STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911225	R
NAME OF PROVIDER OR SUPPLIER **BROOKDALE ENGLEWOOD**	STREET ADDRESS, CITY, STATE, ZIP CODE **925 SOUTH RIVER ROAD** **ENGLEWOOD, FL 34223**	

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

0000 Initial Comments

An unannounced revisit survey was conducted on at Grand Villa (license number 5501), in Englewood, Florida. This was a follow-up to the Change of Ownership and Extended Congregate Care survey conducted on and .

The following is description of the deficiencies found at the time of the visit.

0056 Medication - Labeling and Orders

Based on observation, record review and interviews, the facility failed to have medication records and medications labeled, in accordance with physician orders for 3 (Residents #4, #3 and #19) out of 7 residents reviewed for medications.

The findings included:

1. On at 10:15 a.m., Resident #4's Medication Observation Record (MOR) for 2016 was reviewed and indicated the resident was to receive 81 mg chew 1 tablet once a day with food. A bottle of 81 mg was in the medication cart and labeled with the resident's name. No directions were observed on the bottle. Medication Assistant Staff S, said she gave this to the resident this morning and had her swallow the tablet. Staff S said the resident's physician had changed this pill from a chewable tablet to a pill to swallow "a while ago" and may have not been transferred to the new MOR. The physician's order dated indicated the resident was to receive chew 81 mg take one tablet once daily with food. On at 12:28 p.m., the Corporate Nurse confirmed the physician order did not indicate the resident was to receive .

2. On at 10:20 a.m. Resident #3's MOR dated 2016 indicated the resident was to receive 81 mg take one tablet daily. The medication dispensed from the pharmacy was labeled 81 mg take one daily. On at 12:32 p.m., the Corporate Nurse confirmed the MOR did not match the pharmacy label.

3. On at 10:35 a.m., Resident #19's MOR for 2016 indicated the resident was to receive 81 mg take 1 tablet by mouth daily. A bottle of Bayer low dose was labeled with the resident's name and had no visible directions on the bottle. Medication Assistant Staff U confirmed this was for Resident #19. The AHCA form 1823 had attached medication orders dated the resident was to receive 81 mg. There were no directions for use. The Corporate Nurse confirmed the MOR did not match the physician order and there were no directions for use.

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NAME OF PROVIDER OR SUPPLIER **BROOKDALE ENGLEWOOD**	STREET ADDRESS, CITY, STATE, ZIP CODE **925 SOUTH RIVER ROAD** **ENGLEWOOD, FL 34223**	

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

Class III

0078 Staffing Standards - Staff

Based on record reviews and staff interview, the facility failed to provide a written statement from a health care provider of being free from communicable for 3 (Staff P, Q and R) of 4 staff personnel files reviewed.

The findings included:

1. Resident Care Staff P, with a hire date of , had no statement of being free from communicable to include .

2. Resident Care Staff Q, with a hire date of / , had no statement of being free from communicable to include .

3. Staff , a hire date of , had no statement of being free from communicable to include .

These findings were confirmed by the Interim Administrator on at 1:00 p.m.

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11911225 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ENGLEWOOD	925 SOUTH RIVER ROAD ENGLEWOOD, FL 34223

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0081	Correction	ID Prefix A0082	Correction	ID Prefix A0086	Correction
Reg. # 58A-5.0191(2) FAC	Completed	Reg. # 58A-5.0191(3) FAC	Completed	Reg. # 58A-5.0191(9) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0093	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 58A-5.020(2) FAC	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	[illegible]	6-13-16	[illegible] Dawn White, RNS	6.13.16
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 3/8/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Brookdale Englewood
925 South River Road
Englewood, FL 34223

Dear Administrator:

This letter reports the findings of a State Licensure Revisit Survey conducted on 8, 2016 by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

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. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form and Revisit Report

YOSF

Fort Myers Field Office
2295 Victoria Avenue, Room 340
Fort Myers, FL 33901
Phone:(239) 335-1315; Fax:(239) 338-2372
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