreed that it was required that unlicensed Medication Technicians identify the resident, read resident medication labels to them, and give the ordered dose when assisting with self-administration of medications. The RD and the RCC both agreed that the standard of medication pass practice was to give residents their medications up to one hour before and one hour after a medication was scheduled. The RCC stated that

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

it "is a big control issue" to place medication pill packs where a resident sits and then put the medication pill packs into the central storage med cart. The RD and the RCC agreed that unlicensed Medication Technicians were not documenting on the MORs as required each time medications were given or offered to residents. The RD agreed that each page of resident MORs were required to include residents', Health Care Provider's names, telephone numbers, and the residents' . The RCC stated, "That's what they (referring to unlicensed Medication Technicians) do (referring to issues/concerns with medications not available and not documented as given)". The RCC indicated that the RCC was working with the Medication Technicians to inform the RCC when medications were missing. The RD and RCC both agreed that the medication pass went outside of the standard of practice window of one hour before and one after hour, a medication was due. The RD stated that, "I would have to say no" when questioned whether residents' Health Care Providers and Responsible Parties were notified that the residents were not receiving their medications. There was no documented evidence provided that residents' Health Care Providers or Responsible Parties were notified.

Due to uncorrected medication deficiencies as well as a medication deficiency cited at a Class II (direct threat to residents), the facility is required to have a registered nurse or pharmacist as a consultant.

Class III