STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964912	**07/07/2016**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE SOUTHPOINT**	STREET ADDRESS, CITY, STATE, ZIP CODE **6895 BELFORT OAKS PLACE JACKSONVILLE, FL 32216**	

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

0000 Initial Comments

On , 2016, a biennial re-licensure survey was conducted at Brookdale Southpoint (License #9380). Deficient practice was identified during the survey.

0026 Resident Care - Social & Leisure Activities

Based on observation, document review, family interview, resident interviews and staff interviews the facility failed to provide an ongoing activities program six days a week.

The findings include:

During the biennial licensure survey on a tour of the facility was conducted. The activities observed at 11:10 am. The occupied by a staff member and two family members for Resident #12. No group activity was taking place.

Review of the Activities Calendar posted in the activities at 11:00 am a Tea Social was to be conducted as a group activity in the Activity (AR). Photo obtained.

During an interview with the son of Resident #12 on at 11:25 am he stated that the Activities Director was driving the facility van taking residents to doctor's appointments. She does it on Tuesdays and Thursdays. When she does, no activities take place.

During an interview with Resident #5 on at 1:00pm she stated that the Activities Director is also the Transportation Director. She stated that there are no activities on Tuesdays or Thursdays because she's driving the van to take the residents to doctor's appointments.

During an interview with the Activities Director on at 6:25 pm she stated she is the activities director for the facility. She confirmed that she does drive the residents on Tuesdays and Thursdays to their doctor's appointments. She takes them in the facility van. She stated that no other staff member covers for her when she is out of the building and no activities are conducted while she's gone. She stated that some days she was gone all day because the appointments are late in the day.

During the exit conference with the Administrator, Health and Wellness Director, District Nurse Consultant and Business Office Manager on at 7:00 pm, the Administrator acknowledged that the Activities Director does drive the van two days a week and no one conducts group activities while she is out of the building.

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Class III

0030 Resident Care - Rights & Facility Procedures

Based on record review, resident, and staff interviews, the facility failed to ensure that residents retained the right to adequate and appropriate health care consistent with established and recognized standards of care for one (Resident #5) of three sampled residents of a total of 69 residents currently living in the facility.

The findings include:

During a interview 1:00 pm, Resident #5 related an incident that happened in 2016. She stated that on Friday, , she felt that she was getting , again. She said that she told the nurse (Employee G) about this on Saturday morning, . She stated that the nurse then went and called her physician. She said she was told by the nurse that the physician ordered . She did not get any over the weekend. She stated Employee G came back to see her on Sunday, , and told her that she looked better and that the must be working. Resident #5 laughed and said, "I was too weak and sick to tell her that I hadn't gotten any ( )." Resident #5 stated that she asked the medication technician on Monday morning (23 rd) when she came in to give her her medications if she was getting an . Resident #5 stated that the medication technician looked at her, apparently , and asked her why she'd be getting an . Resident #5 told the medication technician what had transpired, and the medication technician then went to find out. At that point an appointment was made with Resident #5's primary care physician for Tuesday, . She did not know why she was not getting the the physician had ordered. She could not remember who the medication technician was. Resident #5 stated that Employee G came to see her on Monday, , and apologized for her not getting her medications. Employee G told her that she was trying to find out why, and had made her an appointment with her doctor.

A review of Resident #5's and 2016 medication observation records (MORs) revealed the following:
No were documented on the MORs before .
, 500 milligrams (mg) by mouth for ten days was to start on . The MOR was not signed off as if the medication had been given, and "discontinued" was written over it.
500 mg by mouth on was not initialed as given.

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250 mg by mouth for six days was to start on . This medication was initialed as given on and , but not on / , and it was not carried over into , so was not received after .

250 mg by mouth daily for 10 days starting on was written and this medication was provided as ordered. (Photographic evidence obtained)

A review if Resident #5's clinical record revealed the following:
On , the physician wrote on the 2016 physician's order sheet, "Make sure she is getting the every day. Patient claims they are skipping her dose?"
On / , the physician wrote, "Patient recently hospitalized with and is to finish her ."
On / a physician's order was written for 500 mg by mouth daily for ten days.
The nurses' notes indicated the following:
On / at 10:00 a.m., a note was written indicating that the resident complained of feeling poorly, like she felt when she had last year. The doctor was called.
On / at 1:00 p.m., a note was written that read, "Start , 500 mg (milligrams), one by mouth daily. If feels worse, send to emergency . In this note, the 500 mg dosage was lined out with the word "error" written above it.
The next note written was dated / . It indicated that Resident #5 went out to her doctor's appointment, and that the doctor's office had called stating that they would probably be sending the resident to the hospital. (Photographic evidence obtained)

