

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964582	(X3) DATE SURVEY COMPLETED 02/06/2018
NAME OF PROVIDER OR SUPPLIER THE WATERFORD AT CREEKSIDE	STREET ADDRESS, CITY, STATE, ZIP CODE 9015 UNIVERSITY PARKWAY PENSACOLA, FL 32514	

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

0000 - Initial Comments

An unannounced biennial standard survey with Extended Congregate Care was conducted on 2/5 and 2/6, 2018 at The Waterford at Creekside (license #9068). Deficiencies were found at the time of the survey.

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on interview and record review, the facility failed to ensure a resident met admissions criteria for 1 of 4 residents sampled, #8.

Findings include:

An interview was conducted with resident #8 on 2/6, 2018 at 11:40 AM. He stated he had lived at the facility for a few months. A record review revealed the date of admission as 11/15/2017. Form 1823, the admission health assessment, dated 11/15/2017, stated the resident required 24-hour nursing or skilled nursing care for Parkinson's and dementia. Further, it was documented the resident's individual needs could not be met in an assisted living facility. Additional documentation stated the resident required special care for Parkinson's and dementia. An interview was conducted with the Director of Nursing on 2/6, 2018 at 12:19 PM, in which she stated she reviewed the form but was not aware the 1823 stated he did not meet criteria for admission. She further revealed the facility did not have licensed nurses working between the hours of 11 PM and 7 AM.

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation, record review, and staff interview, the facility failed to dispense the appropriate amount of medication, consistent with the prescription's label, for 1 of 2 residents observed for medication review. (Resident #12)

The findings are:

On 2/6, 2018 at approximately 8:20 am, medication pass was observed for resident #12, completed by staff E, a medication technician. Staff E was observed to accurately measure 30 milliliters (ml) of Promod, which is a thick liquid protein, into a medicine cup. The staff was then observed to pour the Promod from the medication cup into an 6 ounce glass of orange juice, leaving approximately 8 ml of

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

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FORM APPROVED

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Promod in the bottom of the medication cup. When resident #12 was unsuccessful in drinking from the glass of orange juice, staff E poured the juice, along with the medication, into a plastic cup, leaving approximately 8 ml of Promod in the bottom of the glass. When staff E assisted the resident in drinking, the resident did not drink the full amount, leaving approximately . . . ml of the medication in the bottom of the plastic cup. According to the Medication Administration record, resident #12 was to receive 30 ml of Promod liquid by mouth twice daily. An interview was conducted with staff E and she confirmed that the Promod should have been mixed/stirred into the orange juice and then given to resident #12. Class III E206 - ECC - Service Plans - 58A-5.030(7) FAC Based on interview and record review the facility failed to ensure an Extended Congregate Care (ECC) quarterly update was completed and included resident and/or resident representative agreement for 1 of 1 residents sampled, #11. The findings are: Review of the resident (#11) record indicated that he had a service plan for CPAP (continuous positive airway pressure) for sleep Further review of resident (#11) record showed he was admitted on, 2017 and his initial service plan was created on, 2017. Additionally, On, 2017 resident (#11) had a second quarterly update for his service plan but no update for 2017 or 2018. On, 2018 at approximately 9:15 AM an interview was conducted with the interim Administrator. She explained that the resident had a resident assessment dated, 2018 but no current updated quarterly ECC service plan for the resident. She agreed that a service plan should have been created and signed off by the resident or resident guardian indicating their agreement. Class III		