STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963949	**05/04/2018**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE BRADENTON GARDENS**	STREET ADDRESS, CITY, STATE, ZIP CODE **5612 26TH STREET WEST** **BRADENTON, FL 34207**	

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

0000 - Initial Comments

Assisted Living Facility

On , 2018 complaints CCR#2018002634 and CCR#2018003916 surveys were conducted at Brookdale Bradenton Gardens. Deficiencies were identified during the visit. (license # 6528)

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and interview the facility failed to ensure 2 of 4 (#1, #2) residents whose records were reviewed included documentation on their health assessment form (1823) stating they were appropriate and their needs could be met in an Assisted Living Facility (ALF).

Findings included:

On a record review was conducted for Resdent #1. Resident #1's record revealed an 1823 that did not include the date it was conducted. There was no documentation stating Resident #1's needs could be met in an ALF.

On a record review was conducted for Resident #2. Resident #2's record revealed an 1823 dated . Resident #2's 1823 revealed they require 24 hour nursing or , care, does not state if their needs can be met in an ALF, states the individual needs help with taking their medications but does not state what type of assistance is required.

An interview was conducted with the Interim Administrator on at 3:28 PM. They confirmed the facility does not employ 24-hour nurses and the missing details on the 1823's.

Class III

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

Based on record review and interview the facility failed to provide the required level of supervision needed for 3 of 4 residents (#1, #2, #3) whose records were reviewed and had documented incidents ( ). Specifically, the facility failed to provide documentation they notified the required persons following the incidents.

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Findings included:

A review of the facility incident reports for Resident's #1, #2 and #3 was conducted on . The reports were computer generated and only included the resident profile, incident date, community, location, nature, injury list and severity code. The report does not provide details of the incident or documentation of notification of the required persons.

During an interview with the Interim Administrator on at 3:38 PM they stated their corporate attorney does not allow them to share internal incident reports.

Class III

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

Based on observation and interview the facility failed to ensure residents were treated with consideration and respect and lived in a safe and decent living environment, free from and neglect, including .

Finding Include:

During a tour of the memory care unit, it was revealed that multiple had doors that auto lock when the door is shut. #56, # 59, # 60, # 62, # 69, # 72, and # 76 all had the automatic lock in place so that when the resident went to bed and the door was closed, the resident could not open the door to the exit into the hallway. On at 4:00pm the Director of Nursing (DON) stated she did not know why the door handles were installed but the maintenance staff were supposed to replace the handles as soon as the new ones on order came in. The new locks were ordered in . The DON stated that when the facility was remodeled the wrong type of handles were installed. The staff have a key that allows them to unlock the door.
The Director of Nursing accompanied Agency staff to test each to identify what had the auto locking doors. While checking A a family member of the resident that had just moved in overheard the conversation and was concerned that her husband would not be able to exit his .
The on the plate of the door latch were loose. The DON stated she would call maintenance to repair the door handle.

Class III

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

Based on record review and interview the facility failed to ensure residents received their medication at the required times as prescribed.

Findings included:

During multiple resident interviews conducted on , it was discovered that Staff G was unable to pass morning medications to all residents as prescribed. Per interviews, Staff G would start to assist residents with their medication and then needed to leave to assist with dining . The residents would have to wait until after breakfast to receive their morning medication. Some of the residents did not receive their medication within the time frame of one hour before or one hour after the time listed on the Medication Observation Record (MOR) and prescription label.

A review of the electronic Medication Observation Record revealed for Resident # 5 revealed that she was to receive one Tablet 81 mg by mouth one time a day at 9:00 AM.
On it was recorded she received the medication at 10:32.
On it was recorded she received the medication at 10:13.

Fish Oil Capsule tablet 1000 mg Give one capsule by mouth one time a day at 9:00 AM.
it was recorded she received the medication 10:31.
it was recorded she received the medication 10:08.

Tablet 12.5 MG Give one tablet by mouth one time a day for at 9:00 AM.
It was recorded she received the medication at 10:35.
It was recorded she received the medication at 10:13.

