STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932659	05/02/2014
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)		

Revisit Corrected Tags:
0052-Medication - Assistance With Self-Admin-05/02/2014

Revisit Repeat Tags:
0030-Resident Care - Rights & Facility Procedures-58a-5.0182(6) Fac; 429.28 Fs
0053-Medication - Administration-58a-5.0185(4) Fac

0000-Initial Comments
On 5/2/14 an unannounced revisit survey to CCR 2014001673 was completed in conjunction with two new complaints CCR 2014003769 and CCR 2014003027 and LNS monitoring at Pacifica Senior Living Woodmont. Deficiencies were cited.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation, clinical record review and staff interview the facility failed to ensure residents received adequate and appropriate health care by not providing medications as ordered by the physician for 1 of 22 residents observed for medication pass (#9) and by not providing a licensed staff member available to administer medications according to the physicians order on 6 out of 65 days reviewed for staffing (, , , and).

The findings are:

1) On during the medication administration pass it was also observed the LPN (licensed practical nurse) was providing medication to resident #9 and she did not provide the correct dosage for the medication . The physician's order/MOR (medication observation record) read give 15mg. The medication available was 7.5 mg and the order was to give two. The LPN drew up only one pill for 7.5 mg. This surveyor stopped the LPN prior to administering the medication to confirm the dosage. She confirmed the dosage was 15 mg and she should be giving 2 pills of the 7.5 mg and not just one. She corrected the dosage and administered the proper amount.

2) Staffing was reviewed since last survey on . It was observed from checking the staffing schedules that there were days that a nurse was not available during the times residents would have been required to have sugar checks completed and provided if needed by the results of the glucose testing results.

On Wednesday the facility had no nurse working between the hours of 7:00 AM and 12:53 PM. Reviewing the MOR the residents glucose was checked by the night shift nurse and the nurse who came on duty at 12:53 documented glucose checks (beyond 1 hour after 11:30). No residents glucose levels required at this time.

On Friday , 2014 the facility had no nurse between 9 AM and 11:45 AM. Morning glucose had been checked by the night shift nurse and am also given to residents by the night shift nurse. Resident #33 did not have 8:00 AM documented as given. The nurse at 11:45 was within the time frame for checking the resident's glucose at 11:30 Am.

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On Saturday , 2014 the facility had no nurse between 6 AM and 11:00 AM Resident #33 does not have 8 AM documented and 11:30 glucose is not documented. Resident #34 has no glucose check documented for 11:30 Am. Resident #35 had no glucose check documented for 11:30 AM.

On Friday , 2014 the facility had no nurse between 6:27 AM and 8:44 AM glucose checks done by the night shift nurse and given by the night shift nurse. No residents required in this time frame.

On Saturday , , 2014 the facility had no nurse between 6:00 AM and 3:16. Residents # 1, 33, 35, 36, 37, 38, and 39 did not receive glucose checks at 11: 30 AM. Residents 1, 33, and 37 had sliding scale per the results of the glucose testing.

On Tuesday , 2014 the facility had no nurse between 2:22 PM and 6:00 PM. Residents #33, 36, 39 did not receive 4:00- 4:30 PM glucose testing. Resident #1 did not receive scheduled at 5:00 PM. Resident #36 did not receive scheduled at 4:30 PM. Resident #28 did not receive scheduled at 5:00 PM.

An interview with the administrator on at approximately 3:45 PM. She stated they have made many changes which included hiring the director of nursing who started on . Some of the staff left and some were let go. She could not explain the lack of nursing coverage for the above days in question.

Uncorrected Class III

0053-Medication - Administration 58A-5.0185(4) FAC
Based on observation, clinical record review the facility failed to administer medication as ordered by the physician for 1 of 22 (#9) residents observed for medication observation and the facility failed to have a licensed staff member available to administer medications according to the physicians order on 6 out of 65 days reviewed for staffing (, / , , , and).

The findings are:

1) On during the medication administration pass it was also observed the LPN (licensed practical nurse) was providing medication to resident #9 and she did not provide the correct dosage for the medication . The physician's order/MOR (medication observation record) read give 15 mg. The medication available was 7.5 mg and the order was to give two. The LPN drew up only one pill for 7.5 mg. This surveyor stopped the LPN prior to administering the medication to confirm the dosage. She confirmed the dosage was 15 mg and she should be giving 2 pills of the 7.5 mg and not just one. She corrected the dosage and administered the proper amount.

2) Staffing was reviewed since last survey on . It was observed from checking the staffing schedules that there were days that a nurse was not available during the times residents would have been required to have sugar checks completed and provided if needed by the results of the glucose testing results.

On Wednesday the facility had no nurse working between the hours of 7:00 AM and 12:53 PM. Reviewing the MOR the residents glucose was checked by the night shift nurse and the nurse who came

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SUMMARY STATEMENT OF DEFICIENCIES
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on duty at 12:53 documented glucose checks (beyond 1 hour after 11:30). No residents glucose levels required at this time.

On Friday , 2014 the facility had no nurse between 9 AM and 11:45 AM. Morning glucose had been checked by the night shift nurse and am also given to residents by the night shift nurse. Resident #33 did not have 8:00 AM documented as given. The nurse at 11:45 was within the time frame for checking the resident's glucose at 11:30 Am.

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Uncorrected class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

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

Dear Administrator:

This letter reports the findings of a State Licensure Revisit Survey conducted on May 2, 2014 by representatives of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, and uncorrected deficiencies that were identified on the day of the visit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2014.**

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 surveyors. Should you have any questions please call me at 850-412-4540.

Sincerely,

Patricia M Patterson

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

DH/pm
Enclosure

YOSF

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