

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 06/01/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11964582	(X3) DATE SURVEY COMPLETED R 05/22/2015
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 TAGS AND REGULATORY IDENTIFYING INFORMATION)		

0000 - Initial Comments

An unannounced visit was made to Creekside Senior Village on _____ for a re-visit survey to the annual re-licensure survey completed on _____. There were deficiencies noted during the visit.

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on observation, staff interview and facility policy review, the facility failed to follow their policy regarding medication order changes to properly alert staff of the changes for 2 of 6 residents observed during the medication pass. (#2 and 4).

The findings are:

During medication observation on _____ at 8:45 AM for resident #2, the label for the medication _____ 5 milligrams (mgs) read take 1 tab by mouth every night. The Medication Observation Record (MOR) read _____ 5 mg give one tablet by mouth daily and was identified with an 8 AM time. The Physician's order was change from evening hours to daily on _____ when the AHCA form 1823 was updated on _____. Interview with staff A on _____ at 8:52 AM indicated when there is a difference in the label and the MOR, we notify the nurse and then check the orders. A sticker is to be placed on the packages to alert the staff of a change. Staff A indicated she did not follow the procedure.

During medication observation on _____ at 8:45 AM for resident #4, the label for _____ 50 mg read take one tablet twice a day. The MOR for the medication _____ read _____ 50 mg daily at 8 AM. Review of the Physician's order indicated the medication was changed from twice a day to daily on _____.

Interview with staff D on _____ indicated there should be a sticker to alert staff of any change in orders. She agreed the label was different than the MOR.

Review of the facility policy dated _____ indicated "the MOR and prescription label must match exactly".

Interview with the Executive Director on _____ at 10:30am indicated the staff are to attach a label to the package to alert the staff there had been a change in the order and they should check the Physician's orders.

Class III

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11964582	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
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Name of Facility CREEKSIDE SENIOR VILLAGE	Street Address, City, State, Zip Code 9015 UNIVERSITY PARKWAY PENSACOLA, FL 32514
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This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix A0052 Reg. # 58A-5.0185(3) FAC LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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Reviewed By State Agency	Reviewed By <i>Kalvin Q</i>	Date: 6/1/15	Signature of Surveyor: <i>For Miguel Bernal</i>	Date: 6/1/15
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?

YES NO



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Creekside Senior Village
9015 University Parkway
Pensacola, FL 32514

Dear Administrator:

This letter reports the findings of a State Licensure Revisit Survey conducted on May 22, 2015 by a representative of this office.

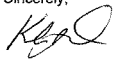
Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

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 , 2015.**

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

YOSF

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