

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 06/24/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932659	(X3) DATE SURVEY COMPLETED 06/15/2016
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 2016003765 & CCR 2016003504 & CCR 2016004723

An unannounced complaint survey for allegations contained within CCR#2016003504, CCR#2016003765 and CCR#2016004723) was conducted in conjunction with a revisit survey from to at Woodmont Pacifica Senior Assisted Living Facility. At the time of survey, deficient practice was identified.

0030 Resident Care - Rights & Facility Procedures

Based on observation, staff interviews and resident reviews the facility failed to ensure the rights of residents by not providing care and services to meet the needs of the residents associated with the facility not having adequate staffing.

The Findings:

Upon entering the facility, interviews were conducted with staff members of various disciplines and residents on different units. These interviews revealed a concern that residents were not receiving appropriate care and services due to inadequate staffing. Multiple staff members stated that they frequently worked short-staffed and, therefore, could not take care of their residents the way they should. Staff reported that on one day about 2 weeks prior to the survey, there were only two resident care staff members in the entire building. They finally got help around lunch that day but until more staff arrived, they were overwhelmed and found it impossible to take care of residents appropriately.

On the morning of an observation was made of the memory care unit. During this observation there was two staff members observed in the back area getting the residents out of bed assisting with bathing, and Activities of Daily living (ADL) care. Also, one nurse was observed in the front area with the residents that were sitting in the front area. At approximately 9:00am the two staff members finished the resident care and the residents went to breakfast. Observation revealed that the residents' food had gotten while they were receiving care and the two staff members had to reheat the food.

On at approximately 10:23AM and interview was conducted with employee A, resident aide who reported that the facility was very understaffed and that it was hard to provide needed care for the residents. Employee A reported: "For example, this morning there were only 2 staff members with 17 memory care residents and they were trying to get all the residents up and ready for breakfast". Employee A reported that the residents were late to breakfast and did not get to eat until around 9a.m,

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and the food had to be reheated. On at approximately 10:34am an interview was conducted with employee B, resident aide who reported that staffing was very poor, and the shortage of staff was really affecting the resident care. Employee B stated that the residents become upset with staff because staff are not able to respond in a timely manner, the food is sometimes because there are not enough staff to get the residents up for meals. The resident aide reported that the past weekend had been terrible because there were only two staff and a nurse in the entire building. The nurse passed medications in the memory unit and the two resident aides had to pass medications and take care of the residents and this was for all three shifts. Employee A reported that it was always like this in the facility and the residents are not able to receive care in a timely manner or receive their medications in a timely manner, especially on the weekends. On at approximately 10:55am an interview was conducted with employee C, housekeeping, who reported that the facility was very understaffed and she had witnessed the facility being short on staff during weekdays and weekends. Employee C reported that the staff shortage means the residents normally have to wait a long time to receive care. On at approximately 11:13am an interview was conducted with employee D, resident aide/medication technician who reported that she had worked the past weekend. Employee D stated that the facility normally had 5 to 6 resident assistants on the floor, but that during the weekend there had only been 3. She stated that the staff had to pass medications and provide care to the residents. Some of the residents had to wait for care. Stated that for the 6am to 2pm shift, there had been one staff for each floor, memory care had 1 staff with 15 to 16 residents, transition where there was 1 staff for 12 -13 residents Assisted Living had 1 staff to 40 to 50 residents. Employee stated that they did the best they could with passing medication and providing care. Stated that the Executive Director was aware of the staffing issue. On at approximately 11:48am, an interview was conducted with resident #1 who reported that she does not always get her medication on time, probably about three times a week, due to short staff and the facility has such a turn over of staff. Stated that she would like to get her medication about 8am but sometimes she receives it as late as 10:30am, depending on the staffing. Resident #1 reported that her biggest problem was not receiving her medication in a timely manner. On at approximately 12:44pm, an interview was conducted with resident #2 who reported that when staff is short she does not receive her medication on time. Resident #2 reported that right now the facility was short and trying to hire some more staff. On at approximately 1:01pm an interview was conducted with resident #3 who reported that she does not think the facility has enough help because sometimes she has to wait on medication when short of staff. Stated that if she does not get her medication, she would become On at approximately 2:50pm, an interview was conducted with resident #4 who reported the facility had been short of staff and did not have enough staff working. Resident #4 reported that the last couple of weeks a lot of staff had been calling in and made the facility short of staff. On at approximately 3:00pm, an interview was conducted with resident #6 and resident #7 who		

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reported that reported that the facility had a huge turnover rate with staff and the facility overworked their staff and it sometimes caused their food to be

On at approximately 9:45AM, an observation was made of resident #8's family moving the resident out of the facility. An interview was conducted with resident #8's sons-in-law. During this interview the son-in-law reported that resident # 8 resided in the memory care unit and that they were moving her from the facility because the facility was understaffed on the weekends, and were not keeping up with washing resident #8's clothing and she always smelled like "poop". he stated that on one occasion the family came to visit the resident and she was observed sitting in an adult brief and a tank top. He reported that he did not think that resident #8 was in danger living at the facility, but stated that the care she had received had not been dignified.

On at approximately 10:00am, an interview was conducted with the Executive Director who reported that according to the Agency for Healthcare Administration regulations the facility was appropriately staffed. The Executive Director reported that she was not aware of any staff . . . out and if staff had a problem they could come talk to her. The Executive Director denied that the residents were not provided care and services to meet their needs and denied that the facility did not have adequate staffing to meet the needs of residents.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUKE
SECRETARY

, 2016

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

RE: CCR #2016003504, 2016003765, and 2016004723

Dear Administrator:

This letter reports the findings of a state licensure complaint 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
Fol Donah Heiberg, M.S.W.
Field Office Manager

DH/kc
Enclosure

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