STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932659	10/19/2015
NAME OF PROVIDER OR SUPPLIER **WOODMONT BY ENCORE SENIOR LIVI**	STREET ADDRESS, CITY, STATE, ZIP CODE **3207 NORTH MONROE STREET TALLAHASSEE, FL 32303**	

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

0000 Initial Comments

On , 2015 an unannounced complaint survey (CCR# 2015010284) was conducted at Woodmont a Pacifica Senior Living facility. Deficiencies were identified at the time of the survey.

0053 Medication - Administration

The facility failed to provide medications in a timely manner for 7 of 11 residents reviewed for medication administration (#5, 6, 7, 8,9,10, and 11).The facility also failed to conduct glucose monitoring and administer medication in timeframes specified on medication orders for 4 of 4 residents receiving . (#1, 11, 12, 13)

The findings:

On , 2015 at approximately 8:00 a.m. medication pass was observed with staff D on the transition unit. Staff D was observed passing medications to eleven residents starting at 8:00 a.m. and ending at 10:36 a.m. Review of the medication observation records for the eleven residents indicated all eleven residents had medications ordered for 8:00 a.m. the Staff D passed medications to eleven residents and seven of the residents were observed receiving 8:00 a.m. It was observed that resident # 5,#6,#7,#8, #9, and #10 all received medications scheduled for 8:00 a.m. at 10:10 a.m., 9:29 a.m., 9:35 a.m., 9:49 a.m., 10:04 a.m., and 10:13 a.m. respectively. During the medication pass observation it was also observed that resident # 11 did not receive Acidophilus which was ordered for 8:00 am due to the medication not being refilled, resident # 8 did not receive 5mg scheduled for 8am due to the medication not being refilled, and staff D reported resident # 7 did not receive 50mg scheduled for 6:30 a.m. because it was overlooked on the medication observation record. At approximately 10:36a an interview was conducted with staff D, licensed practical nurse (LPN) regarding the facility's policy for medication administration. Staff D reported, "I know I was late passing my medications because I really didn't know all the residents, but once I get to know all them (residents) things will be a lot smoother". When asked what is time frame for passing medications staff D stated, "We have one hour before and one hour after the (administration) time, but like I said I am new and I'm still getting to know all the residents".

On , 2015 at approximately 10:51 a.m. and interview was conducted with the Director of nursing (DON) regarding timeframes for passing medications. The DON reported, "The time overage for the medication pass is due to the nurse being new, most of the nurses know the residents and complete the medication pass in no later than one hour after scheduled administration time which is our policy". The DON also asked about staffing on , , 2015 and reported, " I informed the Executive Director on Sunday that I was going to the emergency I was ill and that I had tried to get coverage, in my conversation with the Executive Director I informed her that nurse on the memory care unit could perform glucose at 8:00 a.m. when she got on duty and she (Executive Director) stated that was unacceptable because the residents will have already eaten. I don't know what

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happened after that regarding the coverage. I returned to work on Wednesday the 30th and I was informed at that time that we didn't have a nurse in the building until around 10:30 a.m. on the morning of . I was informed by staff that the Executive Director, came into building and she did glucose checks. To my knowledge she does not have a current LPN license because she let it expire. Staff E reported to me that the Executive Director called her in to help give . To my knowledge the Executive Director only gave to resident #1. I was told by staff that residents got their medications on that day, but that their medications were late."

On , 2015 the medication observation record (MOR) dated , , 2015 through , , 2015 for resident #1, #11, #12, and #13 were reviewed. The medication observation record for each resident indicated orders for 6:30 a.m. glucose monitoring and 8:00 a.m. administration. The MORs for resident #1 indicates the Executive Director initialed she performed glucose monitor at 6:30 a.m. and administered 8 units of 100 units/ML at 8:00 a.m.; the MOR for resident # 11 and #12 indicates staff E initialed she performed glucose monitoring at 6:30 a.m. and administered 16 units of N 100 units/ML and 12 units of N 100 units/ML respectively; the MOR for resident #13 indicates staff E initialed she performed glucose monitoring at 6:30 a.m. and the Executive Director initialed for administering 20 units of N 100 units/ML at 8:00 a.m.

