STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963962	07/13/2015
NAME OF PROVIDER OR SUPPLIER BROOKDALE HAVERHILL ROAD	STREET ADDRESS, CITY, STATE, ZIP CODE 2939 S. HAVERHILL ROAD WEST PALM BEACH, FL 33415	

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

0000 Initial Comments

An unannounced Relicensure survey was conducted on at Brookdale Haverhill Road. The facility had deficiencies found at the time of the visit.

0008 Admissions - Health Assessment

Based on resident record review and staff interview, the facility failed to ensure an accurate and complete initial health assessment (AHCA Form 1823), for 1 of 2 residents whose records were reviewed (Resident #5).

The findings include:

1) Resident #5 was admitted to the facility on The initial health assessment (AHCA Form 1823) for Resident #5, dated documents diagnoses of Prostrate Hyperplasia and While reviewing the list of medications included on the initial health assessment, the list reveals Resident #5 is being prescribed and taking medications for the following health conditions: and which are not listed among the diagnoses on the Form 1823.
A review of the latest physician's orders for Resident #5, dated 2015, confirm the above diagnoses and add the following: Failure, history of Hip Permanent In-Dwelling and aneurysm (AAA).

2) The Assessment did not contain any explanation for all of the ADLs requiring supervision or assistance. Section 1, Part A, of the initial Health Assessment (AHCA Form 1823) documents the extent of the Resident's ability to conduct various Activities of Daily Living (ADLs). If a activity requires supervision or assistance, the facility is to explain the extent to which the resident requires the supervision/assistance.

3) The Health Assessment does not contain any explanation for all of the Task requiring supervision or assistance. Section 2-A, Part A, of the initial Health Assessment documents the Ability to Perform Self-Care Tasks. No indication was noted for the ability of the resident to perform the task of "preparing meals". Also, if a task requires supervision or assistance, the facility is to explain the extent to which the resident requires the supervision/assistance.

4) The Health Assessment does not document whether the resident needs help with taking his/her medications in Section 2-B, Part B; however, it is noted the resident "needs assistance with self-administration of medications.".

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During interview with Administrator on at 3:35 PM, she acknowledged the missing information on Resident #5's Form 1823.

Class III

0030 Resident Care - Rights & Facility Procedures

Based on observation, interview, and record review it was determined the facility failed to ensure residents received adequate and appropriate health care consistent with established and recognized standards within the community, specifically related to hand hygiene (hand washing/sanitizing) while providing assistance with the self administration of medications for 4 of 5 sampled residents (Residents #2, #11, #14, and #15) and during meal service.

The findings include:

1) During observation of the provision of assistance of self administration of medications conducted with Staff A on beginning at approximately 8:25 AM, she was not observed to wash and/or sanitize her hands prior to providing assistance with the self administration of medication for the following Residents:

1) Resident #14: at approximately 8:25 AM
2) Resident #15: at approximately 8:35 AM
3) Resident #2: at approximately 8:55 AM
4) Resident #11: at approximately 9:13 AM

Staff A was observed to transport residents to and from the Wellness Center (where the medication cart was located). She was observed to handle tissues; walkers; wheelchairs; touch residents clothing; and not wash or sanitize her hands except for one time at 8:45 AM when she sanitized her hands before pushing a resident in their wheelchair out of the Wellness Center.

A copy of the facility's policy related to medication guidelines was requested from the LPN (Licensed Practical Nurse), on at approximately 9:35 AM. He provided a copy of the policy entitled "Medication and Treatment - General Guidelines for Medication Administration/Assistance". The policy noted "Appropriate control practices, such as washing hands or using hand sanitizer in between resident medication administration/assistance is required". The LPN acknowledged that it is the expectation of the facility that the staff member providing assistance with the self administration of medication washed/sanitized their hands in between resident contact at a minimum.

