STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968854	06/06/2016
NAME OF PROVIDER OR SUPPLIER **LEGACY AT HIGHWOODS PRESERVE**	STREET ADDRESS, CITY, STATE, ZIP CODE **18600 HIGHWOODS PRESERVE PARKWAY TAMPA, FL 33647**	

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

0000 Initial Comments

Assisted Living Facility

On , 2016 a change of ownership survey was conducted at Legacy at Highwoods Preserve. Deficient practice was identified during the survey.
(License #12715)

0052 Medication - Assistance with Self-Admin

Based on observation, record review, and interview the facility failed to provide assistance with the self-administration of medications in accordance with the procedures described in Section 429.256 of the Florida Statues, which states that assistance with self-administration of medications does not include medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration, requires judgment or discretion on the part of the unlicensed person. This occurred for one (Resident #3) of three residents (Resident # 3,6,9).

Findings included:

The surveyor conducted a medication pass observation on / at 11:30am. Staff E provided assistance with the self-administration of Resident #3 ' s medication. Staff E provided assistance with the following medications for Resident #3: 2.5mg by mouth once daily, Preservision tablet AREDS one tablet by mouth once daily, 50mg take one tablet by mouth daily with 100mg to equal 150mg, HCl tablet 150mg XL take one tablet by mouth once daily, tablet 100mg take one tablet by mouth once daily with 50mg to equal 150mg. tears solution 1.4% instill 2 drops in both eyes twice daily, / tablet take ½ tablet by mouth twice a day, and Salonpas patch apply 1 patch to lower back every 12 hours, remove old patch.
During the medication pass on / at 11:30 am, the surveyor read the medication observation record (MOR) for Resident #3 and observed that all the medications Resident #3 took at that time were listed on the MOR to be given at 8:00am.
A record review of Resident #3 ' s MOR on at 2:00pm revealed that the medications listed above, that this surveyor observed the resident taking during the 11:30am medication pass observation, were initialed as being given at 8:00am on / by Staff E.
A record review of the facility's medication management policy at 1:30pm on revealed that the facility's policy on the assistance with the self-administration of medications states that assistance with self-administration of medication does not include medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires

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judgement or discretion.
An interview with Staff E at 11:30am on revealed that the medication time for Resident #3's medication was listed as 8:00am on the MOR, but Staff E stated she assisted Resident #3 with the medication at 11:30am because the resident does not like to get up early. Staff E stated that the policy for medication timing was that medications were supposed to be given within an hour before or an hour after the time listed on the MOR.
An interview with the Health and Wellness Director at 2:00pm on / revealed that her expectation would be that residents would be assisted with the self-administration of medications within the timeframe of an hour before and an hour after the medication time listed on the MOR.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. . . . . I, 2016

Administrator
Legacy At Highwoods Preserve
18600 Highwoods Preserve Parkway
Tampa, FL 33647

Dear Administrator:

This letter reports the findings of a change of ownership (CHOW) state licensure survey that was conducted on , 2016 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 , 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 surveyor(s). Should you have any questions please call **Paul Brown**, HFES at (727) 552-2000.

Sincerely,

for Patricia Reid Caufman
Field Office Manager

PRC/clt
Enclosure: State (5000-3547) Form

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