On , 2015 at approximately 12:30 p.m. an interview was conducted with the Executive Administrator regarding medication pass on , , 2015. She reported, "I came in one day, don't remember if it was the 28th, and staff E came in and did all the . The DON was not here, I think she was in the hospital, the nurse that was supposed to come in didn't, and so staff E came in and did the limited nursing services (LNS) and administration. Staff E also did the memory care medication pass. I put the aides/medication technicians on the carts. The medications probably were late, but I don't know how late. I was focused on the and getting that done." The Executive Director was shown MOR from indicating glucose monitoring were initialed as being conducted at 6:30 a.m. and was initialed as being administered at 8:00 a.m. by her and by staff E. The Executive Director reported, "I did not give the or perform the glucose monitoring, just as I was preparing to do the glucose monitoring and staff E came in and took over. I did initial for the 6:30 a.m. glucose monitoring and 8:00 a.m. administration; the actual times of performance and administration would have been after the times listed on the MOR, even though I initialed for the times. I ended up calling staff E to help and she had to leave her job and come over to help. Staff E came in and administered the and performed the limited nursing services (LNS) and she passed medications in memory care. I am a licensed practical nurse (LPN) but I did not renew my license. It is my belief that as the Executive Director I can pass medications ". The Executive Director provided a timecard for staff E which indicated staff E did not punch in as on-duty until 10:19 a.m. on , 2015.

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0054 Medication - Records

The facility failed to accurately document glucose monitoring and administration on the medication observation record (MOR) reviewed for 4 of 4 residents receiving . (#1, 11, 12, 13) Findings include:

On , 2015 the medication observation record (MOR) dated , , 2015 through , , 2015 for resident #1, #11, #12, and #13 were reviewed. The medication observation record for each resident indicated orders for 6:30 a.m. glucose monitoring and 8:00 a.m. administration. The MORs for resident #1 indicates the Executive Director initialed she performed glucose monitor at 6:30 a.m. and administered 8 units of 100 units/ML at 8:00 a.m.; the MOR for resident # 11 and #12 indicates staff E initialed she performed glucose monitoring at 6:30 a.m. and administered 16 units of N 100 units/ML and 12 units of N 100 units/ML respectively; the MOR for resident #13 indicates staff E initialed she performed glucose monitoring at 6:30 a.m. and the Executive Director initialed for administering 20 units of N 100 units/ML at 8:00 a.m.

On , 2015 at approximately 10:51 a.m. and interview was conducted with the Director of nursing (DON) regarding staffing on , , 2015. The DON reported, "I informed the Executive Director on Sunday that I was going to the emergency I was ill and that I had tried to get coverage, in my conversation with the Executive Director I informed her that nurse on the memory care unit could perform glucose at 8:00 a.m. when she got on duty and she (Executive Director) stated that was unacceptable because the residents will have already eaten. I don't know what happened after that regarding the coverage. I returned to work on Wednesday the 30th and I was informed at that time that we didn't have a nurse in the building until around 10:30 a.m. on the morning of . I was informed by staff that the Executive Director, came into building and she did glucose checks. To my knowledge she does not have a current LPN license because she let it expire. Staff E reported to me that the Executive Director called her in to help give . To my knowledge the Executive Director only gave to resident #1. I was told by staff that residents got their medications on that day, but that their medications were late."

