RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Serenades In The Villages
2450 Parr Drive, The Villages
Lady Lake, FL 32162

Dear Administrator:

This letter reports the findings of a complaint inspection survey (CCR# 2014011002) 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 **ten business days** of receipt of this hand delivered report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= G
St - A - 0163 - 429.49 Fs - Records - Resident, Penalties For Alteration S-S= G

Directed Corrective Actions:

1. The Assisted Living Facility is required toConduct an audit on all medication orders received by phone to ensure the orders are valid and accurately transcribed. Ensure all medication orders are transcribed appropriately on the Medication Observation Record. Documentation of a completed audit and the results must maintain on the premises of the facility for review by the Agency.

2. The Assisted Living Facility is required toDevelop a policy and procedure for monitoring the accuracy of medication orders taken by phone. All staff responsible or who have the possibility of being responsible for taking medication orders by phone, including the staff identified in the survey, must be trained on the policy and procedure. A copy of the policy and procedure must be maintained on file for the Agency's review.

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

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Serenades In The Villages
, 2014

Should you have any questions, please call Jasmine Hayes, Health Facility Evaluator Supervisior, at (386) 462-6238.

Sincerely,

Kristie J. Mennella
Field Office Manager

jjh

7JR

Received by:

Administrator

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Alachua Field Office
14101 N W Hwy 441, Suite 800
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Phone (386) 462-6201; Fax (386) 418-5300

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968578	12/02/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Serenades In The Villages	2450 Parr Drive, The Villages Lady Lake, FL 32162	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= G
St - A - 0163 - 429.49 Fs - Records - Resident, Penalties For Alteration S-S= G

Specific Tag Findings:

0000-Initial Comments
An unannounced Complaint Survey, CCCR #2014011002, was conducted on , at Serenades at The Villages Assisted Living Facility, 2450 Parr Drive, The Villages, FL. Deficient practice was identified at the the time of the survey.

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on interviews and record reviews, the facility failed to ensure that 1 of 5 residents reviewed received medications as ordered by a physician or an Advance Registered Nurse Practitioner (ARNP) (Resident #4).

Findings:

A review of Resident #4 ' s record showed letter, dated addressed to Facility Administrator, signed by ARNP, which stated in part: "As you know, I have found multiple orders written with my signature as well as orders written as telephone orders that I did not give, signed by [the Wellness Director]... I am very concerned about the fact that I have seen three occasions that I know of where medication changes were made. The one that I know of directly is that the order regarding the addition of and change in dosage. [the Wellness Director] texted me asking about an order discussed with a residents family member, and why it wasn't written previously. I texted back stating that I thought I gave a verbal order to the evening nurse after we met with that family member. I didn't give any further orders to change the medication or the dosage over the phone/text. She took it upon herself to lower the dosage. This concerned me, not only because I didn't give the order the way it was written, but also because, she titrated the dosage down too much from what would have been recommended. This caused the resident to have increased outbursts during the transition..."

On Resident #4 ' s medication orders were reviewed. The review revealed an order dated, stating, "Start: Patch 4.6 mg x 2 weeks then recontact MD/ARNP. .25 mg PO phone order " The order was signed by the facility ' s Wellness Director. Continued review of the order revealed a note at the bottom of the page dated 11 and signed by the ARNP. The noted stated, "This was not given as a T.O. (telephone order) at this dosage."

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A review nurse ' s notes in Resident #4 ' s record showed 1500 Nurse's Note stated in part: "CNA notified this nurse that resident had increased agitation, he was pulling hair of another resident and became combative towards staff while trying to redirect. This nurse and ARNP went to neighborhood of resident. He was upset saying people were trying to take his clothes off ...[ARNP], D/C'd patch, D/C'd risperdol 0.25 to risperdol 0.5 mg ..."

On at 11:38 AM, an interview was conducted with the ARNP. She stated she did not write the order for Resident #4, dated decreasing the and increasing the . She stated Staff A wrote the order without her direction. She confirmed she wrote the note dated on the bottom of the order which stated that she did not give the original documented order for resident #4. She further stated Resident #4 had aggressive outburst as a reaction to change in the

On at 2:27 PM, an interview was conducted with the facility Administrator. She stated she was aware of the order for increase in patch. She stated it was not brought to her attention that Resident #4's behavior had changed after the increase in the patch .

On at 3:51 PM, an interview was conducted with Staff A. She stated, regarding Resident #4, that she wrote the order, she signed her name, then ARNP's name after her name because she got the telephone order from the ARNP. She stated she does not know if Resident #4 had an adverse reaction to change in medication.

Class II

0163-Records - Resident, Penalties for Alteration 429.49 FS

Based on record review and interview, the facility failed to ensure that medication orders were not altered without direction of physician or Advanced Registered Nurse Practitioner (ARNP) for 1 of 5 residents reviewed (Resident#4)

Findings:

A review of Resident #4 ' s record showed letter, dated addressed to Facility Administrator, signed by ARNP, which stated in part: "As you know, I have found multiple orders written with my signature as well as orders written as telephone orders that I did not give, signed by [the Wellness Director]... I am very concerned about the fact that I have seen three occasions that I know of where medication changes were made. The one that I know of directly is that the order regarding the addition of and change in dosage. [the Wellness Director] texted me asking about an order discussed with a residents family member, and why it wasn't written previously. I texted back stating that I thought I gave a verbal order to the evening nurse after we met with that family member. I didn't give any further orders to change the medication or the dosage over the phone/text. She took it upon herself to lower the dosage. This concerned me, not only because I didn't give the order the

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On Resident #4 ' s medication orders were reviewed. The review revealed an order dated, stating, "Start: Patch 4.6 mg x 2 weeks then recontact MD/ARNP. .25 mg PO phone order " The order was signed by the facility ' s Wellness Director. Continued review of the order revealed a note at the bottom of the page dated and signed by the ARNP. The noted stated, "This was not given as a T.O. (telephone order) at this dosage."

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Class III