During a interview with Employee B (HWD - Health and Wellness Director) at 1:45 p.m., she stated that Resident #5 wasn't feeling well "around / .", and that she acquired easily. She reviewed the nurses' notes in Resident #5's clinical record with this surveyor, and stated that she would have to look over the record to see what happened. After doing that she stated that the for Resident #5 had been ordered without a dosage, so the pharmacy did not fill it. She stated that when the mistake was caught, the pharmacy was faxed again for the medication, but that this occurred a couple of days later. She stated that after that, Resident #5 had a doctor's appointment, and the doctor sent her to the hospital from her office. When Resident #5 returned to the facility, she had more ordered. Employee B stated that she didn't know what happened with the that was started on but was not carried over to the next month. She stated, "We compare to the physician's order sheets and the previous orders when we do the monthly changeover." She stated that whomever completed the changeover for Resident #5 made a mistake and did not transcribe her orders accurately.

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During a interview with Employee G (RN - registered nurse) at 2:40 p.m., she stated that she had called Resident #5's physician on , who ordered but didn't specify a dosage. Employee G stated, "When I got back on Monday I saw that she hadn't started her . She had a Tuesday appointment with her pulmonologist, and so she went to her appointment and they sent her to the hospital. I did tell the doctor that the resident didn't start the . At the time that this happened we did not have an evening nurse. There was no one to report to. I can't remember exactly what happened on the 21rst, but I would have told the Med Tech that she (Resident #5) wasn't feeling well and to look after her. I would have told them that when the pharmacy delivered the to give it to her. On Monday I learned from Resident #5 that she hadn't gotten her . I actually had to order it again; it wasn't in her drawer in the medication cart. I ordered the 500 mg (milligrams) by mouth for ten days to start on Tuesday, , then when she went to the doctor's appointment, she was sent straight to the hospital, so the order was discontinued. I did write up an incident report."

A review of the incident report revealed that a medication was ordered, but never given. It indicated that the doctor was notified on at 10:00 a.m. "No dosage given for . Order sent to pharmacy. No notice from pharmacy of nursing dose (Guardian). Med not on MOR or in facility. 1600 - Received dosage (500 mg) from MD office. Refaxed and called Guardian. Has appointment at 10:45 a.m. on to see MD." (Photographic evidence obtained)

A interview with Employee B at 5:19 p.m., revealed that when she was asked how the staff communicated things like residents' illnesses and medications that have been ordered and should be delivered during their shift or later that night, she replied that the nurses and medication technicians did not use a 24-hour report log; they communicated verbally to one another what was going on and what to expect. She stated that the nurse who worked after Employee G on Sunday, , should have noticed the problem, then should have called the pharmacy to see what happened. She should have called the physician to see how to follow up. Employee B stated that that nurse was no longer employed by the facility.

Class III

0077 Staffing Standards - Administrators

Based on record review and staff interview, the facility Administrator failed to supervise the operation and maintenance of the facility including management of staff and provision of care to residents. This is

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evidenced by the Administration's failure to ensure that staff providing services requiring licensure or certification, were appropriately licensed or certified for one (Employee E) of five sampled employees.

The findings include:

A review of Employee E's (a licensed practical nurse) personnel record revealed no current Florida nursing license was on file. In fact, no nursing license was on file at all. A copy of her driver's license revealed that it was obtained in Georgia.

Review of the file revealed that Employee E was terminated effective . The form stated that on Monday, , it was discovered that Employee E had failed to provide the company with the proper state licensing endorsements. The form was signed by the Executive Director and a supervisor on . The form indicated that Employee E was terminated via telephone on . (Photographic evidence obtained)

A handwritten note signed by Employee E and dated read, "I applied for Florida nursing licensure this morning, and I'm providing a copy of my fingerprint report. (Photographic evidence obtained)

A copy of a Time Card report dated 12-25, 2016 had a handwritten note on it dated which read, "Sent home early. Unable to provide current Florida LPN license." It was signed, but the initials were illegible. The form indicated that Employee E worked on , , , , and . The top of the form indicated a start date of . Two more time sheets in the file indicated that Employee E worked in and 2015. (Photographic evidence obtained)

During an interview with the Business Office Manager (Employee F) on at 4:45 p.m., he confirmed that Employee E was hired on . He confirmed that she was employed by the facility until ; more than seven (7) months.

A review of the Agency for Health Care Background Screening website revealed that Employee E was eligible for employment as of . The form also read, "No employment history records".

