STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943102	R 12/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH COURT OF THE PALM BEA	**2090 N. CONGRESS AVENUE WEST PALM BEACH, FL 33401**

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

0000 - Initial Comments

An unannounced Revisit survey to complaint investigation, CCR #2018014564, was conducted on 12/18/18 at Savannah Court Of The Palm Beaches, License #8367. The facility had an uncorrected deficiency identified at the time of the survey.

This survey was conducted in conjunction with licensure complaint (CCR#2018017697, CCR#2018016968 & CCR#2018016656) on the same date . See separate report for findings.

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

Based on record review and interviews, the facility failed to accurately complete the Medication Observation Record (MOR) at the time the medications were to be given, for 3 out of 3 sampled residents (Residents #1, #2 and #3).

The findings included:

1. On at 10:00 AM, the current MOR for Resident #1 was reviewed. The MOR had the following omissions and errors identified:

a. / mg, 1 capsule to be given daily was documented as provided from through . Review of the medication bottles showed the resident was receiving 1 capsule daily of 10 mg and 1 capsule daily of 20 mg (2 capsules/tablets total daily). During interview with the Resident Care Director (RCD) at 11:00 AM on , she confirmed that the current MOR did not have two separate entries for the two separate pills that were to be provided to the resident, and that the documentation of the "one capsule" given daily was incorrect.

b. Iron dietary supplement was located in the resident's current medications. Review of the current MOR showed the medication was not listed. There was no documentation to show that the resident received the medication from through . Review of the previous MOR for and showed that the resident was provided the medication listed as " ", one tablet daily. The RCD stated that the nurse who transcribed the previous MOR to the current MOR had not added this medication.

c. .1 mg, to be given as needed (PRN), was documented as given once in . The facility's supply of the medication included 399 pills according to interview with the RCD on at

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12:00 PM. During interview with a pharmacy representative on at 3:00 PM, she stated that they had distributed 600 pills to the facility since , and that they do not accept returned medication. There was no documentation to show that the resident received 200 pills that were allegedly missing out of the resident's supply, or that they had been discarded. The RCD stated on at 12:00 PM that it is not known where the extra pills that were allegedly dispensed from the pharmacy are as she was not employed by the facility at that time.

2. On at 11:00 AM, the current MOR for Resident #2 was reviewed. The MOR had the following omissions and errors identified:

a. All morning medications scheduled to be given at 9:00 AM were not yet documented as given. During interview with Staff B at 11:00 AM on , she stated that the resident was out of the building and would take her medication when she returned. It was discussed that the medication could not be documented (initialed by staff) as given at 9:00 AM when the resident does not receive the medication at that time, and that the resident's health care provider would need to be notified if the resident was going to take the medication later than the 2 hour window around 9:00 AM. The following medications were not initialed as given at 9:00 AM on :

1.
2.
3.
4.
5.
6.
7.
8.
9. Sevelamer Powder
10. D3

b. All morning medications on the second page of the MOR, scheduled to be given at 9:00 AM on , were not documented as given. The following medications were not initialed as given:

1.
2.
3.
4.
5. Sevelamer Powder

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c. [redacted] 100 mg was not initialed as given on [redacted] and [redacted] at 9:00 PM.

d. [redacted] 20 mg was not initaled as given on [redacted] at 7:00 AM.

e. The MOR was blank for Sensipar 30 mg on [redacted] at 9:00 AM. The medication was not available, and was not initialed with a circle around the staff member's initials to indicate this.

f. D3 2000 units was not initaled as given on at 9:00 AM.

3. On at 11:00 AM, the current MOR for Resident #3 was reviewed. The MOR had the following omissions and errors identified:

a. [redacted] 25 mg, [redacted] 100 mg, [redacted] 25 mg and Thera-M [redacted] were not initaled as given on at 9:00 AM.

These findings were discussed with the RCC at 2:00 PM on . The facility provided no additional information for review at the time of the survey.

This is an uncorrected deficiency from the survey conducted on [redacted].

Class III

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

Based on the findings of an uncorrected deficiency related to medication, documented under A54 in this report, the facility is required to employ the consultant services of a licensed pharmacist or a licensed registered nurse to provide onsite quarterly consultation until the Agency determines that such consultation services are no longer required.

The findings included:

Any assisted living facility in which the agency has documented an uncorrected class III deficiency regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, F.S. (Florida Statutes), be required to employ the consultant services of a licensed pharmacist or a licensed

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registered nurse. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required.

A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening.

After developing and implementing a corrective action plan in compliance with Section 429.42(2), F.S., the initial on-site consultant visit must take place within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license of the consultant pharmacist or registered nurse and the consultant's signed and dated review of the corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit.

The facility must provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff have been trained to ensure that proper medication standards are followed and that such consultant services are no longer required. The agency must provide the facility with written notification of such determination.

Based on the findings of the uncorrected class III deficiency (cross reference A54 on this report), the facility must adhere to the above action plan. The Administrator was notified of the general requirements above during interview on at 10:00 AM.

Class III