STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11922281	**02/08/2018**
NAME OF PROVIDER OR SUPPLIER **WESTBROOKE MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **6701 DAIRY ROAD ZEPHYRHILLS, FL 33542**	

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

0000 - Initial Comments

Assisted Living Facility

The statement of deficiencies was amended on .

A complaint investigation, (CCR# 2017014704), was conducted at Westbrooke Manor on in conjunction with an abbreviated biennial relicensure survey with extended congregate care (ECC). Westbrooke Manor had deficiencies at the time of the investigation.

(license # 6061)

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

Based on observation, interview, and record review the facility failed to honor resident rights by (1) providing a safe and hazard free living environment; and, (2) providing appropriate health care to meet the needs of residents who are admitted to the facility.
Findings Included:

A medication (med) pass observation conducted on at 09:19am revealed unsecured meds, two med bubbled packs on top of med cart flipped upside down. While observing Staff B, a Medication Technician (MT) giving meds to Resident #15, the MT actually administered Resident #15's , inhaler to her. Staff B did not wash or sanitize her hands between assisting a previous Resident with meds and Resident #15. Staff B did not wash or sanitize hands after administering Resident #15's , . Staff B administered two quick puffs (1-2 second duration) of the , to Resident #15. Staff B did not clean the , inhaler's mouthpiece before placing it back in the med cart. Upon exiting Resident #15's , six med bubble packs were observed in the cubby shelf on the right side of med cart. When asked about the unsecured medications, Staff B stated that "those are empty and need to be put in the pharmacy bin." The unsecured medications included:
Resident #11: : , 50mcg, which contained 30 pills within one bubble pack.
Resident #17: 48mg tablets, which contained 25 pills within one bubble pack; and , 60 pills within two bubble packs.
Resident #16: 70mg tablets, which contained 30 pills within one bubble pack.

An interview conducted with Resident #1 on at 09:30am revealed that Resident administers her own as she stated that, "I take care of it myself." Resident #1 also stated that she was at the

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hospital two weeks ago "with a low sugar" and "they gave me ."

An observation of Resident #1 conducted on at 10:15am - 10:30am revealed that Resident #1 keeps for self-administration in her .

A record review of Resident #1 conducted on revealed that the most current Agency for Healthcare Administration Health Assessment Form 1823 dated stated that Resident #1 "needs assistance with self-administration of medication."

A Medication Observation Record review for Resident #1 conducted on revealed that that multiple meds are marked as self-administered and at bedside which included:
Accu-chek Aviva Plus test strips (at bedside)
70% prep pads (at bedside)
Easy comfort pen (at bedside)
100 units/ML
Flextouch pen 100 units/ML

An interview with Resident #2 conducted on at 10:07am revealed that Resident #2 administers their own and stated that, "I take my own sample and administer ."

An observation with Resident #2 conducted on at 10:15am revealed that Resident #2 has a refrigerator in shared no locking mechanism, storing inside.

An interview with the Resident Care Director conducted on revealed that Resident #2 administers own and stated that, "she administers her own ."

A record review of Resident #2's resident record conducted on revealed that Resident #2 required assistance with self-administration of meds. Resident #2 had a significant change in condition warranting Hospice admission on . The most current Agency for Health Care Administration Health Assessment Form 1823 dated does not provide Hospice information or change-in-condition. Resident #2's record does not include an interdisciplinary care plan which specifies the services being provided by hospice and those being provided by the facility developed and implemented by Hospice in consultation with the facility and agreeable between the Resident, Facility, and Hospice.

A Medication Observation Record review, conducted for Resident #2 conducted on revealed that the following meds scheduled as self-administration:

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- Prop 50mcg tablets
- 2.5% cream (keep at bedside)
- Lantus 100units/ML
- MPAP 500mg tablets
- Fuoate 0.1% solution
- Nystop 100,000 units/GM
- Voltaren 1% GEL (keep at bedside)
- 25mg tablets
- 12% lotion
- 137mcg nasal spray

An observation of Resident #7's on 10:15am - 10:30am revealed that Resident #7 had four pens lying on a table and the Accu-check machine next to it with a used test strip (with) in the test machine. was smeared on table and the a full sharps container with used lancets and bloody test strips.

A record review of Resident #7's 1823 dated revealed that Resident #7 "needs med observation" and "needs assistance with medication." A Self-Administration Management Assessment performed by the facility on signed by the Resident Care Director who is a Licensed Practical Nurse for Resident #7 stated that Resident #7 is:

Unable to name all prescribed meds w/o assistance
Unable to read labels on all meds including name and dose of medications

A Medication Observation Record review for Resident #7 conducted on revealed that multiple meds are marked as self-administered and at bedside, which included:

150mg tablets (at bedside)
Zeasorb-AF 2% powder (at bedside)
100untis/ML Kwik-pen
Lantus 100units/ML
100mg capsules (keep at bedside) - SELF
100mg capsules

A closed record review of Resident #13 conducted on revealed that the most current Agency for Healthcare Administration Health Assessment Form 1823 dated obtained upon return from hospitalization due to a episode. This 1823 stated that Resident #13 required medication administration, total care for all Activities of Daily Living, accu-checks frequently, and was

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with being oriented to person only. According to Resident #13's 2017, Medication Observation Record with accu-checks only scheduled daily.

