STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964130	**11/27/2018**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE CLEARWATER**	STREET ADDRESS, CITY, STATE, ZIP CODE **2750 DREW STREET** **CLEARWATER, FL 33759**	

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

0000 - Initial Comments

Assisted Living Facility

A complaint investigation (CCR 2018015043 and 2018017399) was conducted at Brookdale Clearwater on . . . . . Brookdale Clearwater had a deficiency at the time of the investigation.

(License #6670)

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

Based on record review and interview, the facility failed to ensure that prescriptions for residents that received assistance with self-administration of medication were refilled in a timely manner for two (Resident #9 and Resident #4) of three resident records sampled.

Findings included:

A review of Resident #9's health assessment dated indicated that Resident #9 required assistance with self-administration of medication and had a diagnosis of . . . . . A review of Resident #4's health assessment dated showed that the resident required assistance with self-administration of medication.

A review of medication observation records (MORs) conducted on showed that Resident #9 was prescribed the medication , Tablet Delayed Release 500 MG- Give 2 tablets by every day for . . . . . A review of Resident #9's MORs showed that they did not receive the medication on (8am and 8pm dosages), (8am and 8pm dosages) and (8am dosage) (photographic evidence obtained).

A review of the facility's Resident Log for Resident #9 showed that the resident was seen in their room at 9:15 AM on and was unable to speak, diaphoretic (sweating), and showing labored breathing. The local emergency medical services ( ) was called and the resident was taken to the hospital (photographic evidence obtained).

An interview was conducted with the Health and Wellness Director at 1:37 PM on and they stated that Resident #9 went to the hospital then rehabilitation due to a . . . . . They stated that the resident was on a medication to control

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An interview was conducted with the Assisted Living Manager at 1:42 AM on and they stated that Resident #9 was out of their , medication for two days and the licensed nursing staff was not made aware of this. The Assisted Living Manager stated that Resident #9 had a and they sent the resident out with to the hospital.

A review of the MORs for Resident #4 showed the medication , Tablet-10 MG was not given at 8 AM on and Tablet was not given on 11/6/18 at 8 AM.

An interview was conducted with the Health and Wellness Director at 4:06 PM on concerning the missed dosages of , Tablet and for Resident #4. The Health and Wellness Director reviewed the computer records and stated that it showed a message that the medications were not in the medication cart and the pharmacy was notified. They stated that the resident missed the 8 AM dosages of , Tablet and on .
A review of the facility's policy entitled "Medications & Treatments-Availability", last revised on , stated that it is Facility policy that all currently ordered medications will be available to the resident.

Class III