STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965138	**01/18/2018**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE DR PHILLIPS AL**	STREET ADDRESS, CITY, STATE, ZIP CODE **8001 PIN OAK DRIVE** **ORLANDO, FL 32819**	

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

0000 - Initial Comments

A re-licensure survey with Limited Nursing Services (LNS) was conducted on . Brookdale Dr Phillips I Assisted Living, license #9566, had deficiencies at the time of the survey.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record reviews and interviews, the facility failed to ensure the health assessment form 1823 was complete and accurate for 2 of 2 sampled residents (#4 and #6).

Findings:

1. Review of a health assessment form 1823, dated on , for resident #6 revealed the section that pertained to whether resident #6 had a communicable was answered yes and the documentation in the comment section indicated she was positive for A and was being treated with .

During an interview with the director of nursing on at 1:38 pm, she confirmed the findings and said the health care provider made an error when it was documented that resident #6 had a communicable .

The record for resident #6 did not contain documentation to indicate the facility contacted the health care provider for clarification or correction of the documentation.

2. Record review for resident #4 revealed an 1823 Health Assessment dated was not documented by the physician what type of assistance was required for medication on page 4 section B.

On at 2 PM, an interview with the Health & Wellness Director who confirmed the finding.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on resident record review, Medication Observation Record (MOR) review and interview, the facility failed to provide care and services appropriate to the needs of 1 of 2 sampled residents and 2. Did not ensure a prescribed medication was given according to the physician orders for 1 of 3 sampled

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residents (#8).

Findings:

In an interview with resident #8 on at 10:15 AM, she stated she had missed some of her medications in the past few weeks.

Review of the record for resident #8 revealed she was admitted on . The health assessment, dated , revealed a diagnosis of muscle , , difficulty walking and , . She required assistance with self-administration of medications. Her record contained orders for , Tablet, 5 mg, prescribed for 's , 1 tablet daily; , Tablet Chewable 81 mg, 1 tablet daily for anticoagulation; , Capsule Delayed Response 40 mg, 1 capsule one time a day for .

Review of the printed electronic MOR for 2017 for resident #8 revealed:
, 5mg printed on the MOR and the timing was documented as 1600 hours. During the month of 2017, the medication was not documented as being given on . The box on had a code of 09 in the box. The legend for code 09 stated "other/see nurse notes." Nurse's note for documented "MD aware of missed dose," but there was no further explanation as to why the dose was missed. The medication was documented as being given on . On the nurses note indicated "waiting on order." The medication was given on .

, 81 mg was printed on the MOR and the timing was documented as 0900 hours. The box for was blank. There was no code, no indication the medication was given or not given, and no notes in the nurse's notes as to what happened with the medication that day.

, Capsule Delayed Response 40 mg was printed on the MOR and the timing was documented as 0600 hours. The boxes for 12/6, and were blank. There were no codes, no indication the medication was given or not given, and no notes in the nurse's notes as to what happened with the medication on those days.

In an interview with the nursing director on at 1:30 PM, she confirmed the MOR did not indicate if the medication was given or not, and confirmed the notes indicated , was out of stock for at least 2 days. She did not have an explanation as to what happened with the notes or the reordering of the medication, but said she would look into the matter.

Class III

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0054 - Medication - Records - 58A-5.0185(5) FAC

Based on resident record review, Medication Observation Record (MOR) review and interview, the facility failed to ensure the electronic Medication Observation Record (eMOR) was accurate for 1 of 3 sampled residents (#8).

Findings:

In an interview with resident #8 on at 10:15 AM, she stated she had missed some of her medications in the past few weeks.

Review of the record for resident #8 revealed she was admitted on . The health assessment, dated , revealed a diagnosis of muscle , difficulty walking and . She required assistance with self-administration of medications. Her record contained orders for , Tablet, 5 mg, prescribed for 's , 1 tablet daily; Tablet Chewable 81 mg, 1 tablet daily for anticoagulation; Capsule Delayed Response 40 mg, 1 capsule one time a day for .

Review of the printed e-MOR for 2017 for resident #8 revealed:
5mg printed on the MOR and the timing was documented as 1600 hours. During the month of 2017, the medication was not documented as being given on . The box on had a code of 09 in the box. The legend for code 09 stated "other/see nurse notes." Nurse's note for documented "MD aware of missed dose," but there was no further explanation as to why the dose was missed. The medication was documented as being given on . On the nurses note indicated "waiting on order." The medication was given on .