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2) On , at approximately 8: 10 AM, Staff G was observed getting off the elevator carrying a breakfast tray for a resident's residing on the 2nd floor. Staff G proceeded down the hallway on the second floor carrying the breakfast tray which contained a covered plate of food ,an uncovered cup of coffee, and and uncovered glass of orange juice.
During interview conducted with the Administrator on at 3:35 PM, she acknowledged the beverages should have been covered during transport to resident's
Class III

0052 Medication - Assistance with Self-Admin

Based on observation, interview, and record review, it was determined the facility failed to ensure that staff followed Rule 58A-5.0191, F.A.C. and followed procedures described in Section 429,256, F.S. when providing assistance with the self administration of medications, for 2 of 5 sampled residents (Resident #2 and Resident #11).

The findings include:

During observation of Staff A providing assistance with the self administration of medications on beginning at approximately 8:25 AM, the following concerns were identified:

1) On beginning at 8:55 AM Staff A was obtaining Resident #2's medications when she dropped a 150mg XL on the top of the medication cart. Staff A then proceeded to pick this pill up with her bare (unwashed/unsanitized) hand and place in the container with 6 other medications. She proceeded to attempt to hand the container of a total of 7 medications to Resident #2 when this surveyor asked her to place the medications on the medication cart. Staff A was asked if this was how she would normally handle a medication that had been contaminated. She looked puzzled. The LPN (Licensed Practical Nurse) entered the I was informed that Staff A had dropped a pill on the top of the medication cart and then handled it with her bare hands and then was going to provide all medication in the medication container to the resident. The LPN informed Staff A that she had to discard all medications for this resident and start over with a new medication cup. This is what Staff A proceeded to do.

A copy of the facility's policy related to medication guidelines was requested from the LPN (Licensed Practical Nurse), on at approximately 9:35 AM. He provided a copy of the policy entitled "Medication and Treatment - General Guidelines for Medication Administration/Assistance". The policy, noted "Gloves should also be worn when cutting tablets in half or touching them for other reasons". The

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LPN acknowledged the top of the medication cart could have been contaminated and that gloves should be worn with touching any pill.

2) On [redacted] beginning at approximately 9:13 AM Staff A was observed obtaining Resident #11's medications and providing this resident with her oral medications. Resident #11 picked out a large white oblong pill and proceeded to hand it to Staff A and asked Staff A to cut this pill in half so it would be easier to swallow. Staff A proceeded to place this pill that had been handled by Resident #11 and now with Staff A's bare hand into the pill splitter. She proceeded to split the pill for this resident and hand it back to this resident. Staff A then proceeded to attempt to place the pill splitter back in the medication cart drawer. At this time she was asked to discuss this with the LPN. He instructed her to clean the pill splitter as both the resident and she handled the pill that was placed in the pill splitter. She proceeded to clean the pill splitter. Staff A was asked if the pill that was split was scored, as only scored pills are to be split. She stated she did not know that and that Resident #11 always asks for that pill to be split (it was [redacted] D-3 1000U). Staff A acknowledged she did not have an order to split this pill.

3) On [redacted] beginning at approximately 9:13 AM Staff A was observed to place 2 drops of [redacted] Solution 0.2/0.5% in Resident #11's right eye. She stated, "Oh, I must have squeezed too hard". She acknowledged that the MOR indicated only 1 drop is to be placed in Resident #11's right eye. Review of the [redacted] 2015 physician's orders confirmed that only 1 drop is to be placed in this resident's right eye. Staff A did not wash/sanitize her hands nor did she apply gloves. She attempted to placed the drops in this residents eyes with bare hands. This surveyor asked her to stop and obtain guidance from the LPN. He informed her she needed to wear gloves.

A copy of the facility's policy related to medication guidelines was requested from the LPN (Licensed Practical Nurse), on [redacted] at approximately 9:35 AM. He provided a copy of the policy entitled "Medication and Treatment - General Guidelines for Medication Administration/Assistance". The policy, noted "Gloves should be worn when administering eye/ear drops". The LPN was asked what the facility's expectation was. He stated gloves are to be worn when providing assistance with the administration of eye drops for all residents.

