STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932659	04/11/2016
NAME OF PROVIDER OR SUPPLIER **WOODMONT A PACIFICA SENIOR LIVING COMMUNITY**	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

CCR 2016000490, CCR 2016001858 & CCR 2016003089

An unannounced complaint survey was conducted on / at Woodmont A Pacifica Senior Living Assisted Living Facility. At the time of survey the allegations to CCR#2016000490 was substantiated with deficient practice, allegations to CCR#2016001858 was substantiated with out deficient practice and CCR#2016003089 was substantiated with deficient practice.

0025 Resident Care - Supervision

Based on record review and interviews, the facility failed to supervise the overall care and services to prevent an adverse event in regards to giving routine medications ( ) in 1 of 3 sampled residents (#3).

The findings:

On at 10:05 AM, an interview was conducted with a family member of resident #3, who reported the resident had a on the 23rd of . The complainant reported that she asked the staff what had changed and they informed me that resident #3 was out of her for a couple of days and they couldn't fill it because it was too soon to be filled and that Hospice wrote another order for 60 on that same day she had the and she picked them up. The complainant reported that she was concerned that resident #3 medications were running out too soon.
On /_ _, a record review was conducted for resident #3 medical record to find the dates listed were / and and no notes a were listed for days in between. The document indicated that on , resident #3 was found unresponsive at 7:05am. Hospice was notified at 07:20am. Emergency Medical Services ( ) and a sheriff's deputy arrived to the resident's 07:30am but were turned away by staff stating that the resident #3 was a hospice patient. By 8:00 am, the resident began screaming making attempts to jump out of the bed. "Resident had to be held by staff to prevent injury to self. Resident now screaming 'Go home. Go home.' Social worker arrived. Writer spoke to staff at Hospice and requested that he call in PRN (as needed) medications to pharmacy. Resident remains agitated. Family was at bedside." At 09:25 am, the PRN was given to the resident. The documentation further stated improvement in speech and that the resident states she was feeling better.
A record review was conducted of resident #3 1823 Health Assessment on / . It indicated in the medical history section, " history of . "
An interview was conducted with employee #C/ on /_ _ at 11:00 am. Who stated that resident #3 has ran out of and had an unresponsive episode and when she woke up, she was screaming. Employee #C reported that the facility didn't have any to give her. Hospice was here and they

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wrote her an order. Her niece went to Walgreens and picked it up." Employee #C was could not show documentation within the chart that the had been reordered timely. She stated, "I don't see any documentation really. I just know that we didn't have it and they wrote us another."
An interview was conducted with the Executive Director (ED) on / / at 12:22 PM who reported that the protocol for documenting when a resident is out of medication was that staff are to contact the pharmacy and on the back of the Medication Observation Record (MOR), staff are to document who they spoke to at the pharmacy and what their response was. The next day, if the medicine wasn't here, staff is supposed to find the reason on the back of the MOR and then again follow up with the pharmacy. They are again supposed to document it on the back of the MOR. When the next shift comes in, staff is to notify the family. The ED reported that all of the staff has been in-serviced by her personally on this." The ED reported that the process was the same for or controlled substances and if the pharmacy needs a hard script, then they call the physician and let them know that the pharmacy needs it." The ED was reported that the Director of Nursing (DON) was responsible for ensuring that the residents have their medication and if the DON not here the nurse was responsible and they are to notify me. The ED reported that she was not informed that any resident was out of medicines."
A record review was conducted for resident #3 on / . There was no documentation on the back of the MOR indicating any conversations or correspondence with the pharmacy or resident's medical doctor, nor the resident's family.
class III

0054 Medication - Records

Based on record review and interview, the facility failed to maintain an accurate medication observation record (MOR) in regards to for 1 of 3 residents (#3).

The findings are:

On /, a record review was conducted of resident #3 medical records and upon reviewing the MOR for the month of , 2016, the document indicated that on / and , the resident was given her nightly dose. Upon review of the Administration Record, the last dose of was given and not resumed until .
An interview was conducted with employee #C who confirmed that there was no in the facility for this resident during this time period. An interview was conducted with the Executive Director who reported that it was the facility policy to initial the date box then circle the initials to indicate that a medication wasn't given. The ED reported that on the back of the MOR there should be documentation explaining why the medication wasn't given. A record review of the back of the MOR for the month of 2016 shows no entries for any medications held or not given.

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class III

0056 Medication - Labeling and Orders

Based on record review and staff interview, the facility failed to ensure a written, signed order within the resident's medical record; failed to have a transcribed telephone order within 10 working days of the order being given; and failed to ensure that prescription medications were filled in a timely manner for 1 of 3 residents (#3).

