STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910810	**01/31/2018**
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#2017014961) was conducted at Brookdale Pinecrest on . . . . . Brookdale Pinecrest had deficiencies at the time of the investigation.

License (#93)

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

Based on observation, interview and records review, the facility failed to provide daily observation and awareness of a resident's general health, safety, and physical and emotional well-being (1 resident of 8 observed and interviewed, Resident #6).

Findings Included:

On /8 at 10:35am, Resident #6 was interviewed in the resident's apartment. The resident's apartment was observed to be exceedingly cluttered with papers, boxes, pill bottles, over the counter medications, mailing envelopes, and various other items. The clutter was seen in every the apartment including the kitchen, the . . . . , the . . . . . the living . . . (Photographic evidence obtained). The large assortment of over the counter medications and nutritional and herbal supplements, in the apartment, was striking - numbering in the hundreds of containers. A large number of the pill bottles, many of which would be considered nutritional or herbal supplements of various sorts, had writing, in magic marker, on the lid with instructions such as "1 a day with food" or "empty stomach". There were also containers of eye drops, stool softeners, an and ,, medications.

In an interview with Resident #6 at 10:45am, Resident #6 stated that she had bought the medications from catalogs and had received them through the mail. The resident confirmed writing the written instructions seen on the medication bottles.

In another interview with Resident #6 at 2:00pm, the resident revealed that the over the counter supplements and herbal medications had been purchased from catalogs over the course of about the past 8 months. The resident said it was healthier than regular medications. Resident #6 stated that there was no set schedule for taking any of these medications, no set time or day or dose and the resident's response implied there was uncertainty of how many different medications there were and what all the resident was taking. The resident stated she was taking about 10 pills per day, but it

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depended upon remembering to take them.

In a records review of Resident #6's records on , it was revealed that the resident had only 2 medications on order: a stool softener and an . A doctor's notation in the resident's records stated that Resident #6 could self-administer medications. Nothing in Resident #6's records made any mention of the nutritional supplements, herbal medications and over the counter medications (eye drops and medications) that were found in resident's . It was observed that the resident did have the stool softener and the prescribed in the apartment. The resident's health assessment (1823 -date unknown) indicated that the resident required assistance with medication self-administration.

In an interview with the facility Director of Nursing (DON) at 4:00pm on , the DON stated that Resident #6 was supposed to have "assistance with medication self-administration". The DON stated she met with Resident #6 a few days ago, on Friday , regarding the disarray (evidence of hoarding) in the resident's apartment. The DON stated that the resident was admitted to the facility in large part because of the resident's hoarding behavior. (The facility records show that Resident #6 moved in to the facility on .) In the meeting, the resident promised to clean up the apartment in a week. The DON stated that there was no documentation of the meeting or what the facility's plan was to address this issue. There was no evidence that the facility had contacted Resident #6's healthcare provider regarding all the medications the resident was taking, or that the healthcare provider had any knowledge of it. In the interview, the DON stated that the facility only recently noticed that the resident had all those medications in the apartment. The DON said that they told the resident they would have to move the medications out of the apartment. The DON stated that the resident's healthcare provider sees the resident about once per month but that as far as they knew, the resident's doctor or the nurse practitioner were not aware of all the over the counter medications the resident is taking.

Class III

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

The facility failed to ensure that all existing electrical and mechanical systems and appurtenance are maintained in good working order for 5 of 5 resident's checked (Residents #1, #3, #5, #9 and #10).

Findings Included:

During a tour of the facility on , several emergency call lights boxes in residents' had the pull wrapped around them so they could not be pulled in case of emergency. All of the were

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wrapped around the call boxes neatly and tightly in a similar manner (photographic evidence obtained.) The findings of the tour revealed the following:

An observation of the call light system in Resident #5's apartment at 10:00am on 1// revealed that , call light box had the pull cord wrapped around it, and was therefore and it had to be unwrapped before it could be pulled to alert the facility staff in case of an emergency.

An observation of the call light system in Resident #9's apartment at 12:15pm on revealed the emergency pull in both of the had the pull were wrapped around the boxes rendering both emergency call boxes and not able to be pulled if someone had and were on the floor.

An observation of the call light system in Resident #3's apartment at 12:25 revealed the emergency pull cord in the completely wrapped around the call box rendering the call box .

An observation of the call light system in Resident #1's apartment at 12:30pm revealed the call light in the half wrapped around the call box at a height out of reach if the resident were on the floor.

An observation of the call light system in Resident #10's apartment at 12:35pm revealed a the pull cord wrapped around the call box in one of the , the cord was wrapped in a manner that would make it impossible for the cord to be pulled if someone had to the floor and was trying to call for assistance.

When the Director of Nursing (DON) was interviewed about this issue at 1:00pm, the DON stated she had no idea why the were wrapped around the call boxes or who is doing it. The DON stated that the maintenance department was responsible for insuring that call lights were functional. The DON surmised that perhaps the housekeeping department was wrapping cord around the call boxes. The DON stated that the facility should do an audit of all the call boxes in assisted living resident's to see if they were wrapped with the cord rendering them nonfunctional.

In an interview with Executive Director at 4:00pm, the Executive Director surmised that the residents probably wrapped the around the call lights in the . The Executive Director opined that it was because the pull are long and maybe the residents don't want to trip over them. The Executive Director did not have an explanation of why the facility did not take measures to shorten the to prevent them from being a trip hazard.

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Class III