4) Staff A was observed on [redacted] at beginning at 9:13 AM, to be assisting Resident #11 with the self administration of her medications. The following medications were noted on the MOR (Medication Observation Record) to be provided at 8:00 AM. Staff A acknowledged that is was past the 1 hour window:

a) [redacted] Solution (eye drops) 0.2/0.5%
b) [redacted] 6.25mg every 12 hours at 8:00 AM and 8:00 PM

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A copy of the facility's policy related to medication guidelines was requested from the LPN (Licensed Practical Nurse), on [redacted] at approximately 9:35 AM. He provided a copy of the policy entitled "Medication and Treatment - General Guidelines for Medication Administration/Assistance". The policy, noted "Medications should be administered in the correct window of time, that is, 1 hour before or 1 hour after the stated time". The LPN acknowledged the above 2 medications were not provided within the required time frame.

5) During observation of Staff A providing assistance with the self administration of medications on [redacted] at approximately 9:30 AM, she was observed initialing(electronically) the MOR for Resident #5. This MOR indicated the following 10:00 AM medications were scheduled:

a) [redacted] 0.125mg
b) [redacted] 100mg
c) Famotadine 20mg
d) [redacted] 5mg
e) [redacted] 50mg
f) [redacted] 300mg
g) [redacted] 100mg
h) Losartin [redacted] 25mg
i) [redacted] 30mg
j) Reno Cap soft gel
k) [redacted] 0.4mg

As this surveyor was with Staff A continuously from 8:25 AM, she was asked why she was initialing Resident #5's MOR at 9:30 AM for his 10:00 AM scheduled medications. Staff A stated that she had given Resident #5 his medications before 8:30 AM because he was on his way to breakfast at that time and that she was just getting around to initialing the MOR. At this time, the LPN (Licensed Practical Nurse) was asked if this was an acceptable practice at this facility. He proceeded to inform Staff A that the MOR must be updated when the medications are provided.

A copy of the facility's policy related to medication guidelines was requested from the LPN (Licensed Practical Nurse), on [redacted] at approximately 9:35 AM. He provided a copy of the policy entitled "Medication and Treatment - General Guidelines for Medication Administration/Assistance". The policy, noted "Medications should be administered in the correct window of time, that is, 1 hour before or 1 hour after the stated time". The LPN acknowledged the above noted medications were not provided within the required time frame.

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0054 Medication - Records

Based on observation, interview and record review, it was determined the facility failed to ensure that each resident's MOR (Medication Observation Record) was immediately updated each time the medication is offered or administered, for 1 of 5 sampled residents (Resident #5).

The findings include:

During observation of Staff A providing assistance with the self administration of medications on [redacted] at approximately 9:30 AM, she was observed initialing(electronically) the MOR for Resident #5. This MOR indicated the following 10:00 AM medications were scheduled:

a) [redacted] 0.125mg
b) [redacted] 100mg
c) Famotadine 20mg
d) [redacted] 5mg
e) [redacted] 50mg
f) [redacted] 300mg
g) [redacted] 100mg
h) Losartin [redacted] 25mg
i) [redacted] 30mg
j) Reno Cap soft gel
k) [redacted] 0.4mg

As this surveyor was with Staff A continuously from 8:25 AM, she was asked why she was initialing Resident #5's MOR at 9:30 AM for his 10:00 AM scheduled medications. Staff A stated that she had given Resident #5 his medications before 8:30 AM because he was on his way to breakfast at that time and that she was just getting around to initialing the MOR. At this time, the LPN (Licensed Practical Nurse) was asked if this was an acceptable practice at this facility. He proceeded to inform Staff A that the MOR must be updated when the medications are provided.