A review of the Department of Health website for verification of nursing licensure revealed that Employee E was licensed as a practical nurse (LPN) in Florida effective . The address listed on the website as Employee E's place of employment was the facility being surveyed on .

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A review of the Georgia Board of Nursing website for verification of nursing licensure revealed that Nursys.com should be used. A review of that website revealed that Employee E was licensed in Georgia, but provided no further information.

A review of the Florida Nurse Practice Act revealed the following:
64B9 - 3.008 Licensure by Endorsement
(1) An applicant for licensure by endorsement must apply to the Department on prescribed forms, including verification of licensure forms from the original state or territory in which licensure was obtained, and from a state or territory in which the applicant holds an active license, and pay the required fee.

64B9 - 3.009 Practice of Nursing by Applicants for Licensure by Endorsement
(1) An applicant for licensure by endorsement holding a current license in another state may perform nursing services in Florida for sixty (60) DAYS after furnishing the employer the following:
(a) Evidence of current licensure in another state
(b) Verification from the Board that the applicant has submitted the proper endorsement form and fee

Class III

0078 Staffing Standards - Staff

Based on employee record review and staff interview the facility failed to ensure that staff submitted a statement from a health care provider within 30 days of employment documenting that they did not have any signs or symptoms of a communicable including ( ) for one (Employee B) of three sampled employees.

The findings include:

1) A review of Employee B's personnel record revealed no statement by her physician indicating that she was free from communicable .

During an interview with Employee B on at 4:00 pm she confirmed that she did not have a statement from her physician indicating she was free from communicable .

Class III

0081 Training - Staff In-Service

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Based on employee record review and staff interview the facility failed to ensure employees received or obtained required trainings for one employee (D) out of four sampled employees.

The findings include:

Review of Employee D's employee record revealed no Elopement and Response training within 30 days of hire.

During an interview with the Business Office Manager on at 6:35 pm he confirmed Employee D did not have Elopement and Response training within 30 days of hire.

Class III

0082 Training -

Based on employee record review and staff interview the facility failed to ensure employees received or obtained required trainings for one employee (C) out of four sampled employees.

The findings include:

Review of Employee C's record revealed no ( ) training within 30 days of hire.

During an interview with the Business Office Manager on at 6:35 pm, he confirmed Employee C did not have training within 30 days of hire.

Class III

0083 Training - First Aid and

Based on employee record review and staff interview the facility failed to ensure employees received or obtained required trainings for three employees (B, C, and D) out of four sampled employees.

The findings include:

Review of Employees C and D's records revealed no current and valid First Aid and ( ) training.

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Review of Employee B's employee record revealed no current and valid training.

During an interview with the Business Office Manager on at 6:35 pm,a he confirmed Employees C and D did not have current and valid First Aid and training. He confirmed that Employee B did not have current and valid training.

Class III

0093 Food Service - Dietary Standards

Based on record review and staff interview the facility failed to maintain a menu substitution log on file for 6 months.

The findings include:

A review of the menu and dietary documentation revealed no menu substitution log.

During an interview with the Dining Services Coordinator on at 3:05 pm it was revealed he had only been working at the facility for 1 month and was not sure where the substitution log was kept. He stated he would go look for it.

During a second interview with the Dining Services Coordinator on at 4:53 pm, he stated he could not find a substitution log for the facility.

Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observation, resident interview and staff interview the facility failed to provide a safe living environment maintained free of hazards by allowing one resident (#5) to store her tanks in an unsecured manner in her .

The findings include:

During an interview with Resident #5 on at 1:00 pm an tank was observed sitting on the floor, unsecured, next to a rack full of tanks. Photo obtained.

Resident #5 stated that the tank should be in the rack, but she left it out because it was still half full and

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she wanted to remember which one it was so she could use it later. She stated she usually puts them in the rack for storage. During the interview, a direct care staff member knocked on her door and then came into the check on her and her . The staff member did not observe the tank on the floor.

During the exit conference on at 7:00 pm the Administrator, Health and Wellness Director and District Nurse Consultant acknowledged that the resident's tanks need to be stored in a secure manner and the staff should be aware that they need to secure them when they are in the resident's .

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Brookdale Southpoint
6895 Belfort Oaks Place
Jacksonville, FL 32216

Dear Administrator:

This letter reports the findings of a state biennial licensure survey that was conducted on , 2016 by representatives 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 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 29, 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 surveyors. Should you have any questions please call this office at -4201.

Sincerely,

Jana Meyering, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

JG/JM/sm
Enclosure
XG90

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