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just as I was preparing to do the glucose monitoring and staff E came in and took over. I did initial for the 6:30 a.m. glucose monitoring and 8:00 a.m. administration; the actual times of performance and administration would have been after the times listed on the MOR, even though I initialed for the times. I ended up calling staff E to help and she had to leave her job and come over to help. Staff E came in and administered the and performed the limited nursing services (LNS) and she passed medications in memory care. I am a licensed practical nurse (LPN) but I did not renew my license. It is my belief that as the Executive Director I can pass medications." The Executive Director provided a timecard for staff E which indicated staff E did not punch in as on-duty until 10:19 a.m. on , 2015.
Class III

0079 Staffing Standards - Levels

The facility failed to provide resident services in accordance with the residents ' scheduled and unscheduled service needs.
The findings:
On at approximately 8:29 a.m. an interview was conducted with staff B, resident aide, regarding facility staffing and resident care. Staff B reported, "we have had issues with shortages in staffing. We are short now and they (administration) are pulling us (aides) off the floor to pass medications then once we finish we have to go back to patient care. I think patient care is suffering because the residents have been complaining because we cannot get to them in a timely manner. The residents have had to wait longer times to get out of bed and get assistance with changing. I have been here for 3 years and this is the worst it has been. Monday, Friday, Saturday and Sunday are the worst days. They try to call staff in but no-one will come in."
On / at approximately 9:59 a.m. an interview was conducted with staff C, aide/medication technician, regarding facility staffing and resident care. Staff C reported, "the facility has been short staffed since I started working here in . I think the shortage has affected resident care and that is why I got hurt. Staff are working harder to complete duties. Residents have to wait to be assisted out of bed, getting meals, medications and some are still in the bed right now. I know there were issues with nurses not reporting to work on a weekend and the aides were left to pass medications and provide patient care. When we are short staffed it causes medications to be late and resident care to be delayed."
On / at approximately 10:58 a.m. the DON also asked about staffing on , 2015 and reported, " I called the Executive Director and informed her that I could not find coverage, I informed her that I would be the nurse on the floor from 6a-2p, but began feeling ill and I called and informed the executive director that I didn't know if nurse scheduled for the transition unit would be in and that coverage needed to be found. She told me that she didn't know what I was going to do but coverage needed to be found. I was on my way the emergency after that conversation due to

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high . I was admitted to emergency I called her when I got into the informed her that I had been admitted. She (Executive Director) asked about the coverage and I informed her nothing had changed. I don't know what happened after that regarding the coverage. I returned to work on Wednesday the 30th and I was informed at that time that we didn't have a nurse in the building until around 10:30 a.m. on the morning of . I was informed by staff that the Executive Director, came into building and she did glucose checks. Staff E also reported to me that the Executive Director called her in to help give . I was told by other staffs that residents got their medications on that day, but that their medications were late. I think staffing is adequate, however, on the day of , based on the schedule when only four aides were on duty there was not adequate staffing in the building because there was not a nurse in the building from 6a-2p. I will also state that the Executive Director knew that there would not be a nurse in the building."

On at approximately 11:43 a.m. an interview was conducted with staff A, resident aide, regarding facility staffing and resident care. Staff A reported, " it is a problem with staffing being short. I think resident care suffers because we are always pulled off the floor to pass medications and we cannot get the residents up in time for meals. I just got the last resident up on the assisted living side. Usually the resident should be up for breakfast. I was working on when no nurse showed up for work, staff E came in about 10a and stayed about an hour. Staff E came to assist with passing medications. I had to pass medications that day too. The medications were not on time because we had to get the resident's up for breakfast. After staff E left there was no nurse in the building. I got off at 2p and no nurse was in the building when I left. On that day I think resident care suffered, because we had to pass medications and the medications were late and we were not able to get all the residents up on time. This a normal thing and the residents are always complaining, but we cannot do anything about the schedule. They have actually hired some more people but they didn't stay".

Review of staffing schedule for , 2015 indicated both nurses scheduled for the 6:00 a.m. to 2:00 p.m. did not show for their shifts and four resident assistants were the only staff on duty.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

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

RE: CCR # 2015010284

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 by representative(s) 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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(s). Should you have any questions please call me at 850-412-4540.

Sincerely,

Donah Heiberg, MSW
Field Office Manager

DH/dh
Enclosure

XG90

Tallahassee Field Office
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Tallahassee, FL 32308
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