STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965335	04/05/2018
NAME OF PROVIDER OR SUPPLIER **BROOKDALE PALMER RANCH**	STREET ADDRESS, CITY, STATE, ZIP CODE **5111 PALMER RANCH PARKWAY** **SARASOTA, FL 34238**	

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

0000 - Initial Comments

An unannounced relicensure survey was conducted through at Brookdale Palmer Ranch, an assisted living facility (license #9737) in Sarasota, Florida.

The following is description of the deficiencies.

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

Based on record review and interview, the facility failed to ensure a physician order for 2 (Resident #6 and Resident #11) out of 2 resident records reviewed, identified whether or not the resident requires any help/assistance with taking medication.

The findings included:

1. Review of the medical record for Resident #6 on , revealed that a Resident Health Assessment (AHCA Form 1823) was completed on due to a change in condition requiring hospice care. The physician failed to document "Yes" or "No" to the question "Does the individual need help with taking his or her medications? If yes, please place a checkmark in front of the appropriate box below: Needs Assistance with Self-Administration, Needs Medication Administration, Able to Administer w/o (without) Assistance."

Further review of the medical record revealed a Medication Review Report, signed by the physician on , documenting that the physician renewed an order, dated , for "Needs assistance with self-administration of medications."

During an interview on at 4:00 p.m., the Health and Wellness Director acknowledged that the physician orders needed to be clarified due to the lack of a complete and accurate Resident Health Assessment.

2. On , review of the records revealed Resident #11's Health Assessment was incomplete and did not indicate what type of assistance the resident needs in taking his medication. The area was left blank. While reviewing physician orders after admission, an order was noted that Resident #11 was able to take medication on his own and did not need staff assist.

On , while observing medication pass with Licensed Practical Nurse (LPN) Staff D, Resident #11

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was spoon fed his medication and then given a glass of water to swallow the medication. Resident # 11 was unable to take the pill and administer to himself.

On . . . at 8:25 a.m., LPN Staff D stated that she spoons the medications into Resident #11's mouth because he is unable to take them on his own because he get stiff from his diagnosis of Parkinson .

During an interview on at 3:20 p.m., the Health & Wellness Director acknowledged that Resident #11's Health Assessment was incomplete as to how resident should take his medication and acknowledged the most current physician order was for the resident to administer his medication himself.

Class III

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

Based on record review and interview, the facility failed to ensure that 2 (Resident # 11 and Resident #13) out of 2 residents sampled, were treated with consideration and respect and with due recognition of personal dignity and individuality.

The findings included:

1. On at 8:30 a.m., Resident #11 was found in his apartment living , sitting in a chair infront of a small tray table with a laptop computer on it. The resident's left hand was on the mouse of the computer and the right hand was on the arm of the chair and was shaking. The resident stated that he could not move or stop his right hand from shaking. Licensed Practical Nurse (LPN) Staff D noted to the resident that his private duty assistant had not shown up yet this morning. The resident had not been cleaned up or dressed yet for the day, he was barefoot with underwear and an open housecoat on. LPN Staff A called for assistance of another staff member and stopped her medication pass to get the Resident #11 up and dressed so the resident could make breakfast at 9 a.m. before the dining . .

.

Review of Resident #11's medical record revealed that the resident had a history of and needed assistance in all areas of Activities of Daily Living (ADL), including stand by assist to walk to the dining

.

During an interview at 4:00 p.m., the Health and Wellness Director advised that Resident #11's personal care aide did not advise the facility that they would be unable to care for the resident this date.

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She also acknowledged that there was no mechanism in place to provide care to the resident, in a timely manner, for such an event. As a result, the resident's individuality (related to care needs) was not respected and her personal dignity was compromised.

2. On at 8:50 a.m., a communication pager was overheard by the surveyor, stating that Resident #13's personal care aide was not in the facility. The pager also communicated that the resident was not washed or dressed, did not have breakfast, and that the dining be closing at 9:00 a.m.

On , review of Resident #13's medical record revealed that the resident had a history of , needed assistance in all areas of ADL (including transport to the dining), and identified that the resident's personal care aide gave the resident her medications.

