STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932659	R 10/28/2016
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

On 28, 2016 an unannounced follow-up survey was conducted at 3207 North Monroe Street. License #99. Deficient practice was identified at the time of the survey.

0052 Medication - Assistance with Self-Admin

Based on observation, interview and resident record review, the facility failed to ensure that residents requiring assistance with self administration of medications were accurately provided, and that medication was given at the time the physician recommended for 1 of 1 residents observed during staff assistance with self administration of medication. (Resident #2)

The findings include:

On begining at approximately 9:00am, assistance with self-administration of medication was observed with Staff Member A for Resident #2. Staff Member A removed all of the resident's medications from the medication cart and sorted out which medications were due to be provided. Each medication was recorded by the surveyor. Staff Member A, after entering Resident #2's , set all the medication packs on the resident's reclining chair. The Resident was seated in her motorized wheelchair. As she picked up a medication, she announced the name of the medication and popped the required number of pills into the medication cup. She then placed the card into a different stack. There were numerous stacks of cards spread on the reclincer. When Staff Member A finished with each card, and just prior to handing the medications to the resident. She was asked to verify the total number of pills she had in the medication cup. There were a total of 14 pills. The total count should have been 16. Staff Member A overlooked the medication, misplacing the card into the stack of medications that she had already popped into the cup. This was corrected before exiting the .

Resident #2 was prescribed 1 tablet 40mg one tablet daily 30 - 60 minutes before eating; scheduled for 7:00am. Resident #2 who was observed during staff assistance with self-administration of medication and stated she had already eaten breakfast. Staff Member A indicated resident doesn't like to take medication on an empty stomach. An interview conducted with Resident #2 at approximately 10:00am stated that she didn't know she had any medications to take before breakfast and that she normally doesn't like to take pills on an empty stomach. Resident #2 did not know what the 7:00am medication was for and was not opposed to taking it. The medication, , was not given 30 - 60 minutes before eating or was the physician contacted to change the time the medication was provided to the Resident.

0053 Medication - Administration

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	AL11932659	R 10/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODMONT A PACIFICA SENIOR LIVING COMMUNITY	3207 NORTH MONROE STREET TALLAHASSEE, FL 32303

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

Based on observation, interview and facility and resident record review, the facility failed to ensure an effective process to ensure medications for residents were reordered timely for 1 of 3 Residents receiving assistance with medications or medication administration. (#3)

The findings include:

A review of the - Medication Administration Record (MAR) was conducted for Resident #3. The resident was prescribed 10mg (milligrams) one tablet by mouth once daily for an elevated [illegible]. The MAR indicated the medication was not available on / /, noted to be circled with a notation on the back "on order from pharmacy. "

Per interview with Staff B on at approximately 10:30am and an interview with the Director of Nursing (DON) at approximately 11:30am, the medication tech should be notifying the nurse before the resident runs out of medication, so that the nurse can re-order the medication. Both Staff B and the DON stated that the medication should have been ordered when the resident had about 7 pills/days remaining.

A review of the 'medication reorder' form identified the medication was re-ordered on , the day the resident ran out of medication. It was received from the pharmacy on . The resident missed one dose of medication.

The facility's previous POC (Plan of Correction) was reviewed with the DON, she indicated that they were doing daily MAR (Medication Administration Record) audits to ensure medication were given and medications were available, but the techs and nurses were having difficulty with the audit form, so they began performing audits without a doucmented process. The medication techs are required to review the MARs and medication availability daily, and the nurses are responsible to ensure the review has been completed. The facility's auditing process failed to ensure that medications were being ordered timely to ensure residents did not run out of medication.

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

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

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2016, by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **five business days** of receipt of this hand delivered report.

The inspection resulted in findings of non-compliance in the following areas:
St - A - 0053 - 58a-5.0185(4) Fac - Medication - Administration S-S= D

Directed Corrective Actions:

-The Assisted Living Facility is required to hire a pharmacist consultant to review the medication ordering/ administration process. This consult shall take place no later than , 2016.

-The Assisted Living Facility is required to provide four hours of medication training to all non-nurse staff who provide medication assistance. This training shall take place no later than , 2016.

-The Assisted Living Facility is required to establish a medication policy that will address obtaining/ordering resident medications from the pharmacy. This policy shall be established no later than , 2016.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law. Should you have any questions, please contact me at 850-412-4540

Sincerely,

Donah Heiberg
Field Office Manager

DH/dh

D7JR

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