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)

0000 - Initial Comments

Assisted Living Facility

A complaint investigation, (CCR# 2017006256), was conducted at Brookdale Pinecrest on . Brookdale Pinecrest had a deficiency at the time of the visit.

(License # 93)

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on interviews and records review, the facility failed to implement control measures and physician ordered treatments designed to prevent the outbreak of a highly condition called , putting the entire facility at risk for for 3 of 17 residents sampled.

Findings included:

The facility's policy and procedure on was reviewed at 4:00pm on . The facility policy states the following: is an infestation of the skin by a microscopic mite. spreads quickly in crowded conditions where there is frequent skin to skin contact. The elderly and compromised individuals are at highest risk. Once is suspected it is imperative to seek the advice of a health care provider. Associates should utilize standard precautions once is suspected. Until the resident receives their first treatment or the physician determines that is not the problem, they should limit contact with other residents. This could mean eating meals in his/her apartment and doing activities alone.

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 , which causes intense discomfort. On , the healthcare provider prescribed an oral medication for the treatment of . 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 records show that Resident #14 finally received the medication for that was prescribed on . The records also revealed a note from the resident's healthcare provider on that stated, "We called facility again, appears nobody on their nursing

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staff is communicating and these orders have been clear. It is very clear from our many communications with my staff and (the facility) that we have no idea whether medications and orders have been administered". A search in Resident #14's records turned up no indication of whether or not the resident was put on an isolation alert or that standard precautions, such as gowns or gloves were to be utilized when caring for this resident (as the facility's policy and procedure requires) even though the initial treatment for was finally given to the resident 10 days after the healthcare provider diagnosed and ordered a treatment.

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 review of Resident #16 records was conducted at 3:15pm on . The records revealed that on , Staff D, an LPN, sent a request to a healthcare provider that the resident "had a (red small dots) under axillary area (under arms), top of both wrists, and couple on chest /abdomen. It is itchy. (The resident) stated that someone seated at the same dining complained of having mites. (Staff D) had residents by maintenance. Do you want an office visit or can you prescribed a cream for itch?" The healthcare provider responded by writing orders for a cream medication to treat on (2 days later), to be applied from neck to feet that day and washed off the next morning and to apply the cream again in 4 days with the same instructions. The resident's records showed that the resident received the cream treatment for on (3 days after the nurse sent the request to the healthcare provider that was suspected) and again on . The resident's records did not reveal any indication of whether or not the resident was put on an isolation alert, or that standard precautions, such as gowns or gloves were to be utilized when caring for this resident, as they facility's policy and procedure for requires, even though 3 days went by before the first treatment for was applied to the resident.

A review of Resident #17's records was conducted at 3:30pm and the records revealed that the residents was diagnosed with on . The healthcare provider ordered the resident prescription for a cream to treat the , stating "launder clothing per protocol and apply the cream treatment for from head to toe". The resident's record revealed that the resident was treated with the cream on . The resident's records did not reveal any indication of whether or not the resident was put on an isolation alert, or that standard precautions, such as gowns or gloves were to be utilized when caring for this resident, as they facility's policy and procedure for requires, even the treatment for was applied to the resident the day following the diagnosis of .

In an interview with the ALF Administrator and the Health and Wellness Director at 4:30pm, they could

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not explain why there was no documentation in the records, of any of the 3 residents diagnosed with , that there was any effort to use control standard precautions or isolation measures until the treatment for was completed.

Class III