STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964948	R 03/28/2018
NAME OF PROVIDER OR SUPPLIER **BROOKDALE DR PHILLIPS MC**	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 revisit to the re-licensure survey with Limited Nursing Services (LNS) was conducted on . Brookdale Dr Phillips 2 license #9453 had deficiencies the time of the visit.

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

DEFICIENCY REMAINED UNCORRECTED

Based on observations, record review, and interview, the facility failed to ensure the unlicensed staff who assisted 2 of 2 residents (12 &13) with medications followed the correct procedure.

Findings:

Observations during the medication pass on at 11:10 AM noted staff A, an unlicensed caregiver, went to the asked if she was ready to take her medications. The resident agreed. The staff went to the locked medication cart and poured the pills in a cup, she secured the medications in the cart. She took the cup to the resident's . She told the resident here are your 12 PM medications: and . She observed the resident take the medications and then returned to the medication cart to sign the electronic Medication Observation Record (MOR). The medication pass continued.

The same staff asked resident #13 if he was ready to take his medications. He agreed. The staff went to the locked medication cart and poured the pills in a cup, she secured the medications in the cart. She took the cup to the resident's told him here are your medications: , , , , and . She observed the resident take the medications and then returned to the medication cart to sign the electronic MOR.

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

In an interview with staff A on at 11:30 AM, who stated that what was observed was how she always did the medication passes.

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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 1 of 3 sampled residents (1) who according to the health assessment report needed administration of medications.

Findings:

Record review for resident #1 revealed a resident health assessment form 1823 dated that listed diagnoses of , , and high , . She had memory loss and needed administration of medications.

Review of the Medication Observation Record (MOR) dated 2018 the initials of 6 different staff, as having given resident #1 his medication daily from 3/1 until .

In an interview with the Resident Care Coordinator, a nurse, who identified all 5 of the initials as those of unlicensed staff, not nurses who could administer medications. The resident did not need medication administration; she was able to assist with her medications.

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 1 sampled staff (A) who provided direct care to persons with 's and Related (ADRD) obtained 4 hours of additional training that was provided by an approved ADRD trainer.

Findings:

Personnel record review for staff A, a caregiver, hired revealed 4 on-line training certificates dated that indicated: 1 hour (hr.) continuing education (CEU) and signs and symptoms, 1 hr. from the person's perspective, 1 hr. Learning to communicate through

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and 1 hr. Helping Families Cope. Further review of the certificate revealed there evidence to confirm that the online trainer was an approved ADRD trainer, there was no Department of Elder Affairs (DOEA) provider training number on the certificates.

A review of the University of South Florida's website (where approved ADRD providers are listed) on at 12:30 PM revealed the online trainer was not one that was listed as an approved provider.

Class III

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

Based on record reviews and interviews, the facility failed to ensure completed nursing progress notes were maintained for 1 resident (#6) in a sample of 3 who received a Limited Nursing Service (LNS).

Findings:

During the entrance interview on at 9:30 AM, the Resident Care Coordinator identified resident #6 as receiving LNS for the application and removal of compression stockings.

Resident record review revealed nurse's progress notes dated to that indicated the compression stockings were "applied". There were no nurse's progress notes that documented the removal of the hose.

The nurse's progress notes did not include the scope, amount, duration, and outcome of services that are rendered; the general status of the resident's health or any deviations.

The Resident Care Coordinator said on at 1:30 PM there were no additional notes.

Class III