STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965138	**07/30/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DR PHILLIPS AL	**8001 PIN OAK DRIVE** **ORLANDO, FL 32819**

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

0000 - Initial Comments

A complaint investigation 2018006259 was conducted on , , and . Brookdale Dr. Phillips Assisted Living Facility, license #9566, had deficiencies at the time of the investigation.

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record reviews and interviews, the facility failed to ensure the Medication Observation Record (MOR) was accurately updated for 1 of 4 sampled residents (#1) who required assistance with self-administered medications.

Findings:

Resident #1's record revealed a facility admission date of . A most recent 1823 health assessment form, dated on , indicated her diagnoses included Left Neck and head , status post Open Reduction Internal Fixation (ORIF,) , , , Type 2 , , , , , , , long term use of and D Deficiency. In addition, she required assistance with self-administered medications.

Resident #1's MOR contained an entry for Glargine Solution 100 unit/milliliter (ml) inject 13 units , at bedtime for Type 2 . Documentation on the MOR, dated on at 8:30 p.m., indicated that unlicensed caregiver A administered the which was a task unlicensed caregivers were not permitted to do.

On at 12:45 p.m. the health and wellness director said nurse B was the one who administered the to resident #1 on and not caregiver A as was documented on the MOR.

On at 1:28 p.m. nurse B said that on at 8:30 p.m. she administered the Glargine to resident #1 however, caregiver A was signed in on the computer so when nurse B signed that she gave the , caregiver A's computer identification was documented on the MOR instead of her own.

On at 4:42 p.m., caregiver A said nurse B gave resident #1 the Glargine on at 8:30 p.m. and said she never gave or checked resident's sugars but rather a nurse was always responsible for those tasks.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965138	**07/30/2018**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE DR PHILLIPS AL**	STREET ADDRESS, CITY, STATE, ZIP CODE **8001 PIN OAK DRIVE** **ORLANDO, FL 32819**	

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

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on observations, review of the facility's staffing schedules and interviews, the facility failed to maintain a written work schedule that accurately reflected its 24-hour staffing pattern for a given time period.

Findings:

On at 4 p.m., a review of the facility's schedule revealed caregiver A was scheduled to work the evening shift on . The schedule did not indicate her specific hours. In addition, the schedule indicated caregiver H was scheduled to work at 3 p.m. Observations revealed caregivers A and H were not present in the facility and caregiver G was present but was scheduled off. Caregiver G confirmed she was scheduled off on . She further explained she switched days with caregiver H. The staffing schedule was not updated to reflect the changes.

On at 10:25 p.m. observations, revealed caregiver A was present in the facility. She said she usually arrived to work at 5 p.m. because she worked another job.

On at 11 a.m. review of the facility's staffing schedule revealed the changes that occurred on were not noted on the schedule. The health and wellness director confirmed the findings and said although the schedule did not list her hours; caregiver A began working from 4:30 p.m. until 11 p.m. effective on . In addition, she said she just learned of the schedule switch between caregivers G and H on .

Review of the , 2018 Medication Observation Record for resident #1 revealed nurse B signed that she administered to the resident on and at 7 p.m. however, nurse B was not listed on the staffing schedule, as required.

Class III