STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953460	01/02/2019
NAME OF PROVIDER OR SUPPLIER **BROOKDALE DESTIN**	STREET ADDRESS, CITY, STATE, ZIP CODE **2400 CRYSTAL COVE LANE** **DESTIN, FL 32541**	

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

0000 - Initial Comments

An unannounced complaint survey for allegations set forth in CCR# 2018015432 and CCR# 2018016024 was conducted at Brookdale Destin in Destin, FL on . Deficient practice was identified at the time of the survey.

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

Based on staff interview and record review, the facility failed to provide physician ordered medications for 1 of 3 sampled residents, (#2). Resident #2 was without medication for 6 days and subsequently was transferred to the hospital with a diagnosis of (in the).

The findings were:

A review was conducted of the electronic medication administration record for resident #2. Instead of check marks indicating that the medication was given, the section for (a medication for high) 10 milligrams (mg) was marked, "09" for , 2, 3, 4, 5 and 6.

A review of the resident's progress notes for the above listed days revealed nurses' notes that stated that the medication was unavailable and they were waiting on the medication from pharmacy.
- 12:14pm - 10mg by once per day - waiting on pharmacy.
- 10:04am - 10mg by once per day - waiting on pharmacy.
- 09:20am - 10mg by once per day - waiting on medication to arrive from pharmacy.
- 09:58am - 10mg by once per day - waiting on meds to arrive from pharmacy.
- 08:24 - 10mg by once per day - waiting on pharmacy.
- 09:29 - 10mg by once per day - waiting on pharmacy to deliver meds.

Review of vital signs for resident #2 revealed that the last reading in the system was from .

A review of hospital records revealed an emergency department record, an admission history and physical and a discharge summary.
The emergency department record's diagnosis was, " (in the)

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953460	01/02/2019
NAME OF PROVIDER OR SUPPLIER **BROOKDALE DESTIN**	STREET ADDRESS, CITY, STATE, ZIP CODE **2400 CRYSTAL COVE LANE** **DESTIN, FL 32541**	

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

- hypertensive (high) emergency." In the doctor's noted section it stated, "Patient has a left likely secondary to (high ."

The admission history and physical stated the following:
"Chief complaint - Elevated and . Resident is a female with underlying , and medical history below who presents to the emergency department from assisted living facility secondary to elevated with associated and . Workup in the emergency department does reveal left with (top number in readings) have been in the 220s ... ...Also, please note that apparently the patient has been out of her medications for the last several days."

A review of the facility policy, Medications and Treatments - Availability; CS-40-3; Effective ; Last reviewed: ; , revealed the policy was to ensure all currently ordered medications would be available to the facility residents. It further stated the community was responsible for obtaining newly ordered medications or refills for medications and treatment orders, unless otherwise agreed upon with the resident, family, or legally responsible party in accordance with the Pharmacy Services Agreement Addendum to the Residency Agreement. In the event the resident or legally responsible party have signed the Pharmacy Services Agreement stating that they will have the responsibility for obtaining new ordered medication or re-ordering medications, and the medications are not delivered within two days prior to the depletion of the medication stock, the community nurse will do the following: (1) Order or re-order the medications with the 'preferred pharmacy provider' to so no interruption of medication administration takes place (2) The family will be responsible for paying for the medications as well as any associated emergency delivery service charges (3) Fees associated with re-ordering medications from the 'preferred pharmacy' are determined by the preferred pharmacy and are in addition to the service fee.

Review of the pharmacy agreement between the facility and resident #2 revealed, "Use for emergency up only at this point!" written at the bottom of the page by Resident #2's son regarding the facility's pharmacy.

On at 1:54pm an interview was conducted with Staff B. She was asked if the facility ever ran out of medications. She replied that sometimes they ran out, but they could get an emergency supply that could be delivered the same day. When asked how long a resident would go without their medication while waiting for this supply she stated not more than a couple days.

