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	AL11963945	**09/26/2017**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE BRANDON**	STREET ADDRESS, CITY, STATE, ZIP CODE **700 S. KINGS AVENUE** **BRANDON, FL 33511**	

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

0000 - Initial Comments

Assisted Living Facility

An unannounced biennial state licensure survey with Limited Nursing Services (LNS) was conducted on .

The Brookdale Brandon, Assisted Living Facility (License # 7656), had deficient practice identified at the time of this visit.

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation, interview, and record review, the facility did not ensure that an unlicensed person provided assistance with the self-administration of medication according to the health care provider's order for one (Resident #14) of five residents observed for medications.

Findings included:

During a medication pass observation on at 1:23 PM, Staff E, a medication technician, was observed assisting Resident #14 with the self-administration of medication. Staff E removed a bottle of 10Gm/15mL solution and poured 15mL into a graduated measuring cup. The Surveyor observed at that time that 15mL of was in the cup. Staff E verbally confirmed at that time that he had poured 15mL of . Staff E handed the to Resident #14 and observed Resident #14 drink the . Staff E marked on the medication observation record (MOR) that Resident #14 had taken the medication. A review of the MOR for the order revealed that the order stated, " 10Gm/15mL take 30mL by mouth three times a day."

A review of Resident #14's health care provider's order for the , which was dated , revealed that the order was, " 20grams three times a day." The current concentration of the on the medication cart for Resident #14 was 10Gm/15mL, as observed during the medication pass observation. The medication order of 20grams three times a day would require that 30 mL of 10Gm/15mL solution be given.

On at 1:52 PM, the Health and Wellness Director (HWD) confirmed that Resident #14's order

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was for 20grams three times a day. The HWD reviewed Resident #14's MOR and confirmed that the order written in the MOR was correct. The HWD confirmed that Staff E made a medication error.

A review of the facility policy titled, "Medication and Treatment- Administration/Assistance," which was last revised , revealed that, "Medication assistance and administration must be in accordance with the prescriber's orders."

Class III

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

Based on observation, interview, and record review, the facility did not ensure that an alert label was placed on a medication container when there was a change in directions for the use of a medication for one (Resident #14) of five residents reviewed for medications.

Findings included:

During a medication pass observation on at 1:23 PM, Staff E, a medication technician, was observed assisting Resident #14 with the self-administration of medication. Staff E removed a bottle of 10Gm/15mL solution with the following directions listed on the bottle, "Take 60mL by mouth four times daily." A review of the medication observation record (MOR) for the order revealed that the order stated, " 10Gm/15mL take 30mL by mouth three times a day." There was no alert sticker on the bottle indicating that the directions on the bottle had been changed. Staff E was interviewed at this time and confirmed that the directions on the bottle did not match the directions on the MOR and that there was no alert sticker on the bottle indicating that the directions had changed. A review of Resident #14's health care provider's order for the , which was dated , revealed that the current order was, " 20grams three times a day."

In an interview on at 1:52 PM, the Health and Wellness Director (HWD) stated that when a medication order changes, staff are supposed to put an alert sticker on the medication bottle indicating that the order has been changed.

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0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interviews, the facility failed to ensure all staff (2 of 3 reviewed) of the facility with 110 residents submit within 30 days of hire a statement from a health care provider, based on an examination conducted within the previous six months, that the person does not have any signs or symptoms of a communicable including .

Findings included:

Per employee record reviews conducted at the facility on beginning at 10:30am, 2 of 3 employee records reviewed did not contain a written statement from a health care provider documenting not having any signs or symptoms of a communicable including .

Staff B was hired as a Resident Aide/Med Tech on - employee's record contained a testing form that did not include a statement from a health care provider indicating freedom from communicable including .

Staff C was hired as a Resident Aide/Med Tech on - employee's record contained a testing form that included a section for the health care provider to indicate freedom from communicable including ; the section was not completed by the health care provider.

The Administrator acknowledged deficiencies in employee records during exit interview conducted beginning at 3:00pm.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record review and interview, the facility failed to ensure that all staff who provides direct care to residents receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents; a minimum of 3 hours of in-service training within 30 days of employment that covers resident behavior and needs and providing assistance with the activities of daily living; receives a copy of the facility's resident elopement response policies and procedures and in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment, and demonstrates an

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understanding and competency in the implementation of the elopement response policies and procedures; a minimum of 1 hour in-service training within 30 days of employment that covers the facility's emergency procedures including chain-of-command and staff roles relating to emergency evacuation; a minimum of 1 hour in-service training within 30 days of employment that covers reporting major and adverse incidents; a minimum of 1 hour in-service training within 30 days of employment that covers Resident Rights in an Assisted Living Facility and recognizing and reporting resident , neglect, and .