81 mg was printed on the MOR and the timing was documented as 0900 hours. The box for was blank. There was no code, no indication the medication was given or not given, and no notes in the nurse's notes as to what happened with the medication that day.

Capsule Delayed Response 40 mg was printed on the MOR and the timing was documented as 0600 hours. The boxes for 12/6, and were blank. There were no codes, no indication the medication was given or not given, and no notes in the nurse's notes as to what happened with the medication on those days.

In an interview with the nursing director on at 1:30 PM, she confirmed the MOR did not indicate if the medication was given or not, and confirmed the notes indicated was out of stock for at least 2 days. She did not have an explanation as to what happened with the note or the reordering of the

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medications, but said she would look into the matter.

Class III

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

Based on resident record review, Medication Observation Record (MOR) review and interview, the facility failed to ensure medications were reordered in a timely manner for 1 of 3 sampled residents (#8).

Findings:

In an interview with resident #8 on at 10:15 AM, she stated she had missed some of her medications in the past few weeks.

Review of the record for resident #8 revealed she was admitted on . The health assessment, dated , revealed a diagnosis of muscle , difficulty walking and . She required assistance with self-administration of medications. Her record contained orders for , Tablet, 5 mg, prescribed for 's , 1 tablet daily; , Tablet Chewable 81 mg, 1 tablet daily for anticoagulation; , Capsule Delayed Response 40 mg, 1 capsule one time a day for .

Review of the printed e-MOR for 2017 for resident #8 revealed: , 5mg printed on the MOR and the timing was documented as 1600 hours. During the month of 2017, the medication was not documented as being given on . The box on had a code of 09 in the box. The legend for code 09 stated "other/see nurse notes." Nurse's note for documented "MD aware of missed dose," but there was no further explanation as to why the dose was missed. The medication was documented as being given on . On the nurses note indicated "waiting on order." The medication was given on .

In an interview with the nursing director on at 1:30 PM, she confirmed the MOR did not indicate if the medication was given or not, and confirmed the notes indicated , was out of stock for at least 2 days. She did not have an explanation as to what happened with the note or the reordering of the medications, but said she would look into the matter.

Class III

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

Based on personnel record review and interview, the facility failed to ensure all staff had annual

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documentation from a licensed healthcare provider of freedom from ( ) for 2 of 5 sampled staff (#D & #E).

Findings:

1. Personnel record review for Staff D, the administrator, hired , revealed a document that a skin test was conducted on , but was not read at the time of the survey. The previous documentation indicating freedom from was dated .

In an interview with the administrator on at 1:25 PM, he confirmed he just had the test done that morning and did not have results. Staff D confirmed he did not have a test done in 2017.

2. Personnel record review for staff E the registered nurse hired revealed the last documentation to confirm she was free from was dated (due),

During an interview with Staff E on at 1:30 PM revealed she had, a chest x-ray conducted in 2017 and was trying to obtain the documentation from the hospital where it was conducted.

Class III

0086 - Training - ADRD - 58A-5.0191(9) FAC

Based on personnel record review and interview, the facility failed to ensure that 1 of 5 sampled staff (C) had received the required training regarding 's and Related (ADRD).

Findings:

Personnel record review for Staff C, hired , revealed no evidence that she had completed 4 hours of and Related (ADRD), Level I Training within 3 months of employment.

During an interview with the business office manager on at 2:10 pm, confirmed Staff C did not complete the required training.

Class III

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0162 - Records - Resident - 58A-5.024(3) FAC

Based on resident record review and interview, the facility failed to ensure the informed consent form was completed acknowledging unlicensed staff assisting with self-administration of medication would or would not be overseen by a nurse for 1 of 2 sampled residents (#4) as required.

Findings:

Resident #4's record review revealed informed consent dated . . . . that was not marked that unlicensed staff would or would not be overseen by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) with self-administration of medications.

On . . . . . at 2 PM, an interview with the Health & Wellness Director who confirmed the finding.

Class III

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on Observation, Record Review and Interview, the facility failed to register and maintain the employment status of employees within the Agency's Background Screening Clearinghouse for 5 of 5 sampled staff employees (Staff A, B, C, D & E).

Findings:

Review of the Agency's Background Screening website for 5 sampled staff revealed the facility did not list any of the employees on the facility's roster on the Agency's website.

In an interview with the business manager on at 2:00 PM, she confirmed the finding and said she had inadvertently put all of the employees on the memory care facility's roster on the same campus. However the memory care facility has a different license.

Unclassified