During an interview on at 9:10 a.m., the Food Service Manager verified that the main dining (for breakfast) at 9:00 a.m. She also stated that she kept track of all resident attendance in the main dining (which served the first and third floor residents). When asked if there was a check-off list, she stated, "No, I just watch the tables." When asked who was notified if someone didn't come for breakfast, she said she would notify the Health and Wellness Supervisor. The Administrator-in-Training, who was present at this time, acknowledged that there should be a check-off list regarding attendance and they would initiate one to ensure that all residents have the ability to attend the dining their meals. In addition, she acknowledged that the facility needed a mechanism to ensure that residents do not miss a meal without staff being aware and ensure action is taken to offer/provide all meals in a timely manner.

Class III

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

Based on observation, record review, and staff and resident interview, the facility failed to ensure a licensed staff member administer medication to 2 (Resident #5 and Resident #11) of 4 residents records reviewed.

The findings included:

1. During record review of Resident #5 on , it was noted in the resident's current standing orders, sign off by physician, that the resident needed staff assistance with self-administration of medication.

On at 2:25 p.m., Resident #5 was observed sitting in his chair, in his living , and appeared to

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be sleeping. The resident's apartment door was wide open and several prescriptions and over the counter medication bottles were observed around the .

During an interview on at 2:30 p.m., Resident #5 stated that he takes his own medication and does not need any help with them. When asked if the medication should be in the lock box that was on the floor under the kitchen counter, the resident shook his head no, and said it was ok.

During an interview on at 3:00 p.m.., the Health and Wellness Director acknowledged that Resident #5 had been administering his own medication. She also confirmed that current physician orders stated that Resident #5 needed assistance with self-administration of medications.

2. On , review of the records revealed Resident #11 Health Assessment did not indicate what type of assistance the resident need in taking his medication. The area was left blank. While reviewing physician orders after admission, an order was noted that the resident was able to take medication on his own and did not need staff assistance.

On , while observing medication pass with Licensed Practical Nurse (LPN) Staff D, Resident #11 was spoon fed his medication and then given a glass of water to swallow the medication. The resident was unable to take the pill and administer to himself.

On at 8:25 a.m., LPN Staff D stated that she spoons the medications into Resident #11's mouth because he is unable to take them on his own because he gets stiff from his diagnosis of Parkinson .

On at 3:20 p.m., the Health & Wellness Director acknowledged that Resident #11's Health Assessment was incomplete as to how the resident should take his medication and acknowledged the most current physician order was for the resident to administer his medication himself.

Class III

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

Based on observation, interview, and record review, the facility failed to properly store medications for residents that need assistance with their self-administration of their medication for 1 (Residents #5) of 12 residents sampled.

The findings included:

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1. On at 10:30 a.m., during the initial tour of the third floor of the facility, Resident #5's door was found open, the resident was in his bed and appeared to be sleeping. Over the counter and prescription medications were observed throughout the , on the counter and the dresser.

During record review of Resident #5 on , it was noted in the resident's current standing orders, sign off by physician, that the resident needed staff assistance with self-administration of medication.

On at 2:25 p.m., Resident #5 was observed sitting in his chair in his living appeared to be sleeping. The resident's apartment door was wide open, several prescriptions and over the counter medication bottles were observed around the .

During an interview on at 2:30 p.m., Resident #5 stated that he takes his own medication and does not need any help with them. When asked if the medication should be in the lock box that was on the floor under the kitchen counter, resident shook his head no, and said it was ok.

During an interview on at 3:00 p.m., the Health and Wellness Director acknowledged that Resident #5 had been administering his own medication. She also confirmed that the current physician orders stated that Resident #5 needed assistance with self-administration of medications. She admitted that she had spoken to the resident many times about not securing his medication in the lock box provided to him for this purpose. She also stated that she was aware that she had to remind him on multiple occasions that he had to lock his apartment door when he leaves.

Class III

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

Based on observation, interview, and record review, the facility failed to ensure proper labeled medications for 1 (Resident #11) of 3 residents observed in medication pass. Putting residents at risk for medication error.

The findings included:

On at 8:20 a.m., Licensed Practical Nurse (LPN) Staff D was observed preparing medication for Resident #11, she prepared to give 5 capsules of Parkinson medication , which is a combination medication of and extended-release capsules. The label of the medication bottle read Ratary 61. mg capsules as directed 5,4,4,4. Another bottle of the same medication in the nurse's medication cart read Ratary 61. mg capsules take 17 capsules by mouth once daily as

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directed. Prescriptions were noted to be filled by the pharmacy.

