STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964948	**01/31/2018**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE DR PHILLIPS 2**	STREET ADDRESS, CITY, STATE, ZIP CODE **8015 PIN OAK DR.** **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 Service (LNS) was conducted on , 2018. Brookdale Dr Phillips 2, license #9453, had deficiencies at the time of the visit.

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on record reviews and interview, the facility admitted a resident (#9) who exceeded the admission criteria.

Findings:

Review of the record for resident #9 revealed she was admitted to the facility on with diagnoses of , , , , D Deficiency, and a left femur .

Her admission health assessment form 1823, dated on , indicated that she required total assistance with bathing, dressing, , transfers, and eating.

On at 3 pm staff F, a nurse, said resident #9 was able to pivot at times during transfers and she required total assistance with all of her activities of daily living.

On at 3:29 pm, the health and wellness director confirmed the findings.

Class III

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

Based on record review and interview the facility did have evidence of a medical examination completed 60 days prior to admission or within 30 days of admission and did not obtain a complete updated resident health assessment form for 1 of 3 sampled residents (#1).

Findings:

Record review for resident #1 revealed she was admitted to the facility on . The resident health assessment form 1823 located in the record was dated . There was no documentation to confirm the facility obtained a resident health assessment form completed 60 days prior to admission or within

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30 days of admission.

Further record review the resident was admitted to hospice services and a new 1823 form was required. Review of the updated 1823 form revealed it was dated . The sections for the health care providers printed signature, medical license number, address, telephone number and title were all left blank.

On at 3 PM, the wellness director confirmed the findings.

Class III

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

Based on observations, record reviews, and interviews, the facility failed to ensure an order from a health care provider was followed for 1 of 4 sampled residents (#9).

Findings:

Observations made on at 9:05 am revealed staff A, an unlicensed caregiver, held a medicine cup that contained applesauce and a spoon and she held a cup filled with water. Staff A said she was in the process of giving resident #9 her medications. She said the medications were crushed into the applesauce. She approached resident #9, who was sitting in a recliner in the day , and told the resident that it was time for her medicine. Staff A spooned the mixture of applesauce and medicine into the resident's mouth. She then held the cup of water to the resident's mouth and instructed her to drink it. Staff A said the medications she gave to resident #9 were an , 81 milligram (mg) tablet and XR 28 mg capsule. In addition, she provided a container labeled as Benefiber powder and said she used a plastic spoon to place one scoopful of the powder into the drinking cup and filled the cup with water.

Review of the , 2018 Medication Observation Record (MOR) for resident #9 revealed an entry for Benefiber powder, place 1 scoop in 8 ounces of water and give daily.

On at 9:15 am staff A said; she was unsure of how many ounces of water could be held in the drinking cup used to give the resident the Benefiber.

Review of the manufacturer's label on the container that held the cups revealed the cups held only 5 ounces of liquid.

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Review of the record for resident #9 revealed an order from a health care provider, dated on . . . . . that indicated she was to be given Benefiber 1 scoop in 8 ounces of water daily.

Class III

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

Based on observations and interviews, the facility failed to treat a resident (#7) with consideration and with due recognition of personal dignity.

Findings:

On at 1:30 pm, the family member of resident #7 said the facility staff were repeatedly told to keep toilet paper in her . . . . . she used a washcloth to wipe when there was no toilet paper but it continued to be an issue.

Observations made on . at 1:40 pm revealed there was no toilet paper in the . . . . resident #7.

During an interview with the health and wellness director on . . . . at 2:03 pm, she said the family member had previously spoken with her about resident #7 not having toilet paper. She said the residents ran out of toilet paper because they were unable to tell the staff when they needed more.

Class III

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

Based on observations, record review, and interview, the facility failed to ensure the unlicensed staff who assisted a resident (#9) with medications followed the correct procedure.

