STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964912	08/28/2018
NAME OF PROVIDER OR SUPPLIER **BROOKDALE SOUTHPOINT**	STREET ADDRESS, CITY, STATE, ZIP CODE **6895 BELFORT OAKS PLACE** **JACKSONVILLE, FL 32216**	

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

0000 - Initial Comments

An abbreviated licensure survey with renewal of Limited Nursing Services (LNS) was conducted at Brookdale Southpoint on , 2018 (#AL9380). Deficiencies were identified.

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

Based on observation, interview, and record review, the facility failed to maintain an accurate Medication Administration Record (MAR) for 1 of 3 residents (Resident #8) observed during medication pass. Additionally, the facility failed to appropriately use its Controlled Substance Count record while assisting residents with pain medication for 2 of 3 residents sampled (Residents #8 and #9).

The findings include:

Employee A, a licensed practical nurse (LPN), was observed during the 12:00 PM medication pass on preparing to assist Residents #8 and #9 with their medications. She was using an e-MAR (electronic medication administration record).

Employee A checked the e-MAR and prepared Resident #8's ordered medications at 12:05 PM. The medications included , / (, a pain medication which was identified and monitored as a controlled substance) 10-325 mg, which had instructions to take 1 tablet by mouth every 4 hours as needed.When the nurse removed the from her cart, she did not compare the count (number) of tablets in the resident's bubble pack with the number of tablets documented on the resident's controlled substance count sheet. She did not remove the Controlled Substances binder from inside of her medication cart until after she had assisted the resident with the .. She then documented on the controlled substance count sheet that one tablet of had been given at 12:00 PM.

Review of the controlled substance count sheet revealed that the previous dose of had been marked as given by Employee A at 9:00 AM that morning (Photo evidence obtained). Noting that the 12:00 PM dose of had been given only 3 hours after the previous dose, a review of the administration record in the e-MAR was conducted. After reviewing it with Employee A, she verbalized that she forget to document the 9:00 AM dose in the electronic record. She confirmed that she had not checked the e-MAR for the administration time of the previous dose of , and that she had given the an hour early.

Employee A checked the e-MAR and prepared Resident #9's ordered medications at 12:15 PM. The

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medications included 5-325 mg (pain medication which was identified and monitored as a controlled substance). When the nurse removed the from her cart, she did not compare the count (number) of tablets in the resident's bubble pack with the number of tablets documented on the resident's controlled substance count sheet. She did not remove the Controlled Substances binder from inside of her medication cart until after she had assisted the resident with the .

In an interview at 12:19 PM on , Employee A confirmed that for both Resident #8 and #9 she had not counted the number of and tablets, nor compared the actual number to the expected number on the controlled substance count sheet, prior to preparing and assisting the residents with them.

Review of the facility's policy and procedure (CS-40-7), entitled Medications & Treatment - General Guidelines, revealed the following: "Documentation of medications administered should occur promptly after the resident has taken the medication." Further review of Policy CS-40-7, subtitled Medications & Treatment - Assistance, revealed that the following steps should be performed by staff when administering a controlled substance:

10. When assisting with a controlled substance:
    a. Obtain the Controlled Substances Binder
    b. Turn to the Controlled Substance Count Sheet that corresponds to the label on the medication container
    c. Count the number of tablets/capsules or measurement of liquid available before preparing the tablet/capsule for distribution.
    d. Compare the actual number available with the number on the next blank row on the count sheet.

Photo evidence was obtained.

At 12:45 PM on , the Health and Wellness Director confirmed that her expectation is that medications should be documented in the e-MAR right after medications are given. She also verified that the actual count of a controlled substance should be verified against the controlled substance count sheet prior to medications being given.

Class III