STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963819	11/20/2015
NAME OF PROVIDER OR SUPPLIER **WOODLANDS VILLAGE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1055 301 BLVD EAST** **BRADENTON, FL 34203**	

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

0000 Initial Comments

Assisted Living Facility Complaint

A complaint investigation (CCR# 2015009919) was conducted at the Woodlands Village on / . Woodlands Village, Assisted Living Facility, had deficiencies at the time of the visit.

0011 Admissions - Discharge

Based on interview and closed record reviews, the facility failed to ensure that 2 (#1 and #4) of 3 residents discharged from the facility had received the proper notification of discharge.

Findings include:

Resident #1 was admitted to the facility on from home and was discharged on for needing a "higher level of care" according to the Administrator and the Admission/Discharge log. The resident was to a mental health facility on for changes in behavior and attempting to strike a third party provider who was assisting with her care. A review of her closed record revealed no notice of discharge to the resident.

Resident #4 was admitted to the facility on from home and was discharged on / to a "higher level of care" on /. Documentation in the resident record revealed that he required assistance with all activities of daily living. On several occasions, the resident was found outside of the facility and . A review of her closed record revealed no notice of discharge to the resident.

The Administrator stated that she did not know where the notices of discharge for these residents were and was not certain that notices had been given to them. She felt that the facility could no longer meet either resident's needs.

Class III

0025 Resident Care - Supervision

Based on interview and record reviews, the facility failed to maintain documentation of significant

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changes in conditions for 2 of 4 residents whose records were reviewed. (Resident #1 and Resident #2).

Findings include:

On , Resident #1 was observed by the facility wandering about the facility yelling and demanding that staff call her son. The resident's caregiver attempted to re-direct the resident to her she struck the caregiver. The resident was through Law Enforcement.

An interview was conducted with the caregiver on / at 4:00 P.M. She stated that the resident had been displaying some "" behaviors for approximately 2 months. She was following people in and out of their , would upset her tablemate's at meals by being loud and confrontational, began taking her bags off, accused people of stealing her medications and would pull her hair and shout.

An interview with the Administrator on / at approximately 1:30 P.M. revealed that the facility had not maintained documentation of the resident's change in behaviors.

The facility did not maintain a resident record for Resident #1 other than a Resident Agreement for Care, a Progressive Protocol Incident Form and a "Move Out Form" indicating that the resident was responsible for payment until / . The Administrator considered the resident an "independent" resident who resided in a licensed Assisted Living Facility bed. She required assistance from a caregiver for care and the facility for medication management.

Resident #2 was admitted to the facility as an independent resident on . The Resident Health Assessment that was maintained in the resident record was dated / and indicated that the resident had with and forgetfulness at times. She required assistance with all care. During an interview with the Administrator on / at 1:30 P.M. it was revealed that Resident #2 was given a Notice of Discharge on for needing a higher level of care. When asked what she meant by that, she explained that the resident was refusing care and was entering other resident and wandering outside of the building. She refused to accept assistance with her personal hygiene and that this was becoming a problem in that her mattress had become soiled with . The resident moved to a Skilled Nursing Facility on / . There was no documentation in the resident record regarding the resident's changes in behaviors and monitoring of such behaviors that would explain the need for a higher level of care.

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Class III

0160 Records - Facilitv

Based on interview, observation and a review of the facility's Admission/Discharge Log, the facility failed to maintain an accurate Admission/Discharge Log with the required information, including the reason for discharge and identification of the facility or home address to which the resident was discharged.

Findings include:

The Admission and Discharge Log maintained by the facility contained several entries of residents being discharged for needing a higher level of care. In most cases there was no identification of where the resident was discharged to. In some cases, residents whose reason for discharge was needing a higher level of care were discharged to another Assisted Living Facility (ALF). The Administrator stated that it does not make sense for a resident who needs a higher level of care to be discharged to another ALF, unless it was because the other ALF had a secure unit. She stated that if that were the case, it should state that on the Admission/Discharge Log.

According to the Admission/Discharge Log, Resident #' 1, Resident #2 and Resident #4 were discharged to higher levels of care with no destination or address listed as to where they were discharged to.

Class III

0162 Records - Resident

Based on interview and record reviews, the facility failed to obtain a Resident Health Assessment form, (AHCA Form 1823) for 1 of 4 residents whose records were reviewed. (Resident #1)

Findings include:

Resident #1 was admitted to the facility on from home. A review of the closed record revealed no evidence of a Resident Health Assessment, Form 1823, nor was there evidence that she had been

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examined by a health care provider to determine appropriateness of placement.

Interview with the Administrator revealed that the resident was considered "independent" although she required assistance with care and medication supervision. She resided in an assisted living facility licensed bed.

Class III

0165 Risk Mgmt & QA: Adverse Incident Report

Based on interview and closed record reviews, the facility failed to maintain and submit adverse incident reports for 2 of 3 residents who were transferred to higher levels of care and whose behaviors warranted assistance from law enforcement. (Resident #1 and Resident #3).

Findings include:

On , Resident #1 was observed by the facility wandering about the facility yelling and demanding that staff call her son. The resident's third party provider (caregiver) attempted to re-direct the resident to her she struck the caregiver. The caregiver called 911 to report a "change in mental status" and she was dispatched to the Sheriff's office who responded to the facility and the resident.

An interview was conducted with the caregiver on / / at 4:00 P.M. She stated that the resident had been displaying some " " behaviors for approximately 2 months. She was following people in and out of their , would upset her tablemate's at meals by being loud and confrontational, began taking her bags off, accused people of stealing her medications and would pull her hair and shout that she was being abused.

An interview with the Administrator on / / at approximately 1:30 P.M. revealed that the facility had not maintained documentation of the resident's change in behaviors, nor had they filed an Adverse Incident. The Administrator stated that the resident was taken to a local Mental Health Facility on and the facility chose to discharge her for needing a higher level of care on . The Administrator did not know where the resident was residing on the day of the survey.

The facility did not maintain a resident record for Resident #1 other than a Resident Agreement for Care,

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a Progressive Protocol Incident Form and a "Move Out Form" indicating that the resident was responsible for payment until / . The Administrator considered the resident an "independent" resident who resided in a licensed Assisted Living Facility bed. She required assistance from a caregiver for care and the facility for medication management.

The Admistrator was asked if Law Enforcement had been to the facility for any other reasons and she stated that they had to come to escort off the premises on 2 occasions, a visitor of Resident #3's. The resident has a Durable Power of Attorney, who is his sister. On , staff reported to Administration that Resident #3 had a "guest" staying overnight in his . The sister of the resident was called and she expressed concern for the residents safety because the visitor had become violent with the resident in the past . She requested that the visitor be asked to leave the resident's . The facility called Law Enforcement to escort the visitor off the premises. The visitor returned on and was again escorted off from the property by Law Enforcement. The resident is forgetful and requires assistance with care. The Administrator could provide no further information regarding the guest's violent behavior towards the resident that warranted the sister's concern for his safety. No investigation was conducted nor was an adverse incident filed for this.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Woodlands Village
1055 301 Blvd East
Bradenton, FL 34203

RE: CCR #2015009919

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 **Paul Brown**, HFES at (727) 552-2000.

Sincerely,

for Patricia Reid Caufman
Field Office Manager

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