RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Carpenter's Creek Community
5918 North Davis Highway
Pensacola, FL 32503

Dear Administrator:

This letter reports the findings of a state licensure survey that was completed on , 2015 by representatives 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 surveyors. Should you have any questions please call me at 850-412-4540.

Sincerely,

Kristi Combs

FOR Donah Heiberg, M.S.W.
Field Office Manager

DH/kc
Enclosure

XG90

Tallahassee Field Office
2727 Mahan Drive, Mail Stop #46
Tallahassee, FL 32308
Phone:850-412-4540; Fax:(850) 922-9162
AHCA.MyFlorida.com

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910470	12/16/2015
NAME OF PROVIDER OR SUPPLIER **CARPENTER'S CREEK COMMUNITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **5918 NORTH DAVIS HIGHWAY** **PENSACOLA, FL 32503**	

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

0000 Initial Comments

An unannounced biennial survey with specialty license for limited nursing services was conducted in conjunction with a complaint survey (CCR#2015011962) at Carpenter ' s Creek Pacifica Senior Living Assisted Living Facility . At the time of survey there were deficiencies identified.

0030 Resident Care - Rights & Facility Procedures

Based on observations and interviews, the facility failed tohonor the residents' right to privacy for 1 of 4 residents observed during medication observation (resident #14).

Findings are:
On at 10:00am during a medication observation with facility staff "D", the employee stated prior to entering the resident's that sometimes the resident has a male friend in the her. Staff was observed to knock on the outer door of the resident #14, then she walked back into the . Resident was observed to be lying naked, covered only by a small hand towel, on the bed. The resident had a male visitor in the . The staff did not excuse herself or tell resident she would be back later, she told her to " sit up" on side of bed and gave her the medication. Resident swallowed medications and laid back down.

On at 2:14pm an interview with staff D was conducted. Staff D was asked what hwer normal procedure was for entering a resident's she replied, "I knock on the door and wait for a reply. If they don't answer after five minutes then I will go in to check on them to make sure they are OK." She was then asked if she had utilized that procedure during the surveyor medication observation and she stated, "I didn ' t wait until she answered because she is hard of hearing and they won't say anything when they are together, so I just walk in."

0052 Medication - Assistance with Self-Admin

Based on observations and interviews, facility staff failed to properly assist 2 out of 4 residents with self administration of medications (residents #13, and #16).

Findings are;

On at 10:00 AM Staff D was observed gathering a glass of water she had premixed with a powdered the hallway, and the medication packs for resident #14. She entered the resident's sat down in a chair near the resident and proceeded to dispense medications from packs into a medication cup. She did not call out the medications being dispensed to the resident.

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

She handed the cup of water, the cup of pills and a spoon to the resident. Resident took his medications and staff left the .
On at 10:20 AM Staff D was observed to remove medications from a pack for resident #16. She removed the medications from the pack without identifying the medications to the resident and placed them in a medication cup. she then handed the medication cup to the resident and stated " here are your pills ". Resident #16 took medications and staff exited .
During an interview with Staff D on at 2:14 PM, when asked what is her usual practice when assisting residents with self-administration of medications, she stated " We knock on the door, take the medicine with water to the , we ask if they need assistance with the medications and then if they do we open them in the cup and watch them take the medications " . When asked if that is what she had done during surveyor observation, she stated " I always tell them what medications I am about to give them. Most of them will ask anyway, so if they ask then I will tell them. "

0055 Medication - Storage and Disposal

Based on observations and interviews, the facility failed to maintain medications in a secure manner at all times for 1 out of 2 medication carts (second floor medication cart).

Findings are;

On from 9:50 AM thru 10:20 AM, an observation of the assistance with self -administration of medications for residents #13, #15 and #16, was conducted with staff D. During this interaction, it was observed that the medication cart was left in the hallway unlocked with medication on top of cart and the medication observation record (MOR) open in view. There were residents observed walking in the hall past the unattended, unlocked cart. {See photographic evidence.}

On at 2:14pm and interview was conducted with staff D, When asked what her procedure was for securing her medication cart, she stated "When I step away from the medication cart, I lock it and close the book for privacy. " When asked if she thought she did that today, she stated " yes " .