Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932659	A. BUILDING: _____ B. WING _____	03/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODMONT A PACIFICA SENIOR LIVING COMMUNIT	3207 NORTH MONROE STREET TALLAHASSEE, FL 32303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced complaint investigation (complaint numbers and 2021017174, 2022001954, and 2022002247) was conducted at Woodmont A Pacifica Senior Living Community on -22, 2022. Revisits to the licensure survey and two complaint surveys were conducted in conjunction. The facility had deficiencies at the time of the survey.	A 000		
A 053 SS=E	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record. (c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including . . . . g . . . . . testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Chapter 483, Part I, F.S. A valid copy of the federal CLIA Certificate must be maintained in the facility. A federal CLIA certificate is not required if residents perform the test themselves or if a third party assists	A 053		

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A 053	Continued From page 1	A 053		

residents in performing the test. The facility is not required to maintain a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the federal CLIA Certificate is available from the Laboratory and In-Home Services Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500.

This Statute or Rule is not met as evidenced by:
Based on interview and record review, the facility failed to ensure administration was provided and levels were obtained as ordered for 2 of 2 sampled residents (#3 and #4).

The findings include:

Resident #3

A review of the Medication Administration Record (MAR) for revealed Resident #3 had orders for 100 unit/ml-SOL inject 5 units (SQ) 3 times daily taken with meal. The MAR revealed the ordered was not given on at 11:30 AM, at 5:00 PM, (all 3 doses), at 8:00 AM and 11:30 AM, at 5:00 PM, at 11:30 AM, and and 20th at 5:00 PM. Further review of the MAR for revealed Resident #3 also had orders for -100 units/ml-pen 40 units SQ at 8:00 AM. The MAR indicated the ordered was not given on and 6th. Additional review of the MAR for revealed Resident #3 had orders for (level) 3 times per day since . The MAR revealed the

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A 053	Continued From page 2 were not performed on . . . . . at 11:30 AM, ... at 5:30 AM, ... , 9th, and 10th at 5:30 AM, ... at 5:30 AM, ... at 5:30 AM, ... and 17th at 5:30 AM, and . . . . . at 8:00 PM. Resident #4 A review of the MAR for . . . . . revealed Resident #4 had orders for . . . . . 100 unit/ml-Pen 26 units SQ once per day. A review of the . . . . . MAR revealed no . . . . . was provided on . . . . . , 6th, 11th and 20th. A review of the MAR revealed orders for . . . . . levels to be obtained twice daily at 6:00 AM and 4:00 PM. The MAR revealed no . . . . . levels were obtained on . . . . . at 4:00 PM, ... and 20th at 4:00 PM. The corresponding MAR notes reflected the . . . . . level on . . . . . was "too high to read," however there were no notes to support what the facility staff did as a result of that reading. On . . . . . at approximately 2:00 PM, an interview was conducted with the Director of Nursing (DON). She was provided the . . . . . MARs for residents #3 and #4 and asked about the missing doses of . . . . . and . . . . . level checks. She indicated if the medications are not given or other exceptions, there should be notations in the resident's record. The DON provided a Med Pass Exception report for residents #3 and #4 which reflected a few exceptions noted, however there were no notes under the section "result notes." The DON indicated there should be some notes to reflect the details of exceptions. On . . . . . at approximately 3:00 PM, an	A 053		

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A 053	Continued From page 3 interview was conducted with the Facility Administrator. She was shown the MARs for residents #3 and #4 and asked about the missing and level checks. She stated, "We should have caught that and if the resident refuses or something else like level is too high, we should have narrative notes." Class III	A 053		