On at 2:30pm an interview was conducted with Staff C. When asked if the facility ever ran out

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953460	**01/02/2019**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE DESTIN**	STREET ADDRESS, CITY, STATE, ZIP CODE **2400 CRYSTAL COVE LANE** **DESTIN, FL 32541**	

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

of resident medications she stated, "On occasion if pharmacy had not brought it or if the physician needed to sign a new order." She stated that they usually get an emergency fill in that case. She stated that they could go to a local pharmacy to fill it. They would usually get a 2 or 3 day supply while waiting on family to get the full supply. She was not able to state how the facility keeps up with which residents use the in-house pharmacy and which use their own pharmacy. She was then asked how she would document when a medication was not available to which she replied, if we ran out I would document on the medication administration record, you check no and 9 is "other." Then write in the narrative notes.

On at 2:44pm an interview was conducted with Staff D. She was asked if the facility ever ran out of medications for residents. She said, "We do run out, but then we contact the doctors or the pharmacy or the family if they are responsible." She was also not able to explain how one would know if the resident's medications were filled by the facility pharmacy or a private pharmacy. She stated that there was recent training in the building regarding medications.

On at 3:15pm an interview was conducted with the facility pharmacist. At that time she stated that she did not think they were the primary pharmacy for the resident as they had only filled 4 prescriptions in all of 2018. None of those were , , they were instead hospice medications ordered after the resident returned to the facility from the hospital.

On at 4:15pm an interview was conducted with the Director of Clinical Services. Regarding the re-ordering of medications, the Director stated they called the family when down to a weeks' worth of medications. We continue to remind them as we can. If they are about to run out we do a guardian refill and charge it to the family/resident. We have run out of medications when the family will not go refill them. Regarding Resident #2's , , the Director stated, "I think we had been calling son for refills up until she went out to the hospital. I feel like hers were from a mail-order pharmacy. My staff kept in contact with him to say that we needed this medication." "Multiple calls were made to the son to pick it up. We couldn't have it called into Publix to have it delivered because son did not want us to use Guardian." At 4:30pm the administrator entered and was included in the interview, she added, "They wanted to use their own pharmacy. Her things came in mail order. The son agreed that if something was emergent, they would not wait on mail order. He would pick it up locally. On , 5th staff called son to say we were low on meds and out of , ." It was 8pm when we got a phone call from pharmacy that meds would be ready the next morning.

The facility was asked to show documentation of when the facility first reached out to the son. The first time they documented that they reached out to the son for medication refill was on , the night before the resident was sent to the hospital.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953460	**01/02/2019**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE DESTIN**	STREET ADDRESS, CITY, STATE, ZIP CODE **2400 CRYSTAL COVE LANE** **DESTIN, FL 32541**	

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

The administrator was asked about an action plan to prevent this from happening again. The administrator responded, "When someone comes in from a hospital or nursing home they go on the nurse's cart for first 30 days. This is because a nurse is better able to pick up on medication issues quicker, until medications are stable. We did re-training to talk about documentation. We did not find documentation of staff calling son, so there was education on that. Staff were told to notify the Nurse/Director when there was not a medication available so we can get a 3 day supply. We would pay for it if the son declined to pay for the immediate use medication." The administrator was asked why the facilty did not just order the medication per their policy and contract since the resident was out. The administrator responded, "What I was told by staff was that it should be coming in his mom's mailbox. I was not notified that we were completely out. We should have ordered it on our own if we knew that we were out."

The facility provided a corrective action plan which included a 2 hour assistance with medication administration training on for 4 of the med techs, in-services to inform the Director if they run out of medications, end of shift report for any incidents on the shift. There was no evidence of auditing done by administration to ensure that the plan of correction was actually correcting the issues that lead to Resident #2's hospitalization.

Resident #2 was discharged from the hospital to the facility on hospice care on . She four days later at the facility.

Class II