

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11964582	(X3) DATE SURVEY COMPLETED 07/29/2014
NAME OF PROVIDER OR SUPPLIER Creekside Senior Village	STREET ADDRESS, CITY, STATE, ZIP CODE 9015 University Parkway Pensacola, FL 32514	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Revisit Repeat Tags:

0052-Medication - Assistance With Self-Admin-58a-5.0185(3) Fac

0000-Initial Comments

A 2nd follow up survey to complaint (CCR#2014003768) was conducted on 7/29/14 in conjunction with an extended congregate care monitoring visit. Deficiencies were found at the time of the survey.

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC

Based on observations, interviews and record reviews the facility failed to ensure unlicensed staff assisting with self-administration of medications followed physicians' prescribed medication orders for 2 of 4 sampled residents observed during medication pass (#2 and #4).

The findings are:

Observation of medication pass on beginning at approximately 7:40AM in Cottage 7 revealed the medication tech, sampled staff A, assisting residents with self-administration of medications. Observation, at approximately 8:00AM, revealed sampled staff A assisting sampled resident #2 with his medications. After identifying the resident's medications to the resident appropriately. Sampled staff A assisted the resident with self-administration of medications which included: Lopressor 50mg one, one, 5mg one, and ER 0.4mg one. The medication tech placed all of the medications into one medication cup and handed it to the resident. The resident took all of the medications orally with a glass of water. Observation of the medication bottle label and the medication observation record revealed the physician ordered the medication should be taken 1/2 hour following the same meal each day. Interview with this medication tech, sampled staff A, at approximately 8:05AM revealed the resident had not eaten breakfast this morning. When asked if the resident should have been taken the since he has not eaten, she stated she should have notified the nurse first to see what needed to be done. She acknowledged that the medication should have been given after he eats. Record review of the physician orders for revealed an order for this resident to take oral capsule, extended release 24 hour 0.4mg capsules take one capsule by oral route once daily 1/2 hour following the same meal each day for 90 days". Interview with the facility director of nurses at approximately 11:25AM confirmed these findings and stated the resident does not usually eat breakfast and stated she will notify the medical provider.

Observation of medication pass on beginning at approximately 8:17AM in Cottage 5 revealed the medication tech, sampled staff C, assisting residents with self-administration of medications. Observation, at approximately 8:17AM, revealed sampled staff C assisting sampled resident #4 with her medications. Observations revealed the staff assisted the resident with 9 oral medications and one medication. The medication was one 2500 mcg. The medication tech assisted the resident with self-administration of all these medications by placing them all in a medication cup, together, and the resident took all the medications orally with a glass of water. The medication tech did not inform the resident the should be taken When the medication tech was asked about the resident taking the medication orally instead of she stated that the nurse told them the resident could take the medications with all the oral medications and did not need to take it it could be swallowed or chewed up. Record

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review of the physician orders for revealed an order for 2500 mcg 1 tablet daily.
Interview with director of nurses at approximately 11:25AM revealed she is aware of the observation and the
medication tech told her she realized she should have reminded the resident to take the medication as
ordered by the physician.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

Mindy Myers, Administrator
Creekside Senior Village
9015 University Parkway
Pensacola, FL 32514

Amended Letter

Dear _____, Myers:

This letter reports the findings of a revisit inspection survey conducted on _____, 2014, by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within two days.

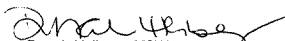
The inspection resulted in findings of non-compliance in the following areas:
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D

As I discussed with you on the phone this morning, the Assisted Living Facility is required to employ the consultant services of a licensed pharmacist or a licensed registered nurse to address ongoing concerns with citations relation to assistance with self administration of medications. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

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

Sincerely,


Donah Heiberg, MSW
Field Office Manager

D7JR

