STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932659	02/25/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Woodmont By Encore Senior Livi	3207 North Monroe Street Tallahassee, FL 32303	

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

0000-Initial Comments
An unannounced complaint survey CCR 2014001673 was conducted at Pacifica Woodmont on . Deficiencies were identified at the time of the survey.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation, staff interview and clinical record review the facility failed to ensure residents access to adequate and appropriate health care by failing to provide medications for 2 of 9 residents observed during medication pass observation (#2, 9), and failing to provide medications as ordered for 3 out of 9 residents observed during medication pass observation (#3, 5, 8).

The findings are:

1) During medication pass observation on at approximately 7:30 AM resident #2 had an order to receive Milk of Magnesia 30 cc po (by mouth) daily. The medication was not available for use.

An interview was conducted with LPN (licensed practical nurse) A on at approximately 7:45 AM. She stated the resident #2 had just been out of the medication 1 day. When asked what the procedure was for reordering medication she stated if the medication was a prescription the medication would either be written on the pharmacy reorder form or the medication sticker placed on the form and sent to pharmacy. She stated if the medication was an over the counter medication the nurse would notify the family and document in the communication book. She confirmed there was no documentation that the family had been notified to reorder the over the counter medication.

2) During medication pass observation on at approximately 8:10 AM resident #9 had an order to receive plus D daily. The medication was not available for use.

On at approximately 8:10 AM the med tech B stated the resident #9 was only out of the medication one day but could not confirm the medication had been reordered.

3). During medication pass observation on at approximately 7:30 AM LPN A was observed crushing an 81 mg for resident #3.

A review of the clinical record for resident #3 revealed the resident was to received 81 mg chewable.

An interview with LPN A on at approximately 7:35 Am was conducted. When asked if she was supposed to crush an she stated, "No". She stated the family provided the over the counter medication. She confirmed the order was for 81 mg chewable.

4). During medication pass observation on at approximately 8:00 Am LPN A was observed giving resident #5 D 5000 iu. The medication observation record documented the resident was to receive the medication with food. No food was provided with the medication.

A review of the clinical record for resident #5 revealed an order written on Please start D 5,000 iu each morning with food.

On at approximately 8:05 the LPN A was asked if the resident was to eat breakfast. She stated he never

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eats breakfast only lunch and dinner. The LPN A was asked how she had provided the medication with food. She stated she should have given crackers or used a snack in the residents . She confirmed she had not provided food with the medication.

5.) During medication pass observation on at approximately 8:15 am the med tech provide resident #8 with the medication 75 mcg.

A review of the medication observation revealed the medication was to be administered daily at 6:00 AM.

An interview with the med tech B was conducted on at approximately 8:18 AM. When asked why she had given a medication ordered for 6 AM at 8:15 AM she stated she did not even notice the time ordered and that she had always given the medication at that time because she was not there at 6 AM.

An interview was conducted with the administrator on at approximately 12:30 PM. When asked what the expectations were for the staff to reorder medications, she stated they should notify the family for a non-prescription medication and document family notification or order the prescriptions from pharmacy. She stated this should be done prior to the medication running out. When asked what were the expectation for staff to provide medication as order she stated nurses are to follow the physicians order to the letter.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observation, staff interview and review of the facility policy and procedure on assisting with self-administration of medications, the facility failed to properly assist 3 out of 9 residents (#7,8,9) with self administration of medications.

The findings are:

On at approximately 8:00 AM medication tech B was observed providing medications to residents #7, 8, and 9. For each of the residents she was observed preparing the medications at the medication cart in the hall way. She opened the bottles of medications or pushed the pill from the bubble packs and put the medication into a medication cup. She then took the medication to the residents provided the residents with their medications.

A review of the facility policy and procedure "Assisting residents to take medications" dated revealed: page 16 1) Resident in ALF's (assisted living facilities) can usually self-administer their medications. They should be encouraged to do so. Many residents need or desire some assistance with self -administration. After successfully complete a course for medication assistance staff may assist them within limits. Unlicensed persons may not "administer"medications. Only a licensed nurse or doctor may administer medications. Page 17 1). What does providing assistance with medication include: Taking a properly dispensed and labeled medication from where it is stored and bring it to the resident, reading the label, opening the container and removing the prescribed amount of medication with the resident.

An interview was conducted with the administrator on at approximately 10:30 AM. She stated medication

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were to be provided according to the facility policy and procedure.

Class III

0053-Medication - Administration 58A-5.0185(4) FAC
Based on observation, clinical record review and staff interview, the facility failed to ensure medications were administered as ordered by the physician for 2 out of 9 residents (#3 and 5).

The findings are:

1). During medication pass observation on at approximately 7:30 AM LPN (licensed practical nurse) A was observed crushing an 81 mg for resident #3.

A review of the clinical record for resident #3 revealed the resident was to received 81 mg chewable.

An interview with LPN A on at approximately 7:35 Am was conducted. When asked if she was supposed to crush an she stated, "No". She confirmed the order was for 81 mg chewable.

2). During medication pass observation on at approximately 8:00 am LPN A was observed giving resident #5 D 5000 iu. The medication observation record documented the resident was to receive the medication with food. No food was provided with the medication.

A review of the clinical record for resident #5 reveal an order written on which stated to 'Please start D 5,000 iu each morning with food'.

On at approximately 8:05am LPN A was asked when resident #5 eats breakfast. LPN A stated that resident #5 never eats breakfast, only lunch and dinner. LPN A was asked how she had provided the medication with food. She stated she should have given crackers or used a snack in the resident's . She confirmed she had not provided food with the medication.

An interview was conducted with the administrator on at approximately 12:30 PM. When asked what were the expectation for staff to provide medications as ordered she stated nurses are to follow the physicians order to the letter.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[illegible], 2014

Administrator
Woodmont By Encore Senior Livi
3207 North Monroe Street
Tallahassee, FL 32303

Dear Administrator:

Re: CCR #2014001673

This letter reports the findings of a state licensure complaint survey that was conducted on [illegible], 2014 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after [illegible], 2014 to verify that the necessary corrections are in place to correct the deficiencies 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 me at (850) 412-4540.

Sincerely,

for Donah Heiberg, M.S.W.
Field Office Manager

DH/kb
Enclosure
XG90

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