The findings:

On / /, a record review was conducted of resident #3 medical records to find that there was no order written for on or about the time resident #3 ran out of in , 2016. On , there was a progress note written by staff stating that an order was obtained and record review indicated no order written. An interview was conducted with employee #C who stated that she took the order herself and doesn't know why it was not in the medical record.
On /, a record review was conducted of resident #3 medical records and there was no documentation to show that on , a sticker was removed from the resident's pill card and faxed to pharmacy. There was no documentation to indicate that the facility had followed up with the pharmacy to ensure timely deliver, nor was there any documentation within the medical record that the facility had attempted to contact the resident's pharmacy, doctor, or family requesting a new order.
A record review was conducted of the facility's policy titled "Medication Refills Policy and Procedures" on /. It indicates that "When medications are not on cycle fill: A refill request is to be completed by the medication technician when medications reach the alert quantity below: Pharmacy Alert Quantity = 7 day supply."
An interview was conducted with the Executive Director (ED) on / at 12:22 PM who reported that the protocol for documenting when a resident is out of medication was that staff are to contact the pharmacy and on the back of the Medication Observation Record (MOR), staff are to document who they spoke to at the pharmacy and what their response was. The next day, if the medicine wasn't here, staff is supposed to find the reason on the back of the MOR and then again follow up with the pharmacy. They are again supposed to document it on the back of the MOR. When the next shift comes in, staff is to notify the family. The ED reported that all of the staff has been in-serviced by her personally on this."
The ED reported that the process was the same for or controlled substances and if the pharmacy needs a hard script, then they call the physician and let them know that the pharmacy needs it." The ED was reported that the Director of Nursing (DON) was responsible for ensuring that the residents have their medication and if the DON not here the nurse was responsible and they are to notify me. The ED reported that she was not informed that any resident was out of medicines."
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0167 Resident Contracts

Based on Administrative staff interview, Senior Management Advisors staff interview and record review the facility failed to honor the residency agreement contract in regards to its refund policy for 4 of 4 sample residents.

The Findings are:

On / a record review was conducted of the facility's Resident Move-in/Move-Out log. An interview was conducted with the Business Office Coordinator at 12:44 PM who confirmed the refunds:

1. Resident #1 move-out date (expired) was on and due a refund for $766. 20. As of the date of survey no refund had been provided.
2. Resident #2 family member move-out date (expired) was on / and due a refund for $936.19. As of the date of survey no refund had been provided.

3. Resident #3 family member move-out date (expired) was on and due a refund for $791.83 As of the date of survey no refund had been provided.

4. Resident #4 family member move-out date (expired) was on and did not receive refund until , 2016 of $459.68.

On / at approximately10:54AM an interview was conducted with the Executive Director (ED) who reported that once the resident moves out the facility will then submit a financial packet to the management company who completes the packet and once completed will submit the packet to Pacifica Senior Living and from there the owner signs the refund check and mail to the family member. The ED reported that residency agreement /refund policy does indicate that the family member would receive the refund 45 days after the move date. The ED reported that during the admission process she sits down with the family member or Power of Attorney (POA) or resident reviewing the entire residency agreement.

On / at approximately 1:24 PM via telephone an interview was conducted with the Lead Accounts Receivable Coordinator for Senior Management Advisors who also confirmed the above move-out dates and refunds. She reported that the delay was in the accounting department and reported there was no reason for the delay with the refunds. She confirmed that all refunds were past the 45 day time line per the residency agreement and that she was aware of the 45 days refund policy.

A record review was conducted of the Residency Agreement which indicated: Section H. Refund Policy. Upon the termination of this agreement, due to , discharge, immediate discharge, or if the Resident has provided the Community with at least 30 days prior written notice, the Resident will be entitled to a prorated refund based upon the daily rate for any unused portion of the monthly fee beyond the

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move-out date after all chargers, including the cost of documented damages to the residential apartment, have been paid to the community. The move-out date is defined as the latter of the end of the required notice to vacate or the date that all of the resident's belongings and property have been removed from the apartment and/or community. A refund will be made 45 days after notice of not returning from hospital or nursing home, or 45 days after the move-out date. Section BB. Beneficiary Designation. The Resident understands that the community shall return all refunds due and all funds held, as well as all other property held in trust, to the personal representative of the Resident's estate if one has been appointed at the time the Community disburses all funds and property which shall not be later than 45 days after Resident's .

class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Woodmont A Pacifica Senior Living Community
3207 North Monroe Street
Tallahassee, FL 32303

RE: CCR #2016000490, 2016001858, 2016003089

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 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 , 2016.** 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,

Donah Heiberg
Field Office Manager

DH/dh
Enclosure
XG90

Tallahassee Field Office
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