

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963819	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER WOODLANDS VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1055 301 BLVD EAST BRADENTON, FL 34203			
(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 Assisted Living Facility An abbreviated biennial state licensure survey was conducted on The Woodlands Village, assisted living facility, had a deficiency found at the time of the visit.	A 000			
A 054	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed under subsection (2), the facility shall keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider 's name, the resident 's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility shall maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications or medication administration. A MOR must include the name of the resident and any known the resident may have; the name of the resident 's health care provider, the health care provider 's telephone number; the name, strength, and directions for use of each medication; and a chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The MOR must be immediately updated each time the medication is offered or administered. (c) For medications which serve as chemical , the facility shall, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician 's annual evaluation of the use of the	A 054			

AHCA Form 3020-0001

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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If continuation sheet 1 of 2

Agency for Health Care Administration

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A 054	Continued From page 1 medication. This Statute or Rule is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to ensure that a morning medication pass was conducted properly for 1 of 1 clients observed during the medication pass (#4). Findings include: Observation of the medication pass at 11:20 a.m., on _____, revealed the the medication technician signed the Medication Observation Record before she gave Resident #4 her medications. Interview with the Administrator, on _____ at 1:00 p.m., confirmed that the medication technician "knows better than to do that." Class III	A 054			

RICK SCOTT
GOVERNOR



ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Woodlands Village
1055 301 Blvd East
Bradenton, FL 34203

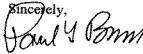
Dear Administrator:

This letter reports the findings of an abbreviated biennial state licensure survey that was conducted on
, 2013, by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiency identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call
Paul Brown, HFES, at 727-552-2000.

Sincerely,

For Patricia Reid Cauffman
Field Office Manager

PRC/kpr

Enclosure: State Form 3020

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