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 _____	08/10/2022

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 number 2022011522) was conducted at Woodmont A Pacifica Senior Living Center on [redacted]. The facility had deficiencies at the time of the survey.	A 000		
A 165	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. [redacted]; 2. or , damage; 3. Permanent [redacted]; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or	A 165		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 165	Continued From page 1 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to	A 165		

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A 165	Continued From page 2 disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to conduct a thorough investigation for 3 of 4 residents reviewed, one resident after ingesting a cleaning chemical (Resident #4) and two residents requiring increased levels of acute care following in the facility (Residents # 1 and 3) to identify possible factors leading to the incidents and failed to develop and implement action plans to reduce the likelihood of reoccurrence of such incidents. The facility failed to submit to complete adverse incident reports or report these incidents to the state agency with the facility's results of the investigations within 15 days of the incidents regarding the chemical ingestion or with injury for 2 of 4 individuals reviewed (Residents #1 and #4). The findings include:	A 165		

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A 165	Continued From page 3 On . . . . . at 1:15 pm, an interview was initiated with the Executive Director (ED) concerning an incident that occurred on . . . involving Resident #4. During the interview the ED stated that on . . . . . , after lunch, staff was wiping down the tables in the dining area. The staff who was there had stepped into the kitchen area (in the locked unit) for a moment but left a bottle of cleaner on the table. When the staff returned, Resident #4 had gotten up from his chair and had the bottle in his . . . No one could actually say they saw him swallow any of the cleaner. The agency contacted his Hospice nurse who stated if there were no symptoms then just observe and call . . . if any symptoms observed. Two hours later, Resident #4 and the decision was made by the Hospice nurse to send him to the hospital just to be safe. He stayed there two days and it was decided due to his general rapidly degenerating condition to admit Resident #4 into the Hospice inpatient unit, where he remained as of the time of the investigation. She also revealed that Resident #1, had lived in the facility's Assisted Living wing and had never been housed in the memory care unit. Because of her level of independence, per her contract she was only checked on when it was time for activities or if she used her call pendant. When Resident #1 was found on the floor on from an overnight . , . . . services were immediately contacted and she was transported to the Emergency Room. She was stabilized but due to the amount of rehab she would need, she would be transferred to a nursing home. She remained in the nursing home at the time of the investigation. When asked about any investigations concerning Residents #1 or #4, the ED stated that she did	A 165		

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A 165	Continued From page 4	A 165		

not personally complete any investigations for these incidents. The ED stated that when the chemical ingestion incident occurred for Resident #4, local law enforcement arrived with Emergency Medical Services ( ) to investigate the details of what occurred. She stated that the law enforcement agents asked questions of everyone but did not file a formal report. The director stated she did not believe she needed to do any investigations since the officer had already done one.

A review of records for Resident #1 indicated she resided in the general Assisted Living area of the building during her entire stay. Her form 1823 states that she was independent in all activities of daily living (ADL's). Her contract with the facility did not include any routine assistance.

A review of records for Resident #4 indicated he was a resident of the facility's locked Memory Care unit since . His diagnoses included advanced . His form 1823 stated that he required assistance with all ADL's. Records indicated he may attempt to steal other people's food but there was no record of him ever trying to ingest non food related items.

On at 3:45 pm, an interview was conducted with Employee D (a medication technician) Employee D stated, "I usually like to clean up after meals as soon as I can so it's not left out to be done. Usually the kitchen provides lunches on paper plates so it is easy to dispose of, but sometimes they use actual dishes. I had the cleaner out to clean up the dishes as soon as I could. I forgot to get a dish cloth so I stepped into the kitchen and grabbed one and, as soon as I got out, [Resident #4] had the bottle in his turned up. He had some cleaner dripping out of

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A 165	Continued From page 5 his . . . . . I can't say for sure he actually swallowed any. I grabbed the bottle out of his . . . and put it away and let the lead med tech know what happened. I was told to watch him and a little while later he threw up clear, bubbly stuff so I let them know." When asked if he had any discussions with the Executive Director, Employee D stated "The Executive Director talked to me about not leaving chemicals out, but that was it." A review of the record for Resident #3 revealed that the resident had a . with injury leading to the need for higher levels of acute care. Per record reviews, on . . . . . , Resident #3 was walking to their room when they lost grip on their walker. Medical care was called and Resident #3 was sent to the hospital via ambulance. Resident #3 had a , ... and required surgery to repair this issue. An interview with Resident #3's family on . . . . . at 1:45 pm revealed that Resident #3 was transferred to a rehabilitation center and remains there as of the date of the investigation. A review of the AHCA Incident Reporting System on . . . . . at 4:15 pm revealed that no report had been submitted concerning Residents #1 or #4. A report had been filed concerning Resident #3. Additional review of the facility's policy titled "Internal Incident Report and State Incident Report" states, "Adverse Incident Reports are completed per State regulation. An "adverse incident" means ... Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident..." During an interview with the ED on . . . . . at 4:20 pm, the ED stated that the incidents for Residents	A 165		

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A	Continued From page 6 #1 and #4 met the definition of an adverse incident and should have been reported as adverse incidents. Additionally, on ..... at 2:00 pm, the ED was asked for all incident reports the facility filled out within the past six months. A review of these reports revealed that no internal incident reports or other investigations were available for Residents #1, #3, or #4. When the ED was asked about this, she stated that there was no additional incident reports or investigations available. Class III	A 165		