Findings:

Observations made on at 9:05 am revealed staff A, an unlicensed caregiver, held a medicine cup that contained applesauce and a spoon and she held a cup filled with water. Staff A said she was in the process of giving resident #9 her medications. She said the medications were crushed into the applesauce. She approached resident #9, who was sitting in a recliner in the day . . . , and told the resident that it was time for her medicine. Staff A spooned the mixture of applesauce and medicine into

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the resident's mouth. She then held the cup of water to the resident's mouth and instructed her to drink it. Staff A said the medications she gave to resident #9 were an , 81 milligram (mg) tablet and XR 28 mg capsule. In addition, she provided a container labeled as Benefiber powder and said she used a plastic spoon to place one scoopful of the powder into the drinking cup and filled the cup with water.

Staff A did not take the medication, in its previously dispensed, properly labeled container from where it was stored, and bring it to the resident, as required.

In addition, staff A did not, in the presence of the resident, read the label, open the container, remove a prescribed amount of medication from the container, and close the container, as required.

On at 1:50 pm, staff A confirmed the findings.

Class III

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

Based on record review and interview, the facility failed to ensure all staff were assigned duties consistent with their level of education, training and preparation and experience and did not ensure a nurse administered medications to 3 of 3 sampled residents (#1, #6 and #9) who was not capable of assisting with the self-administration of their medications.

Findings:

1. Record review for Resident #1 revealed a resident health assessment form 1823 dated , the health care provider noted she needed her medication administered (nurse required).

During an interview on at 2 PM, with Staff A an unlicensed staff who assisted with the self-administration of medications, who said she did give Resident #1 her medications.

A review of the medication observation record (MOR) for revealed Staff A's initials were in the box on at 8 AM as giving the resident her plus 8.6 milligram tablet. Staff A confirmed she did give this medication to the resident.

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2. Observations made on at 9:05 am revealed staff A, an unlicensed caregiver, held a medicine cup that contained applesauce and a spoon and she held a cup filled with water. Staff A said she was in the process of giving resident #9 her medications. She said the medications were crushed into the applesauce. She approached resident #9, who was sitting in a recliner in the day told the resident that it was time for her medicine. Staff A spooned the mixture of applesauce and medicine into the resident's mouth. She then held the cup of water to the resident's mouth and instructed her to drink it. Staff A said the medications she gave to resident #9 were an , 81 milligram (mg) tablet and XR 28 mg capsule. In addition, she provided a container labeled as Benefiber powder and said she used a plastic spoon to place one scoopful of the powder into the drinking cup and filled the cup with water.

Review of the record for resident #9 revealed she was admitted to the facility on with a diagnosis of . Her admission health assessment form 1823, dated on , indicated that she required administration of her medications.

On at 1:50 pm, staff A confirmed that she administered medications to resident #9.

3. Review of the record for resident #6 revealed she was admitted to the facility on with a diagnosis of . Her admission health assessment form 1823, dated on , indicated that she required administration of her medications.

On at 1:50 pm, staff A said she gave resident #6 her 8 am medications on and said the initials on the medication observation record were her initials.

Class III

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

Based on personnel record review and interview the facility maintained a secure area and provided special care for persons with 's and related (ADRD); failed to ensure that 1 of 5 sampled staff (A) who provided direct care to persons with 's and Related (ADRD) obtained the additional 4 hours of training that was provided by an approved ADRD Trainer.

Findings:

Personnel record review for staff A, a caregiver revealed an online training provider conducted an annual

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training. Further review of the certificate revealed there was no way to determine if the online trainer was an approved ADRD trainer, there was no Department of Elder Affairs (DOEA) provider training number.

A review of the University of South Florida's website (where approved ADRD providers are listed) on . . . . . at 3 PM revealed the online trainer was not one that was listed as an approved provider.

On . . . . . at 4 PM, the wellness director said the assistant director would email another certificate with the information, at 4:15 PM the certificate provided was from the same online course with a provider number that was not from the DOEA.

The facility was given the opportunity to provide documentation; the provider was approved by the DOEA via email. The evidence was not received from the facility.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observations, menu review and interview the facility failed to ensure that substitutions were noted before or when the meal was served and 2. Did not maintain the substitutions for 6 months.

Findings:

Observations of the menu on . . . . . at 12 PM revealed it noted, tossed salad Ham and Pineapples, Stir Fried Barley, Steam Green Beans and Cherry Pie.