Patch 5% apply to left shoulder every 12 hours for left shoulder pain apply in the morning and remove at night.
It was recorded
- 2100 17:18
- 0900 10:32
- 2100 20:13
- 0900

A review of Resident #10's Medication Observation Record revealed it was listed that she was to

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receive Levothyroxin Tablet 75 MCG
Give 1 tablet by mouth at bedtime for [redacted] at 2100.
It was recorded she received on - 1 tablet at 22:03
Map [redacted] Pain tablet Extended Release 650 MG
Give 1 tablet by mouth four times a day for pain
It was recorded she was to received on [redacted] at 1700 but received 1 tablet at 16:12 and was to receive 1 tablet at 2100 but received 1 tablet at 21:48
It was recorded she was to receive on
1 tablet at 0900 but received 1 tablet at 09:17 and was to receive 1 tablet at 1300 but received 1 tablet at 13:12,
she was to receive 1 tablet at 17:00 but received 1 tablet at 16:40
[redacted] she was to received 1 tablet at 2100 and received 1 tablet at 22:03.
OLANZanpine tablet 20 mg Give 1 tablet by mouth at bedtime for behaviors.
On [redacted] she was to receive 1 tablet at 2100 and it was listed in the MOR that she received 1 tablet at 22:03.
On [redacted] she was to receive 1 tablet at 2000 and received 1 tablet at 21:35.

OLANZapine 5 mg tablet Give 1 tablet by mouth at bedtime for [redacted].
On [redacted] it was listed in the electronic MOR she was to receive 1 tablet at 2000 and received 1 tablet at 22:00
On [redacted] it was listed she was to receive 1 tablet at 2000 and received 1 tablet at 21:35

A review of Resident #6 medication Observation record revealed that it was listed she was to receive [redacted] /Levodop tablet 25-100 mg give 2 tablets 2 times a day for Parkinson.
It was listed on the electronic medication observation record that on [redacted] she was to receive 2 tablets at 0800 and received 2 tablets at 9:49
It was listed on [redacted] she was to receive 2 tablets at 2000 and received 2 tablets at 22:02
[redacted] she was to receive 2 tablets at 1700 and she receive 2 tablets at 16;33
[redacted] was to receive 2 tablets at 0800 and received 2 tablets at 9:11
[redacted] she was to receive 2 tablets at 2000 and received 2 tablets at 21:36
[redacted] she was to receive 2 tablets at 1700 and received 2 tablets at 16:08

[redacted] Cap 3000 mg give 1 tablet by mouth at bedtime for [redacted].
On [redacted] She was to receive the medication 2000 and received it at 22:02
On [redacted] she was to receive her medication at 2000 and received it at 21:36

An interview was conducted with Staff G. Staff G stated she had to stop giving medication to help in the

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dining all staff are to help to serve the meals. That takes time away from passing medication. Staff G reviewed the MOR and confirmed some of the residents medication is given past the 1 hour time frame.

Class III

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

Based on record review and interview the facility failed to ensure 5 of 5 (A, B, C, D, and E) employees, whose records were reviewed, did not have required hours of training in the following areas: Assistance with Activities of Daily Living and Behavioral Needs, Resident Rights, Recognizing/Report , Neglect and , Incident Reporting, and Emergency Preparedness and Evacuation.

Findings included:

On a record review was conducted for Staff A, with a hire date of and an end date of . Trainings included: Assistance with Daily Living and Behavioral Needs, 70 minutes, Resident rights, and neglect , 45 minutes.

On a record review was conducted for Staff B, with a hire date of and an end date of . Trainings included: Assistance with Daily Living and Behavioral Needs 70 minutes, Resident rights, and neglect , 65 minutes, Major Adverse Incidents and Emergency Procedures 60 minutes.

On a record review was conducted for Staff C with a hire date of . Trainings included: Assistance with Daily Living and Behavioral Needs 70 minutes, Resident rights, and neglect , 60 minutes, Major Adverse Incidents and Emergency Procedures 70 minutes.

On a record review was conducted for Staff D with a hire date of . Trainings included: Assistance with Daily Living and Behavioral Needs 70 minutes, Resident rights, and neglect , 60 minutes, Major Adverse Incidents and Emergency Procedures 60 minutes.

On a record review was conducted for Staff E with a hire date of . Trainings included: Assistance with Daily Living and Behavioral Needs 70 minutes, Resident rights, and neglect , 65 minutes, Major Adverse Incidents and Emergency Procedures 70 minutes.

During an interview with the Administrator on at 5:00 PM she acknowledged and confirmed

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that documentation of the trainings to include the required time frames were not in the charts.

Class III