STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910810	08/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINECREST	**1150 8TH AVENUE, S.W. LARGO, FL 33770**

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

0000 - Initial Comments

Assisted Living Facility

On , 2017, an abbreviated biennial re-licensure survey in conjunction with complaint survey, (CCR# 2017006256), was conducted at Brookdale Pinecrest, Assisted Living Facility. Deficient practice was identified at the time of the visit.

(License # 93)

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on observations, interviews and records review, the facility failed to properly label medications and failed to ensure that prescriptions were refilled in a timely manner for 3 of 6 residents, requiring assistance with medication self-administration, whose medications were observed or whose medication records were reviewed.

Findings included:

A medication observation was conducted between 9:40am and 10:40am on with Staff D, a licensed practical nurse. During the medication observation, Staff D was preparing to assist Resident #12 with medications. Staff D reviewed the medication administration record (MAR) and saw that it was time for Resident #12's dose of a medication to improve function, which was to be given 3 times every day. Staff D looked on the medication cart for the required dose of the medication and discovered only an empty container. Staff D stated that the medication had run out and the facility had not received a refill of the medication. Staff D was not able to provide Resident #12's medication when it was due and subsequently charted in the MAR that the medication was not given because it was not available. Staff D was uncertain if anyone had ordered a refill of Resident #12's medication.

As Staff D was gathering Resident #12's medications in order to assist the resident with medication self-administration, 2 of the resident's medications were over the counter products that were contained in bottles that were unmarked and unlabeled with the resident's name. Staff D stated that the resident's name should have been marked on the medication, indicating it was for Resident #12's use and no one else's.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910810	08/28/2017
NAME OF PROVIDER OR SUPPLIER **BROOKDALE PINECREST**	STREET ADDRESS, CITY, STATE, ZIP CODE **1150 8TH AVENUE, S.W.** **LARGO, FL 33770**	

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

Staff D then began preparing to assist Resident #13 with medications. Staff D reviewed the MAR, which indicated that the resident was due for an iron pill that was to be given twice per day. When Staff D located the required medication on the cart, the label of the resident's medication indicated that the iron pill was to be given only once per day. Staff D stated that there should have been a sticker on the medication label that said the order had changed and that the facility should follow the order as stated in the MAR (not what it said on the label).

A review of Resident #14's records was conducted at 3:00pm on . The records revealed that on , the resident's healthcare provider diagnosed the resident with a highly skin condition, which causes intense discomfort. On , the healthcare provider prescribed an oral medication for the treatment of this highly condition. The resident's records did not have any verification that the prescribed oral medication was ever sent in to the pharmacy or that it had been given to the resident until , 10 days after the medication was ordered. On the MAR for Resident #14 indicated that the oral medication that was prescribed on was finally given. The records also revealed a note from the resident's healthcare provider on that stated, "We called facility again, appears nobody on their nursing staff is communicating and these orders have been clear. It is very clear from our many communications with my staff and Brookdale that we have no idea whether medications and orders have been administered".

At 4:30pm on , the Health and Wellness Director indicated that the facility was not aware of the long lag time in following Resident #14's healthcare provider's orders for treating a highly and uncomfortable skin condition.

Class III