Observations on . . . . . at 12:30 PM revealed the residents were served - Toss Salad, Ham, potatoes, Steam Green Beans and cherry pie.

There were no substitutions noted on the menu that would make the residents aware of the changes.

On . . . . . at 1:30 PM, the kitchen staff said she did not document the substitutions on the log for the day. She said the residents did not like the stir-fried barley; the facility substituted the roasted potatoes for it. She said the facility did keep a substitutions log inside of the kitchen and said she did not know where it was located.

Class

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0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on the department of health inspection report, observations and interviews, the facility did not have evidence that the , that was in a resident's free from communicable in order to provide a safe living environment for the 28 residents of the memory care unit.

Findings:

Observations during the tour of the memory care unit on at 9:30 AM revealed there was a dog in . Further observation revealed both of the dog's eyes was filled with eye discharge that was greenish/yellowish in color.

Interview with the staff during the survey revealed they had to walk the dog for toileting and feed it, because the resident was not capable of taking care of the dog herself. The resident resided in the secured memory care unit. The staff stated the resident would remove the discharge from the dog's eye with her hand and wipe it on her clothes.

The wellness director said on at 3 PM, when the resident arrived with the dog to the memory care unit, the dog's eyes were the same way. She confirmed it was the staff responsibility to walk the dog/toilet and feed it.
On at 2 PM, a representative from the department of health arrived to the facility to conduct a complaint regarding a sick dog.

The representative stated on at 4:30 PM, she had obtained the diagnosis regarding the dog's eye from the veterinarian and had conducted research. She said if the discharge had, in it could be to humans. She informed the facility to have the veterinarian obtain a culture of the discharge in order to make a determination; she said their inspection report was unsatisfactory.

Review of the inspections revealed it noted on :

"The dog has been in the facility approximately six months. Reportedly, the dog arrived to the facility in this condition, having the weeping eye drainage and suffering incontinence. Staff members are made responsible for the dog's care, walking, toileting, and feeding. Upon inspection of the resident's unit, the clean not having any noticeably strong odors at the time of inspection.

The veterinarian has given a diagnosis of , sicca. The facility is to follow up with the veterinarian to ensure that there is no communicable risk to the residents.

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Violation #45. Other Animal Care
All animals that are allowed in the facility must be properly cared for and showing no signs of illness that may be transmitted to humans. Upon inspection the dog has visible signs of an eye ; eyes are weeping having yellowish\green discharge."

Class III

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

Based on observations, record review, and interviews, the facility failed to obtain an order from a health care provider for a resident (#8) who received a Limited Nursing Service (LNS.)

Findings:

Review of the facility's license revealed it contained an LNS designation.

Observations made of resident #8 on at 9 am revealed he wore a on his left hand.

During an interview with staff G on at 2:51 pm, a caregiver she said either the facility nurse or a applied the to resident #8.

During an interview with staff F, a nurse, on at 2:53 pm, she said the facility nurses applied the to resident #8.

Review of the record for resident #8 revealed there was not an order from a health care provider to authorize the facility nurse to apply the , which was a LNS.

During an interview with the health and wellness director on at 3:09 pm, she confirmed the findings.

Class III

N278 - LNS - Records - 58A-5.031(3) FAC

Based on record reviews and interviews, the facility failed to ensure nursing progress notes were maintained for a resident (#6) who received a Limited Nursing Service (LNS).

Findings:

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On at 9:15 am, the health and wellness director identified resident #6 and said she received a LNS for compression stockings.

Review of the LNS progress notes for resident #6 revealed there were no progress notes written during 2017 and , 2018, as required.

On at 4 pm, the health and wellness director confirmed the finding.

Class

Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC

Based on record reviews, review of the Agency's background screening website, and interview, the facility failed to maintain the results of a background screening in the personnel record for 1 of 5 staff (B) who was in a role that required a background screening.

Findings:

Personnel record review for staff B, a resident caregiver, revealed a hire date of .

The record did not contain results of a background screening, as required.

Review of the Agency's background screening website revealed staff B had an eligible background screening on .

On at 4:42 pm, the health and wellness director confirmed the results were not in the personnel record.

Unclassified