During an interview on at 8:25 a.m., LPN Staff D stated that she would not know how to give the medication by what was written on the pill bottles label and if she gave 17 capsules at once it would not be good for the resident.

Observation of the electronic medication administration record on the computer from which LPN Staff D was giving her medication revealed that it indicated Ratary 61. mg take 5 capsules at 9 am.

During record review of the doctor orders for this medication it was written that this medication was to be given as follows:
Ratary 61. mg give 5 tabs q a.m. (every a.m.)
Ratary 61. mg give 3 tabs q p.m. (every p.m.)
Ratary 61. mg give 4 tabs (twice a day)

During an interview on at 3:20 p.m., the Health & Wellness Director acknowledged that the labels on the resident's medication bottles were incorrect and could cause harm to the resident if given in the way noted on the label. She said that she was unaware that the labels were written that way and acknowledged that they did not match the medication administration record or the doctor orders.

Class III

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

Based on record review and interview, the facility failed to ensure that 2 (Staff A and Staff B) of 5 staff personnel files reviewed, had submitted a written statement, from a health care provider, documenting that the individual does not have any signs or symptoms of communicable . This statement must be submitted within 30 days after beginning employment.

The findings included:

On , review of the personnel records for Licensed Practical Nurse (LPN) Staff A and Resident Aide Staff B revealed that there was no statement on record, from a health care provider, stating that the staff members had no signs or symptoms of communicable . Both staff members have been employed by the facility for more than 30 days.

During an interview on , the Personnel Department Head and the Health and Wellness Director

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acknowledged that both employees lack this documentation from a health care provider.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record review and interview, the facility failed to ensure that 5 (Staff A, Staff B, Staff C, Staff F, and Staff G) of a sample of 5 staff members, received 1 hour of in-service training for major incidents and 1 hour of in-service training for emergency procedures. This training is required to be done within 30 days of employment.

The findings included:

Record review for Licensed Practical Nurse (LPN) Staff A, Resident Aide ( ) Staff B, Staff C, LPN Staff F, and Administrator Staff G revealed that they had no documented evidence that they received 1 hour of in-service training related to major incident and 1 hour of in-service training related to emergency procedures within 30 days of employment.

During an interview on . . . at 11:00 a.m., the Health and Wellness Director acknowledged that each staff member had a single certificate of training stating "Major Adverse Incidents and Emergency Procedures" with 1 hour of training, representing a . . . of 0.5 hours of training for each subject.

Class III

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0000 - Initial Comments

An unannounced relicensure survey was conducted . . . through . . . at Brookdale Palmer Ranch, an assisted living facility (license #9737) in Sarasota, Florida.

The following is description of the deficiencies.

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

Based on record review and interview, the facility failed to ensure a physician order for 2 (Resident #6 and Resident #11) out of 2 resident records reviewed, identified whether or not the resident requires any help/assistance with taking medication.

The findings included:

1. Review of the medical record for Resident #6 on , revealed that a Resident Health Assessment (AHCA Form 1823) was completed on due to a change in condition requiring hospice care. The physician failed to document "Yes" or "No" to the question "Does the individual need help with taking his or her medications? If yes, please place a checkmark in front of the appropriate box below: Needs Assistance with Self-Administration, Needs Medication Administration, Able to Administer w/o (without) Assistance."

Further review of the medical record revealed a Medication Review Report, signed by the physician on , documenting that the physician renewed an order, dated , for "Needs assistance with self-administration of medications."

During an interview on . . . at 4:00 p.m., the Health and Wellness Director acknowledged that the physician orders needed to be clarified due to the lack of a complete and accurate Resident Health Assessment.

2. On , review of the records revealed Resident #11's Health Assessment was incomplete and did not indicate what type of assistance the resident needs in taking his medication. The area was left blank. While reviewing physician orders after admission, an order was noted that Resident # 11 was able to take medication on his own and did not need staff assist.

On . . , while observing medication pass with Licensed Practical Nurse (LPN) Staff D, Resident #11

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was spoon fed his medication and then given a glass of water to swallow the medication. Resident # 11 was unable to take the pill and administer to himself.

