Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965474	A. BUILDING: _____ B. WING _____	12/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEKIWA SPRINGS	203 S WEKIWA SPRINGS ROAD APOPKA, FL 32703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Complaint investigations (2020003213, 2020001918, 2020003779) was conducted at Brookdale Wekiwa Springs Assisted Living Facility on , , and . The facility had deficiencies at the time of the survey.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:	A 025		

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A 025	Continued From page 1 (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review, medication observation record (mor) and interview, the facility failed to provide medications as ordered by the Physician to 2 of 5 sampled residents (#3 and #4) and did not timely notify the guardian when 1 of 5 sampled residents (#14)experienced significant changes that required a higher level of care. Findings: 1. Record review for Resident #3, revealed the resident health assessment form 1823, was dated , indicated the resident required assistance with self-administered medications.	A 025		

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A 025	Continued From page 2 Further review of the resident's record revealed a health care provider's order, dated , to decrease the resident's tears from four times a day to twice a day and gel 1%, apply 4 grams to right every day and evening shift for . Review of the resident's MOR revealed documentation that indicated he continued to receive the tears four times a day from through . In addition, documentation on the MOR revealed that on , and the gel was applied to both , on and to his and on and to his . At 4:35 p.m. on , the director of nursing confirmed all of the findings. Record review for resident #4 revealed the resident health assessment form 1823, was dated , indicated the resident required assistance with self-administered medications. Further record review for the resident revealed a health care provider's order, dated , for 3.125 milligrams (mg,) 1 tablet by twice daily for . Hold for less than 100. However, review of the resident's MOR revealed that despite a reading of on and on , the medication was signed as given. At 2:35 p.m. on caregiver A confirmed the initials on the MOR were hers and said she	A 025		

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A 025	Continued From page 3 did, in fact, give the medication on those dates because she did not notice the parameter instruction. 2. Review of the closed record for resident #14 revealed she was admitted to the facility on . The most recent health assessment in the record was dated and included diagnoses of ; she resided in the facility's memory care unit. She required assistance with all activities of daily living, except supervision for ambulation & eating; She received assistance with self-administration of medications. Review of the progress notes for resident #14 from through revealed several incident notes which did not include notification of resident #14's guardian. On , resident #14 had a witnessed incident that caused her to have in her left . Notes showed the executive director and the physician were notified about 16 hours later when the continued. A mobile was ordered. The guardian was not notified until after the resident was sent to the hospital over 2 days later. A witnessed occurred on and it was noted that hospice was notified. The notes did not indicate if the resident's guardian was notified. Notes regarding choking incidents on (Heimlich maneuver applied) and (called) documented hospice was notified but did not indicate if the guardian was notified. Two incidents where the resident slid to the floor on documented calls to hospice but did not indicate guardian was notified. (photographic evidence obtained) On at 3:25 PM, the former administrator (who was administrator at the time of the incidents) stated an investigation was not	A 025		

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A 025	Continued From page 4 done for the . . . . . of resident #14 because a staff member witnessed the incident. She confirmed that the notes for resident #14's incident that resulted in a of her did not include that the guardian was notified until 2 days later after she had been sent to the hospital. She confirmed that several other notes did not include notification of the resident's guardian. She stated staff had been trained to include who was notified after an incident in their progress notes. Class III	A 025		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed;	A 055		

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A 055	Continued From page 5 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued	A 055		

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A 055	Continued From page 6 medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to secure medications in a locked cabinet, locked cart or locked storage receptacle, therefore causing medication to be missing for 1 of 3 residents (#3). Findings: Resident #3's Medication Observation Records (MORs) and facility records confirmed Resident #3's physician ordered , ER 20 milligrams (mg.). The review confimed on at 8:45 AM, saff A accepted two (2) 30 tablet medication cards of , ER (extended release) 20 mg. from the pharmacy	A 055		

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A 055	Continued From page 7 delivery in the lobby of the facility. At approximately 8:50 AM, staff A took the medication to the Wellness station on the 2nd floor and placed them down on the nurses' desk with the delivery receipt on top of the medication. Staff A stated no one was in or around the nurses' station in the Wellness room when the medication was left unsecured. However, the door was unlocked to the Wellness station. At approximately 10:15 AM, the Wellness nurse went into the room and observed only one card of 30 tabs for the Oxycotin ER 20 mg. tablets facing up on the nurses' desk. The nurse then took the medication and secured it in the drawer and logged the medication on the " " sheet. The missing medication was then reported to the administrator. On at 1:30 PM, staff A confirmed the facility protocol is to log in the medications and then lock the medications in the medication cart drawer. She confimed the Wellness office was unlocked at the time she left the medication on the desk unsecured. On at 1 PM, the Wellness Director confirmed the findings above and stated the incident was reported to Law Enforcement. Class III Based on record reviews and interviews, the facility failed to keep a centrally stored medication in a locked cabinet, locked cart, or other locked storage receptacle, room, or area at all times for 1 of 5 sampled residents (#3) who received assistance with self-administered medications. Findings:	A 055		

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A 055	Continued From page 8 Review of a facility incident investigation report, dated , revealed that two of resident #3's medication cards, each containing 30 tablets of , ER 20 milligrams (mg,) were delivered to the facility at 8:45 a.m. and signed for by caregiver F, who placed the cards on a desk in the nurse's station. At 10:15 a.m. the wellness nurse noticed only one card on the desk then locked it in a drawer in the medication cart. Following an investigation, the missing card could not be found. Caregiver F was counseled for leaving medications in an unlocked area. Review of a pharmacy delivery slip revealed that two cards were delivered. At 12:36 p.m. on , caregiver F said after comparing the two cards to the delivery slip, she signed the slip then placed the cards on a desk in the nurse's station and left the room without locking the door. She said the normal process for checking in was that first a nurse checked them into the computer then placed them in the med cart. She said a nurse was not around at the time nor did she look for one to follow the normal process. She said placing them in the nurse's station when a nurse was not around was her normal way of doing it. She said sometime later a nurse, she could not recall who, brought only one card to her at the med cart. When she questioned the nurse about the second card, the nurse said she saw only one on the desk. The caregiver searched the nurse's station but could not locate the other card. At 12:59 p.m. on , the director of nursing (DON) said caregiver F informed her of the missing medication. The DON searched the nurse's station but was unable to find the card. Following her own investigation she was unable	A 055		

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A 055	Continued From page 9 to determine what happened to the medication. She said caregiver F should have locked the door to the nurse's station when she left. She said the normal process was that staff who accepted the medications should compare the meds to the delivery slip then immediately take them to the med cart, log them into the . . . . . book then place them in the cart. Review of the facility's medication storage policy, revised . . , revealed controlled substances were to be stored in a locked and securely fastened box, drawer or permanantly fixed compartments within a locked medication area or cart. Review of resident #3's 1823, dated . . . , revealed the resident required assistance with self-administered medications. Class III	A 055		