An interview conducted with the Resident Care Director conducted on at 10:08am revealed that the facility only used unlicensed Medication Technicians to pass medication.

An interview with the Resident Care Director conducted on at 01:10pm revealed that it is the facility's expectation that medications should "never be left unattended on medication cart." The Resident Care Director stated that it is the expectation of the facility for Medication Technicians to wash their hands in between each Resident and for inhalers to be handed to the Resident and the Resident administers the inhaler themselves.

An interview conducted with the Resident Care Director and Administrator conducted on at 04:00pm revealed that Residents who need assistance with self-administration should not have by the bedside.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, interview, and record review, the facility failed to have a licensed Staff to administer medication (med) for one Resident (#15) of three sampled Residents.

Findings Included:

During a med pass review, an observation of Staff B assisting Resident #15 was conducted on at 09:19am. Staff B, a Med Technician (MT) administered Resident #15's ordered inhaler. Staff B did not wash or sanitize her hands between assisting a previous Resident with meds and Resident #15. Staff B did not wash or sanitize after administering Resident #15 . Staff B administered two quick puffs (1-2 second duration) of the to Resident #15 Staff B did not clean the inhaler's mouthpiece before placing it back in the med cart.

An interview with the Resident Care Director conducted on at 01:10pm revealed that it is the expectation of the facility for Medication Technicians to wash their hands in between each Resident and for the MT to hand the inhaler to the Resident and the Resident administers the inhaler themselves.

Class III

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0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation, interview, and record review, the facility failed to (1) keep centrally stored medication (med) in a locked cabinet or cart at all times (widespread); and, (2) centrally store medications for three Residents (#1, #2, and #7) of three sampled Residents who need assistance with self-administration of medication.

Findings Included:

An observation of a med pass review conducted on at 09:19am revealed unsecured meds on a med cart with no nurse or med tech in attendance. Upon approach to the med cart, two med bubble packs were observed on top of the med cart flipped upside down. Staff B knocked on the door Resident #15's entered. The two med bubble packs remained on top of the med cart. Upon exiting , six med bubble packs were observed in the cubby shelf on the right side of med cart. When the unsecured medications were removed, Staff B stated that "those are empty and need to be put in the pharmacy bin."

Five of the med bubble packs contained medications:
Resident #11: 50mcg, which contained 30 pills within one bubble pack.
Resident #17: 48mg tablets, which contained 25 pills within one bubble pack; and
60 pills within two bubble packs.
Resident #16: 70mg tablets, which contained 30 pills within one bubble pack.

An observation of Resident #1 conducted on at 10:15am - 10:30am revealed that Resident #1 keeps for self-administration in her .

A record review of Resident #1 conducted on revealed that the most current Agency for Healthcare Administration Health Assessment Form 1823 (1823) dated stated that Resident #1 "needs assistance with self-administration of medication."

A MOR for Resident #1 conducted on revealed that multiple medications are marked as self-administered and at bedside, which included:
150mg tablets (at bedside)
Zeasorb-AF 2% powder (at bedside)
100untis/ML Kwik-pen
Lantus 100units/ML
100mg capsules (keep at bedside) - SELF

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, 100mg capsules

An interview with Resident #2 conducted on at 10:07am revealed that Resident #2 self-administers and does own glucose testing. Resident #2 stated that, "I take my own sample" and "I self administer ."

An observation of Resident #2 conducted on at 10:15am - 10:30am revealed that Resident #2 keeps for self-administration in her .

A record review for Resident #2 1823 dated revealed that Resident #2 "needs assistance with self-administration of medication.

A Medication Observation Record (MOR) review for Resident #2 conducted on revealed that that multiple medications are marked as self-administered and at bedside which included:
Prop 50mcg nasal spray
2.5% cream (keep at bedside)
Lantus 100units/ML
MPAP 500mg tablets
Fuoate 0/1% solution
Nystop 100,000 units/GM
Voltaren 1% GEL (keep at bedside)
25mg tablets
12% lotion
137mcg nasal spray

An observation of Resident #7's on 10:15am - 10:30am revealed that Resident #7 four pens lying on a table and the Accu-check machine next to it with a used test strip (with) in the test machine. smeared on table and a full sharps container with used lancets and bloody test strips.

A MOR review for Resident #7 conducted on revealed that that multiple medications are marked as self-administered and at bedside which included:
Accu-chek Aviva Plus test strips (at bedside)
70% prep pads (at bedside)
Easy comfort pen (at bedside)
100 units/ML

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. . Flextouch . . pen 100 units/ML

An interview with the Resident Care Director conducted on . . . . . at 01:10pm revealed that it is the facility's expectation that medications should "never be left unattended on medication cart."

An interview conducted with the Resident Care Director and Administrator conducted on . . . . . at 04:00pm revealed that Residents who need assistance with self-administration should not have by the bedside.

Class III