On . . . at 8:25 a.m., LPN Staff D stated that she spoons the medications into Resident #11's mouth because he is unable to take them on his own because he get stiff from his diagnosis of Parkinson .

During an interview on at 3:20 p.m., the Health & Wellness Director acknowledged that Resident #11's Health Assessment was incomplete as to how resident should take his medication and acknowledged the most current physician order was for the resident to administer his medication himself.

Class III

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

Based on record review and interview, the facility failed to ensure that 2 (Resident # 11 and Resident #13) out of 2 residents sampled, were treated with consideration and respect and with due recognition of personal dignity and individuality.

The findings included:

1. On at 8:30 a.m., Resident #11 was found in his apartment living , sitting in a chair infront of a small tray table with a laptop computer on it. The resident's left hand was on the mouse of the computer and the right hand was on the arm of the chair and was shaking. The resident stated that he could not move or stop his right hand from shaking. Licensed Practical Nurse (LPN) Staff D noted to the resident that his private duty assistant had not shown up yet this morning. The resident had not been cleaned up or dressed yet for the day, he was barefoot with underwear and an open housecoat on. LPN Staff A called for assistance of another staff member and stopped her medication pass to get the Resident #11 up and dressed so the resident could make breakfast at 9 a.m. before the dining . .

.

Review of Resident #11's medical record revealed that the resident had a history of and needed assistance in all areas of Activities of Daily Living (ADL), including stand by assist to walk to the dining

.

During an interview at 4:00 p.m., the Health and Wellness Director advised that Resident #11's personal care aide did not advise the facility that they would be unable to care for the resident this date.

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She also acknowledged that there was no mechanism in place to provide care to the resident, in a timely manner, for such an event. As a result, the resident's individuality (related to care needs) was not respected and her personal dignity was compromised.

2. On at 8:50 a.m., a communication pager was overheard by the surveyor, stating that Resident #13's personal care aide was not in the facility. The pager also communicated that the resident was not washed or dressed, did not have breakfast, and that the dining be closing at 9:00 a.m.

On , review of Resident #13's medical record revealed that the resident had a history of , needed assistance in all areas of ADL (including transport to the dining), and identified that the resident's personal care aide gave the resident her medications.

During an interview on at 9:10 a.m., the Food Service Manager verified that the main dining (for breakfast) at 9:00 a.m. She also stated that she kept track of all resident attendance in the main dining (which served the first and third floor residents). When asked if there was a check-off list, she stated, "No, I just watch the tables." When asked who was notified if someone didn't come for breakfast, she said she would notify the Health and Wellness Supervisor. The Administrator-in-Training, who was present at this time, acknowledged that there should be a check-off list regarding attendance and they would initiate one to ensure that all residents have the ability to attend the dining their meals. In addition, she acknowledged that the facility needed a mechanism to ensure that residents do not miss a meal without staff being aware and ensure action is taken to offer/provide all meals in a timely manner.

Class III

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

Based on observation, record review, and staff and resident interview, the facility failed to ensure a licensed staff member administer medication to 2 (Resident #5 and Resident #11) of 4 residents records reviewed.

The findings included:

1. During record review of Resident #5 on , it was noted in the resident's current standing orders, sign off by physician, that the resident needed staff assistance with self-administration of medication.

On at 2:25 p.m., Resident #5 was observed sitting in his chair, in his living , and appeared to

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be sleeping. The resident's apartment door was wide open and several prescriptions and over the counter medication bottles were observed around the .

During an interview on at 2:30 p.m., Resident #5 stated that he takes his own medication and does not need any help with them. When asked if the medication should be in the lock box that was on the floor under the kitchen counter, the resident shook his head no, and said it was ok.

During an interview on at 3:00 p.m.., the Health and Wellness Director acknowledged that Resident #5 had been administering his own medication. She also confirmed that current physician orders stated that Resident #5 needed assistance with self-administration of medications.

2. On , review of the records revealed Resident #11 Health Assessment did not indicate what type of assistance the resident need in taking his medication. The area was left blank. While reviewing physician orders after admission, an order was noted that the resident was able to take medication on his own and did not need staff assistance.

On , while observing medication pass with Licensed Practical Nurse (LPN) Staff D, Resident #11 was spoon fed his medication and then given a glass of water to swallow the medication. The resident was unable to take the pill and administer to himself.

