STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964693	**01/31/2018**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE ORMOND BEACH**	STREET ADDRESS, CITY, STATE, ZIP CODE **550 WILMETTE AVENUE** **ORMOND BEACH, FL 32174**	

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

0000 - Initial Comments

An unannounced abbreviated relicensure survey with limited nursing servcies monitoring was conducted on . . . . . at Brookdale Ormond Beach (License #9192). The facility had licensure deficiencies at the time of the survey.

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

Based on observation, record review and staff interview, the facility failed to have an accurate Health Assessment (1823) for 1 of 4 sampled residents, Resident #4.

The findings include:

On . . . . . at 8:38 a.m. , Employee B, a Medication Aide was observed assisting Resident #4 with his medications. Employee B read the medication labels in front of the resident and the resident had many questions about what medications he should be taking.

Review of the 1823 dated . . . . . for Resident #4 revealed he was assessed to not need assistance with his medications. The facility's personalized assessment completed by a Registered Nurse on . . . . . also revealed he needed assistance with self-administration of medication.

The Health Wellness Director on . . . . . at 11:55 a.m. stated that the 1823 for Resident #4 was incorrect, since he did need assistance with self-administration.

Class III

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

Based on observation, record review and staff interview, the facility failed to assist with medication administration per physician order for 1 of 4 sampled residents, Residents #1.

The findings include:

On . . . . . at 8:05 a.m., Employee B, a Medication Aide, was observed assisting Resident #1 self-administer medication. She removed 25 mg chewable along with 5 other medications and

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placed them into a small medication cup. She handed the medications to the resident and he swallowed all of them. Employee B then removed a nasal spray (Deep Sea) and gave 1 spray in each nostril.

Record review revealed a physician order dated for Travel Sick Chewable (same as), with instructions to give 1 tablet orally two times a day. There was also a physician order dated for Deep Sea Spray 0.65%, with instructions to give 2 sprays into each nostril in the morning. The Resident's Health Assessment dated 11/ revealed the resident needed assistance with medications.

An interview was conducted with Employee B on at 10:00 am. She confirmed that she only gave 1 spray in each nostril for Resident #1. She confirmed she also did not separate the chewable and resident did swallow it. She did not give directives for him to chew that pill.

Class III

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

Based on observation, record review and staff and resident interview, the facility failed to ensure medications were available for 2 of 4 sampled residents (Resident # 1 and Resident #2), and failed to ensure the accuracy of labeling for 2 of 4 residents sampled (Resident #2 and Resident #4).

The findings include:

1. On at 8:05 a.m. Employee B, a Medication Aide was observed assisting Resident #1 with medications. She removed all of the medications ordered except for the , (81 mg). Record review for Resident # 1 revealed a physician order for , 81 mg, to be given once daily, dated . Employee B on at 8:10 a.m. confirmed the , was not available to give. She stated the pharmacy does not always deliver it, and staff has to manually reorder the medications, because the computer program does not automatically refill them when the volume gets low.

2. On at 8:22 a.m., Employee B was observed assisting Resident #2 with medications. Employee B removed all of the physician ordered medications except for , (25 mg). On at 8:22 a.m., Employee B was also observed to assist with . She removed a from a package that had instructions to give at bedtime.

Record review for Resident #2 revealed a physician order for , 25 mg, with instructions to give

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1 tablet by mouth two times a day, dated . Review of the , 2017 Medication Administration Record for Resident #2 revealed she did not receive this medication on , , 2018 at 1600. Employee B on at 8:23 a.m. stated the , was not in the medication drawer for Resident #2 to get it today either.

Record review for Resident #2 revealed a physician order for Capsule 100 mg ( ), give 1 capsule by mouth at (hour of sleep), dated . There was a new physician order dated for 100 mg, with instructions to give 1 to 2 tablets my mouth once daily. The package did not have an alert label placed on it during the medication assistance observation on .

Resident #2 was interviewed on at 10:30 a.m. She stated they ran out of her , medication (,) last night. She confirmed she also did not receive it this morning. She stated the facility was responsible for reordering the medications for her through the pharmacy.

On at 11:55 a.m., the Health Wellness Director stated that they do have Alert labels to place on the medications when an order changes and they were in the medication cart of Employee B. However, no one placed the alert label on the for Resident #2. She confirmed in reading this new order for that non licensed staff would not know when to give 1 or 2 tablets.

3. On at 8:38 a.m., Employee B was observed assisting Resident #4 with medications. Employee B removed all physician prescribed medications except for . She also removed a medication card for 600 mg , which had instructions to take 2 tablets by mouth daily.

Record Review for Resident #4 revealed a physician order dated for Ultra 1000 tablet chewable, with instructions to give 1 tablet by mouth daily. Employee B on at 8:42 a.m. confirmed the resident's dose was not in the drawer to give to the resident. She stated that she had asked the pharmacy for this medication and they did not send it.

During this observation, Employee B also removed a medication card for 600 mg, which had instructions to take 2 tablets by mouth daily.

The electronic Medication Administration Record for , 2018 contained a line for 600 mg, but the instructions read to give 1 tablet daily. This line had been signed as given for the whole month of , 2018. Employee B was asked how many was she going to give him, and she stated she stated she did not know.

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The Health Wellness Director was interviewed on at 11:55 a.m. confirmed that Resident #4 did need assistance with medication self-administration. She confirmed that Employee B did ask her about the discrepancy and she stated she would have to call the physician and pharmacy to correctly package the and ensure that 1 tablet was correct.

Class III

N276 - LNS - Nursing Services - 58A-5.031(1) FAC

Based on observation, record review, staff interview and resident interview, the facility failed to provide Limited Nursing Services (LNS) according to physician's orders for 1 of 3 sampled residents, Resident #6.

The findings include:

Resident #6 was interviewed on at 2:30 p.m. She stated that she receives nursing services daily for help with putting on compression stockings, which get put on in the morning and off at night. She stated she did not have them on today.

Observation of the legs of Resident #6 on at 2:32 p.m. revealed both legs were and slightly red. She was not wearing compression stockings at the time of the observation.

Record review for Resident #6 revealed a physician order on to admit her to LNS, and for the Community Nurse to apply compression hose in the morning and remove at bedtime. Progress notes were reviewed on at 3:00 p.m. and there were no entries on this day to reveal the compression stockings were applied this morning.

Employee A, a Licensed Practical Nurse, was interviewed on at 3:10 p.m. He stated he was the nurse on duty today and was responsible for the provision of LNS needs. Employee A stated he did put the compression stockings on Resident #6 this morning. When asked to clarify based on the earlier observation and interview with Resident #6, Employee A stated he must have her with another resident. He was asked if he documented putting the compression stockings on. He confirmed he did not document it. He stated he had all day to put on the compression stockings, and to document it.

On at 4:00 p.m., the Health Wellness Director stated that Employee A should have gone to

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the Resident's apply the compression stockings in the morning.

Class III