RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Brookdale Pensacola
8700 University Parkway
Pensacola, FL 32501

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by representative(s) of this office. Attached is the provider's copy of the State (5000-3047) 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 a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** 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 me at 850-412-4540.

Sincerely,

Donah Heiberg
Field Office Manager

DH/dh

Enclosure

XG90

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

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964959	02/03/2016
NAME OF PROVIDER OR SUPPLIER **BROOKDALE PENSACOLA**	STREET ADDRESS, CITY, STATE, ZIP CODE **8700 UNIVERSITY PARKWAY** **PENSACOLA, FL 32501**	

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

0000 Initial Comments

An unannounced biennial survey with a Limited Nursing Monitoring visit was conducted on / - at the Brookdale Pensacola Assisted Living Facility. The facility had deficiencies found at the time of the visit.

0053 Medication - Administration

Based on record reviews and interviews the facility, who provides medication administration, failed to ensure a staff member licensed to administer medications was available to administer the medications in accordance with the resident's physician's orders for 1 of 2 sampled residents (#1).

The findings are:

The surveyor entered the facility, unannounced on / at approximately 1:30PM. An interview was conducted with the facility's Health/Wellness Director at that time. The Health/Wellness Director informed the surveyor the facility provides licensed nurses for medication administration but only on two shifts- the day shift and the evening shift.

Record review for sampled resident #1 revealed the resident was admitted to the facility on . The record revealed a Resident Health Assessment for Assisted Living Facility completed by the resident's physician on . The physician stated the resident needs medication administration. Review of the physician orders revealed an order for Levothroxine 88 micrograms one tablet by mouth every day for . Record review of the medication administration record for 2016 and 2016 revealed the resident takes the medication at 6AM. Record review revealed documentation of the medication being provided by sampled staff E, a resident aide and medication technician not a licensed nurse.

Interview was done with sampled resident #1 on at approximately 3:15PM, she stated that the staff come into her in the morning while she is still sleeping and wake her so she can take some medication, she is not sure what it is but takes it anyway. She does not get the medication from a nurse it is from one of the aides. Interview and record review with the Health and Wellness director and the executive director on at approximately 3:30PM confirmed the resident is to be administered medications by the nurses and not the medication technician. They confirmed sampled staff E is a resident aide/medication technician and not a licensed nurse. They stated this medication is given to the resident prior to the nurses reporting to work.

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0081 Training - Staff In-Service

Based on record reviews and interviews the facility failed to ensure direct care staff received the appropriate training within 30 days of employment. 1) The facility failed to provide appropriate training which covers reporting major or adverse incidents for 2 of 4 sampled staff (B and C). 2) The facility failed to provide appropriate training which covers resident rights for 1 of 4 sampled staff (B). 3) The facility failed to provide appropriate training which covers providing assistance with residents activities of daily living for 1 of 2 sampled staff who are required to receive the training (C). 4) The facility failed to provide appropriate training in safe food handling for 3 of 4 sampled staff (A, C, D). 5) The facility failed to provide appropriate training in resident elopement response policies for 4 of 4 sampled staff (A,B, C, D).

The findings are:

1) Record review of sampled staff #B revealed she was employed and is a resident aide. Record review of the staff's personnel record with the acting executive director failed to reveal documentation of the required 1 hour of training for incident reporting. Interview with the executive director(ED) on at approximately 10:48AM confirmed there is no documentation revealing sampled staff B had received this training at anytime since her employment.

Record review for sampled staff #C revealed she was employed / and is a resident aide and a medication technician. Record of the staff's personnel record with the acting executive director revealed a certificate documenting sampled staff #C had received training which covered reporting of major adverse incidence completed on / /. But the certificate revealed documentation the course was only 26 minutes long and not the required 1 hour of training. Interview and record review with the ED on / at approximately 10:20AM confirmed these findings.

2) Record review of sampled staff #B revealed she was employed and is a resident aide. Record review of the staff's personnel record with the acting executive director failed to reveal documentation of the required 1 hour of training for resident rights. Interview with the executive director(ED) on at approximately 10:57AM confirmed there is no documentation revealing sampled staff B had received this training at anytime since her employment.

3) Record review for sampled staff #C revealed she was employed / and is a resident aide and a medication technician. Record of the staff's personnel record with the acting executive director revealed a certificate documenting sampled staff #C had received training which covered activities of daily living on / /. But the certificate revealed documentation the course was only 1 hour long and not the required 3 hours of training. Interview and record review with the ED on at approximately

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10:14AM confirmed these findings.

4) Record review for sampled staff #A revealed she was employed on and is a licensed practical nurse (LPN). Interview with the ED on at approximately 9:43AM revealed that she is expected to assist with dining at times. Record review with the ED revealed a certificate for safe food handling dated but the certificate revealed documentation the course was only 25 minutes long and not the required 1 hour long training. Interview and record review with the ED on at approximately 9:43AM confirmed these findings.

Record review for sampled staff #C revealed she was employed / and is a resident aide and a medication technician. Record review with the ED revealed a certificate for safe food handling dated /. The certificate also documented the training was only 50 minutes long and not the required 1 hour of training. These findings were confirmed by the ED on at approximately 10:30AM.

Record review for sampled staff #D revealed she has an employment date of / and is a licensed practical nurse. Record review with the ED revealed a certificate for safe food handling dated /. The certificate also documented the training was only 25 minutes long and not the required 1 hour. Interview and record review with the ED on at approximately 10:45AM confirmed these findings.

5) Record review for sampled staff #A revealed she was hired on / and is a LPN. Sampled staff #B is a resident aide and was hired . Sampled staff #C is a resident aide and a medication technician and was hired /. Sampled staff #D is a LPN and was hired /. Record reviews for these staff was done with the ED and failed to reveal documentation these staff had received the required 1 hour elopement response training within 30 days. These findings were confirmed by the ED.

0090 Training -

Based on record reviews and interviews the facility failed to ensure direct care staff received at least one hour of training in the facility's policy and procedures regarding ( ) within 30 days after employment for 3 of 4 sampled staff (A, C, D).

The findings are:

Record review for sampled staff #A revealed she was hired on / and is a LPN (licensed practical nurse). Sampled staff #C is a resident aide and a medication technician and was hired /. Sampled staff #D is a LPN and was hired /.

Record review for sampled staff #A revealed a certificate of training for policy and procedure

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done one . The certificate documented the course is only 40 minutes long not the required 1 hour.

Record review for sampled staff #C revealed a certificate of training for the policy and procedure done on . The certificate documented the course is only 40 minutes long not the required 1 hour.

Record review for sampled staff #D revealed a certificate of training for the policy and procedure done on . The certificate documented the course is only 40 minutes long not the required 1 hour.

These findings were reviewed and confirmed with the executive director on between 9:44AM and 10:45AM. The ED stated the required course is one hour long and these are not.