Findings included:

Per record reviews and interviews conducted at the facility on , the facility employs Resident Care Aides to provide direct care to residents; none of the Aides are nurses, certified nursing assistants, or home health aides. Staff A was hired as a Resident Aide/Med Tech on ; Staff B was hired as a Resident Aide/Med Tech on ; Staff C was hired as a Resident Aide/Med Tech on . Per review of the 3 employee files, there was no documentation of required staff in-service training as follows:

Two of 3 (Staff B & C) records reviewed contained no documentation of completion of Control training that is required prior to providing personal care to residents and no evidence of completion of training.

Three of 3 (Staff A & B & C) records reviewed contained no documentation of 3 hours of in-service training covering Resident behavior and needs and providing assistance with Activities of Daily Living.

One of 3 (Staff B) records reviewed contained no documentation of training in facility's Elopement policy & procedures.

Three of 3 (Staff A & B & C) records reviewed contained no documentation of completion of training in facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.

Three of 3 (Staff A & B & C) records reviewed contained no documentation of training in reporting major incidents & adverse incidents.

Two of 3 (Staff B & C) records reviewed contained no documentation of training in Resident Rights in an

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Assisted Living Facility and Recognizing and Reporting resident , neglect, and .

The Administrator acknowledged deficiencies in employee training records during exit interview conducted beginning at 3:00pm.

Class III

0083 - Training - First Aid and - 58A-5.0191(4) FAC

Based on record review and interview, the facility (with 110 in-house residents) failed to ensure that a staff member who has completed courses in First Aid and , , ( ) and holds a currently valid card documenting completion of such courses is in the facility at all times.

Findings included:

Per employee record reviews conducted at the facility on beginning at 10:30am, 3 of 3 employee records reviewed did not contain evidence of completion of courses and certification in , , ( ).

Staff A was hired as a Resident Aide/Med Tech on and currently works 1st shift - employee's record contained a certificate in recognition of completion of " , , Policy" dated with "Estimated Course Length: 0 minutes" and a 2nd certificate in recognition of completion of " , , Policy (Hands Only)" dated with "Estimated Course Length: 30 minutes." The training/certificates do not meet training requirements.

Staff B was hired as a Resident Aide/Med Tech on and currently works 2nd shift - There was no certificate in Staff B's file documenting training in .

Staff C was hired as a Resident Aide/Med Tech on and currently works 2nd & 3rd shifts - There was no certificate in Staff B's file documenting training in .

There were no certificates in Staff A, B, & C's employee files documenting training in First Aid. Per interviews with the Administrator and the Health & Wellness Director and review of staff schedules, the facility schedules nurses on the 1st & 2nd shifts 7 days a week. There was no evidence of any staff on the 3rd shift having completed First Aid and no evidence of any staff on the 3rd shift having completed

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The Administrator acknowledged deficiencies in employee records during exit interview conducted beginning at 3:00pm and was unable to provide evidence of any staff on the 3rd shift having completed First Aid or .

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on record review and interview, the facility failed to ensure that all staff who provide assistance with self-administration of medications (1 of 3 staff reviewed in facility with 110 residents) have completed the required initial 4-hour training on providing assistance with self-administration of medications and safe medication practices in an assisted living facility.

Findings included:

Per employee record reviews conducted at the facility on beginning at 10:30am, 1 of 3 employee records reviewed did not contain a training certificate evidencing completion of the required initial 4-hour training on providing assistance with self-administration of medications and safe medication practices in an assisted living facility.

Staff B was hired as a Resident Aide/Med Tech on . Staff B's employee record contained a job description including "Assists residents with medication ... Supervises residents who self-administer medication." Per review of the facility's Medication Observation Records, Staff B's initials indicated provision of assistance with self-administration of medications. Staff B's employee record contained a Brookfield, Wisconsin Online training certificate for "Medication Self Administration Training" dated , "Credit: 0." Staff B's employee's record did not contain a training certificate evidencing completion of the required initial 4-hour training on providing assistance with self-administration of medications and safe medication practices in an assisted living facility.

