STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964946	04/25/2018
NAME OF PROVIDER OR SUPPLIER **BROOKDALE MELBOURNE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1765 WEST HIBISCUS BLVD** **MELBOURNE, FL 32901**	

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

0000 - Initial Comments

Complaint Investigation #2018002438 was conducted on . Brookdale Melbourne, License #9396, had a deficiency found at the time of the visit.

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

Based on record review and interview, the facility failed to ensure it provided care and services appropriate to the needs of 2 of 3 sampled residents and did not give medications as ordered (#5 & 6).

Findings:

1. Resident #5 was admitted on . The health assessment report 1823, dated , listed diagnoses of / , D deficiency, and , . She was independent with ambulation, eating, transferring and needed supervisor with bathing and . She needed assistance with self-administration of medications.

The health assessment indicated , 5 milligrams (mg.) one daily. Order dated indicated to increase , to 10 mg. daily - dispense 90. The 2017 Medication Observation Record (MOR) listed , 5 mg. 1 daily from to , from to indicated , 5 mg. 2 daily. The review revealed that on , 5 mg was sent to pharmacy to re-pack medications on cards. Ninety (90) pills were sent for re-packing. The , 2017 MOR listed , 5 mg. 2 daily and was marked as given from to . On , a medication release form indicated that 86 , 5 mg. pills were released to the resident's daughter. The resident went to daughter's house during hurricane Irma. She returned on . If the resident had 90 pills on hand on , and took 2 daily from to , she should have taken 54 pills in that period. There was no evidence to confirm the resident had extra medications to take during that period, leaving her to use only 4 from the 90 she had on .

On at 3 PM, the Health Wellness Director said she terminated a staff because she believed the resident did not get the medications as ordered. She had no knowledge whether or not the resident had extra medication (,).

2. Resident #6 was admitted . The health assessment report 1823, dated , listed diagnoses of right femur , , , high , and . She needed assistance with all activities of daily living and needed assistance with self-administration of medications. On Centrum Silver was ordered every other day. The 2018 MOR listed Centrum Silver 1

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daily at 8 AM and was marked as given on . The , 2018 MOR listed Centrum Silver 1 daily at 8 AM and was marked as given daily from to , not every other day as ordered. Another entry on the MOR listed Centrum Silver give 1 every other day at 8 AM and was marked as started on .

O at 3 PM, the Health Wellness Director, after speaking with the nurse, said once they noticed the order said every other day, not daily, the nurse corrected the MOR to reflect the correct dosage.

Class III