A copy of the facility's policy related to medication guidelines was requested from the LPN (Licensed Practical Nurse), on [redacted] at approximately 9:35 AM. He provided a copy of the policy entitled "Medication and Treatment - General Guidelines for Medication Administration/Assistance". The policy, noted "Documentation of medications administered/assisted should occur promptly after the resident has taken the medication".

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Class III

0081 Training - Staff In-Service

Based on interview and record review, it was determined the facility failed to ensure that staff that provides direct care to residents had training certificates on file for the required trainings within 30 days of hire for 2 of 3 direct care staff sampled (Staff B and Staff C).

The findings include:

During record review and interview conducted with the District Director of Clinical Services on beginning at approximately 12:00 PM, she was provided the opportunity to locate the following trainings for Staff B and Staff C and was unable to locate the required training certificates:

Staff B (date of hire noted as
a) Elopement Response Policies and Procedures
b) Reporting Major Incidents & Reporting Adverse Incidents
c) Recognizing and Reporting Resident Neglect, and

Staff C (date of hire noted as
a) Elopement Response Policies and Procedures
b) Facility Emergency Procedures including Chain-of-Command and staff roles related to Emergency Evacuation
c) Reporting Major Incidents & Reporting Adverse Incidents
d) Resident Rights

During interview conducted with the Administrator on beginning at approximately 3:15 PM she stated they were unable to locate the above noted training certificates for Staff B and Staff C. She stated they have some in-service sign-in sheets but no training certificates with the required components for Staff B and Staff C.

Class

0090 Training -

Based on interview and record review, it was determined the facility failed to ensure that each direct care staff member had documentation that they had received at least one hour of training in the facility's policies and procedures regarding within 30 days of hire, for 1 of 3 sampled direct care staff

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sampled (Staff C).

The findings include:

During record review and interview conducted with the District Director of Clinical Services on beginning at approximately 12:00 PM, she was provided the opportunity to locate the following training for Staff C and was unable to locate the required training certificate:

Staff C (date of hire noted as
a)

During interview conducted with the Administrator on beginning at approximately 3:15 PM she stated they were unable to locate the above noted training certificate for Staff C. She stated they have some in-service sign-in sheets but no training certificates with the required components for Staff C.

Class

0091 Training - Documentation & Monitoring

Based on interview and record review it was determined the facility failed to maintain certificates, or copies of certificates, of any training required by this rule in the facility's personnel files with the required components of title of training program; subject matter of training program; number of hours of the training program; trainee's name; dates of participate; location of training program; training provider's name, dated signature and credentials, and professional license number if applicable for 2 of the 3 direct care staff sampled (Staff B and Staff C).

The findings include:

During record review and interview conducted with the District Director of Clinical Services on beginning at approximately 12:00 PM, she was provided the opportunity to locate the following trainings for Staff B and Staff C and was unable to locate the required training certificates:

Staff B (date of hire noted as
a) Elopement Response Policies and Procedures
b) Reporting Major Incidents & Reporting Adverse Incidents
c) Recognizing and Reporting Resident , Neglect, and

Staff C (date of hire noted as

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a) Elopement Response Policies and Procedures
b) Facility Emergency Procedures including Chain-of-Command and staff roles related to Emergency Evacuation
c) Reporting Major Incidents & Reporting Adverse Incidents
d) Resident Rights

During interview conducted with the Administrator on beginning at approximately 3:15 PM she stated they were unable to locate the above noted training certificates for Staff B and Staff C. She stated they have some inservice sign-in sheets but no training certificates with the required components for Staff B and Staff C.

Class

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Brookdale Haverhill Road
2939 S. Haverhill Road
West Palm Beach, FL 33415

Dear Administrator:

This letter reports the findings of a State Relicensure Survey that was conducted on , 2015 by a representative from 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 your corrective action and any additional documentation to support correction of identified deficiencies and send to the Field Office no later than , 2015.** 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 representative. Should you have any questions please call this office at (561) 381 - 5840.

Sincerely,

Arlene Mayo - Davis
Field Office Manager

AMD/jw
Enclosure

XG90

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