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0090 - Training - - 58A-5.0191(11) FAC

Based on record reviews and interviews, the facility failed to ensure that all direct care staff (1 of 3 reviewed in facility with 110 residents) receive at least one hour of training in the facility's policies and procedures regarding ( ) within 30 days after employment.

Findings included:

Per record reviews and interviews conducted at the facility on , 1 of 3 employee records reviewed contained no evidence of training in the facility's policies and procedures regarding .

Per record review, Staff B was hired as a Resident Aide/Med Tech on . Staff B's employee file contained a Brookdale Foundations Associate online training certificate dated entitled training for an "estimated course length: 60 minutes." The certificate listed training included "First Aid" & " A Residents Right to Decide." There was no documentation of training within 30 days after employment in the facility's policies and procedures regarding .

The Administrator acknowledged deficiencies in employee records during exit interview conducted beginning at 3:00pm.

Class III

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

Based on record review and interview, the facility (with an in-house census of 110 residents) failed to ensure that required training certificates are documented in the facility's personnel files (3 of 3 employee records reviewed) and include title and subject matter/agenda of the training, trainee's name, dates of participation, location of the training, number of hours of the training, and training provider's name, dated signature and credentials, including professional license number, if applicable.

Findings included:

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Three employee records were randomly selected for review on beginning at 10:30am. Per record review, Staff A was hired as a Resident Aide/Med Tech on ; Staff B was hired as a Resident Aide/Med Tech on ; Staff C was hired as a Resident Aide/Med Tech on . All 3 employees provide direct personal care services to 110 current residents of the Assisted Living Facility.

Per Surveyor review of employee training records, Certificates of Completion documenting required staff in-service trainings were not completed and filed in employee records as required. Examples included:

Staff A's employee file included a Brookdale Foundations Associate online training certificate dated entitled Elopement for an "estimated course length: 61 minutes." The certificate listed training included "Safety Sense" and "The Risk of Elopement in the Resident with ." The certificate did not include actual training time, location of the training, and training provider's name, dated signature and credentials.

Staff B's employee file included a Brookdale Foundations Associate online training certificate dated entitled training for an "estimated course length: 60 minutes." The certificate listed training included "First Aid" & " A Residents Right to Decide." The certificate did not include actual training time, location of the training, and training provider's name, dated signature and credentials.

Staff C's file included a Brookdale Foundations Associate online training certificate dated entitled Elopement for an "estimated course length: 61 minutes." The certificate listed training included "Safety Sense" and "The Risk of Elopement in the Resident with ." The certificate did not include actual training time, location of the training, and training provider's name, dated signature and credentials.

A box on the form is labeled for printing Instructor Name and Credentials, Instructor Signature, and Training Location. In all certificates sampled above, the box is blank -- not completed with the required information. Refer to photographic evidence obtained for additional examples.

Surveyor discussed the need for training certificates and documentation requirements specific to facility in-service trainings with the Administrator; the Administrator acknowledged awareness of the requirements. The Administrator acknowledged deficiencies in facility employee records during exit interview conducted beginning at 3:00pm.

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N277 - LNS - Resident Care Standards - 58A-5.031(2) FAC

Based on observation, interview, and record review, the facility did not ensure that limited nursing services (LNS) were provided as authorized by a health care provider's order for one (Resident #12) of two LNS residents reviewed.

Findings included:

A review of the facility's LNS log revealed that Resident #12 began receiving LNS services on for continuous use.

A review of Resident #12's medical record did not reveal a health care provider's order for Resident #12's . The review did reveal LNS progress notes indicating that Resident #12 was on continuous in the facility. A note dated stated that Resident #12 was on at 2 liters per minute via a nasal cannula. A note dated stated that Resident #12 was on continuous with no signs of . A note dated stated that Resident #12 was ambulating with a portable tank and running at 2 liters per minute via a nasal cannula.

On at 12:15 PM, Resident #12 was observed in his via a nasal cannula, which was attached to an concentrator in the . The concentrator was observed to be providing Resident #12 with at a rate of 3 liters per minute.

On at 10:50 AM, the Health and Wellness Director (HWD) stated that Resident #12's should have had a health care provider's order for in his 1823, which is an assessment that includes the resident's health care providers' orders. The HWD confirmed that Resident #12 did not have a health care provider's order for .

Class III