AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964130	07/30/2015
NAME OF PROVIDER OR SUPPLIER **BROOKDALE CLEARWATER**	STREET ADDRESS, CITY, STATE, ZIP CODE **2750 DREW STREET** **CLEARWATER, FL 33759**	

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

0000 Initial Comments

Assisted Living Facility

A biennial licensure survey with limited nursing services (LNS) was conducted on /15 to .

The Brookdale Clearwater assisted living facility had deficiencies found at the time of the visit.

0010 Admissions - Continued Residency

Based on record review and interview, the facility failed to have a hospice interdisplinary care plan for 1 (#12) of 2 residents sampled for record review.

Findings include:

Record review on of resident #12's medical record revealed the resident had been admitted to the facility on and then she was admitted to hospice on / with a diagnosis of . Hospice must develop and implement an interdisplinary care plan with the facility which will document the services being provided by hospice and those being provided by the facility.

Further review of the resident's medical record on / revealed there was no interdisplinary care plan documented in resident #12's medical file.

Interview with resident #12's hospice nurse on / at 10:00 a.m. revealed she had not developed and implemented an interdisplinary care plan with the facility for resident #12.

Class III

0052 Medication - Assistance with Self-Admin

Based on observation and interview the facility failed to ensure that medications were being provided appropriately for 1 (#14) of 3 sampled residents observed receiving assistance with administration of medication. The facility failed to follow the assisting of administration of medication policy and procedure for 1 (#14) of 3 residents by not telling the resident what medications that she was taking and observe resident #14 taking the medication.
Findings Include;

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1. Observation of staff# C on at 9:25 AM during the medication pass for resident #14 revealed after staff #C put 7 pills in the medication cup , poured water into the cup, and proceeded to walk to the resident ' s , she then knocked on the door. Resident #14 opened the door and staff #C stated she had pills and did not explain what pills she was giving and handed the water and medication cup with the 7 pills (, CalCarb plus D , Mult- with and 2 tabs of) to resident #14 who took the medication cup and walked into her shut the door. Staff #C did not observe resident #14 take the medication.
2. Interview on / at 9:30AM with staff #C revealed resident #14 took medications independently and does not like people going into her .
3. Review of the 1823 form, Resident Health Assessment for Assisted Living Facilities dated revealed resident #14 needs assistance with Self-Administration of Medications.
4. Review of the facility's policy and procedure on Medications & Treatment - Assistance with Self Administration of Medication (effective date) documents in the presence of the resident explain the purpose of each medication and observe the resident taking the medication.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Brookdale Clearwater
2750 Drew Street
Clearwater, FL 33759

Dear Administrator:

This letter reports the findings of a biennial state licensure survey with limited nursing services (LNS) that was conducted on , 2015 by representative(s) 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 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 surveyor(s). Should you have any questions please call **Paul Brown**, HFES at (727) 552-2000.

Sincerely,

for Patricia Reid Caufman
Field Office Manager

PRC/clt
Enclosure: State (5000-3547) Form

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