

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968732	(X3) DATE SURVEY COMPLETED 10/25/2018
NAME OF PROVIDER OR SUPPLIER BROOKDALE CHAMBREL PINECASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2950 SE 19TH AVE OCALA, FL 34471	

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

0000 - Initial Comments

On , 2018 through , 2018, an unannounced biennial re-licensure survey in conjunction with Limited Nursing Services survey was conducted at Brookdale Chambrel Pinecastle Assisted Living Facility (License #12614), Ocala, FL. Deficient Practice was identified at the time of the survey.

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, interview and record review, the facility failed to provide medication administration in accordance with a health care provider's order or prescription label for 1 out of 4 sampled residents (Resident #10).

Findings:

On at 09:30 AM, an observation of medication administration was made with Staff F, LPN. Staff F took a medication patch from the medication cart and took it to Resident #10's . Staff F checked her gloved hand down the back of Resident #10's shirt and placed the patch on Resident #10's back.

On at 9:30 AM, an interview was conducted with Staff F, LPN. When asked if she took the old patch off of Resident #10, she stated: "I did not feel an old patch." When asked if the nurses documented where they put the medication patches on Resident #10's body or that the old patch was removed, she stated, "No, but I can look in the MAR (medication administration record)." Staff F looked at the MAR under documentation and orders and stated: "I don't see anything documented about the patch being taken off and we don't document where we place the medication patches and I don't see an order to take the old patch off."

Record review of the medication label showed: "Resident #10's name/ 9.5 mg/24 Generic for 9.5 mg/24 hour patch. Apply one patch , every morning for 's (Remove old patch first).

On at 9:44 AM, an interview was conducted with Staff H, RN (Registered Nurse) and Health and Wellness Director. When asked what the standard practice was for administering medication patches, she stated: "The nurse should take the old patch off the resident's skin and put the new one on in a different spot on the resident's skin." Health and Wellness director also confirmed that the medication label showed: "Before administration take the old patch off first." She added: "The nurse

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

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FORM APPROVED

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should have looked at the whole body to make sure there was no other patch left on before she put a new one on and it should be documented in the medication administration record where the patch is placed and that the old one has been removed." Staff H confirmed that Staff F did not follow the physician order on the medication label by not removing the old medication patch and/or making sure the old medication patch was not still on the resident's skin. Record review of the policy named: Medication and Treatment-General Guidelines for Medication Administration/Assistance CS 40-7 was conducted. The policy reads: "Policy Overview: Trained and/or licensed associates may administer or assist the resident with medication management or medication administration and treatments per physician/healthcare provider (HCP) order and as per state regulation. Policy Detail: 1. Trained or licensed associates administering or assisting with medications should follow: (b). the medication label, pharmacy, and manufacturer directions for each individual medication prescribed." Class III		