STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964490	**08/21/2018**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE DELAND**	STREET ADDRESS, CITY, STATE, ZIP CODE **1210 NORTH STREET** **DELAND, FL 32724**	

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

0000 - Initial Comments

A complaint survey CCR #2018007496 was conducted on , 2018 at Brookdale DeLand. Deficiencies were identified at the time of the survey.

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

Based on record reviews and interviews the facility failed to ensure medication records were accurate for 2 of 4 residents sampled (Resident's #7 and #8).

The findings include:

A record review was conducted for Resident #7 and revealed she had an order for (anti- medication) 0.25 mg, with instructions to give one tablet, by mouth, four times a day. A review of the Medication Observation Record (MOR) revealed that is was scheduled at 8 AM, 12 PM, 4 PM, and 8 PM.

A review was conducted of the sign out sheets for Resident #7, and it revealed that the staff had failed to sign out a pill for her on the following dates, despite being signed off as given on the MOR:

- 8 PM
- 8 PM
- 12 PM
- 4 PM
- 4 PM
- 4 PM
- 4 PM
- 4 PM
- 4 PM

A record review was conducted for Resident #8 which revealed she had an order for (pain medication) with instructions to give one pill, by mouth, four times a day for pain. A review of the Medication Observation Record (MOR) revealed that is was scheduled at 8 AM, 12 PM, 4 PM, and 8 PM.

A review was conducted of the sign out sheets for Resident #8, and it revealed that staff failed

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to sign out a pill for the resident on the following dates, despite being documented on the MOR as being given.

- 12 PM and 4 PM dose
- 12 PM and 4 PM dose
- 4 PM dose

On at 1:17 PM an interview was conducted with Director of Nursing (DON) and Administrator regarding the medication sheets. The DON confirmed that Residents #7 and #8 had not received their medications as ordered, according to the sign out sheets. She explained the only pills that could have been given to them would have been the ones signed out on their sheets.

Class III

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

Based on observations, interviews, and record reviews the facility failed to ensure that the medication card labels matched the current physician orders for 2 of 4 residents sampled (Resident's #9 and #10).

The findings include:

A record review was conducted for Resident #9 and revealed she had an order for , 0.5 mg (milligrams) with instructions to give one tablet, by mouth, two times a day, for behavioral disturbances. , is a controlled that is classified as an anti- medication, but is used to stabilize behaviors.

A review was conducted of Resident #9's Medication Observation Record (MOR) and revealed her current order was for twice a day. A review was conducted of her medication package in the medication cart, and it revealed that the label read to administer it three times a day.

A record review was conducted for Resident #10 and revealed she had an order for , 0.5 mg (milligrams) with instructions to give one tablet, by mouth, two times a day, for increased agitation.

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SUMMARY STATEMENT OF DEFICIENCIES
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A review was conducted of Resident #10's Medication Observation Record (MOR) and revealed her current order was for twice a day. A review was conducted of her medication package in the medication cart, and it revealed that the label read to administer it three times a day.

On . . . at 1:27 PM an interview was conducted with the Director of Nursing, (DON) and she confirmed that the labels on the medication packages did not match the current orders on the Medication Observation Records for Resident's #9 and #10. DON stated that when the order changed the nurse should have applied a change of directions sticker to the medication cards.

Class III