On at 8:25 a.m., LPN Staff D stated that she spoons the medications into Resident #11's mouth because he is unable to take them on his own because he gets stiff from his diagnosis of Parkinson .

On at 3:20 p.m., the Health & Wellness Director acknowledged that Resident #11's Health Assessment was incomplete as to how the resident should take his medication and acknowledged the most current physician order was for the resident to administer his medication himself.

Class III

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

Based on observation, interview, and record review, the facility failed to properly store medications for residents that need assistance with their self-administration of their medication for 1 (Residents #5) of 12 residents sampled.

The findings included:

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SUMMARY STATEMENT OF DEFICIENCIES
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1. On at 10:30 a.m., during the initial tour of the third floor of the facility, Resident #5's door was found open, the resident was in his bed and appeared to be sleeping. Over the counter and prescription medications were observed throughout the , on the counter and the dresser.

During record review of Resident #5 on , it was noted in the resident's current standing orders, sign off by physician, that the resident needed staff assistance with self-administration of medication.

On at 2:25 p.m., Resident #5 was observed sitting in his chair in his living appeared to be sleeping. The resident's apartment door was wide open, several prescriptions and over the counter medication bottles were observed around the .

During an interview on at 2:30 p.m., Resident #5 stated that he takes his own medication and does not need any help with them. When asked if the medication should be in the lock box that was on the floor under the kitchen counter, resident shook his head no, and said it was ok.

During an interview on at 3:00 p.m., the Health and Wellness Director acknowledged that Resident #5 had been administering his own medication. She also confirmed that the current physician orders stated that Resident #5 needed assistance with self-administration of medications. She admitted that she had spoken to the resident many times about not securing his medication in the lock box provided to him for this purpose. She also stated that she was aware that she had to remind him on multiple occasions that he had to lock his apartment door when he leaves.

Class III

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

Based on observation, interview, and record review, the facility failed to ensure proper labeled medications for 1 (Resident #11) of 3 residents observed in medication pass. Putting residents at risk for medication error.

The findings included:

On at 8:20 a.m., Licensed Practical Nurse (LPN) Staff D was observed preparing medication for Resident #11, she prepared to give 5 capsules of Parkinson medication , which is a combination medication of and extended-release capsules. The label of the medication bottle read Ratary 61. mg capsules as directed 5,4,4,4. Another bottle of the same medication in the nurse's medication cart read Ratary 61. mg capsules take 17 capsules by mouth once daily as

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directed. Prescriptions were noted to be filled by the pharmacy.

During an interview on at 8:25 a.m., LPN Staff D stated that she would not know how to give the medication by what was written on the pill bottles label and if she gave 17 capsules at once it would not be good for the resident.

Observation of the electronic medication administration record on the computer from which LPN Staff D was giving her medication revealed that it indicated Ratary 61. mg take 5 capsules at 9 am.

During record review of the doctor orders for this medication it was written that this medication was to be given as follows:
Ratary 61. mg give 5 tabs q a.m. (every a.m.)
Ratary 61. mg give 3 tabs q p.m. (every p.m.)
Ratary 61. mg give 4 tabs (twice a day)

During an interview on at 3:20 p.m., the Health & Wellness Director acknowledged that the labels on the resident's medication bottles were incorrect and could cause harm to the resident if given in the way noted on the label. She said that she was unaware that the labels were written that way and acknowledged that they did not match the medication administration record or the doctor orders.

Class III

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

Based on record review and interview, the facility failed to ensure that 2 (Staff A and Staff B) of 5 staff personnel files reviewed, had submitted a written statement, from a health care provider, documenting that the individual does not have any signs or symptoms of communicable . This statement must be submitted within 30 days after beginning employment.

The findings included:

On , review of the personnel records for Licensed Practical Nurse (LPN) Staff A and Resident Aide Staff B revealed that there was no statement on record, from a health care provider, stating that the staff members had no signs or symptoms of communicable . Both staff members have been employed by the facility for more than 30 days.

During an interview on , the Personnel Department Head and the Health and Wellness Director

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965335	**04/05/2018**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE PALMER RANCH**	STREET ADDRESS, CITY, STATE, ZIP CODE **5111 PALMER RANCH PARKWAY** **SARASOTA, FL 34238**	

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

acknowledged that both employees lack this documentation from a health care provider.

Class III