STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964477	**03/13/2019**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE PORT CHARLOTTE**	STREET ADDRESS, CITY, STATE, ZIP CODE **18440 TOLEDO BLADE BLVD** **PORT CHARLOTTE, FL 33952**	

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

0000 - Initial Comments

An unannounced relicensure, limited nursing services, and emergency power plan monitoring survey was conducted through at Brookdale Port Charlotte, an assisted living facility (license #9027) in Port Charlotte, Florida.

The following is description of the deficiencies.

0008 - Admissions - Health Assessment - 429.26( ) FS; 58A-5.0181(2) FAC

Based on record review and interview, the facility failed to ensure residents had a new completed health assessment within a 3 year time frame for 2 (Resident #7 and #9) of 3 resident's records reviewed.

The findings included:

Record review of Resident #7's chart revealed the last resident health assessment was dated . The resident's record did not have a complete up-to-date health assessment with a current medication list in the last 3 years.

Record review of Resident #9's chart revealed the last resident health assessment was dated . The resident's record did not have a complete up-to-date health assessment with a current medication list in the last 3 years.

On at 11:30 a.m., Registered Nurse Regional Temporary Director of Clinical Services , acknowledged that Resident #7's and #9's health assessments were past due and needed to be updated.

Class III

0050 - Medication - Self Administered Medications - 429.256(2) FS;58A-5.0185(1) FAC

Based on record review and staff interview, the facility failed to follow physician's orders to allow 1 (Resident #7) of 2 resident's records reviewed, to take her own medication as a physician indicated with no assistance.

The findings included.

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During record review of Resident #7's admitting health assessment, the physician indicated the resident did not need assistance with taking her medications.

Record review of the medication observation record (MOR) recorded that Resident #7 had been receiving medication administration from the nurses on day and evening shifts since admission. No assessment was found indicating the resident was unable to administer her own medications. No additional physician orders were found indicating the resident needed assistance with self-administration or needed medication administration.

On . . . . in an interview with Resident #7, she said the nurses bring her the pills she needs to take.

On . . . . at 11:22 a.m., the Health and Wellness Director acknowledged the admission health assessment did indicate the resident could take her own medication and did not need assistance. She then confirmed that the resident has been receiving medication administration, there was no order to change it or assessment to determine Resident #7 was not capable to take her own medication.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview, the facility failed to ensure that within 30 days of employment, newly hired staff submit a written statement from a health care provider documenting the individual does not have any signs or symptoms of communicable . . . . for 1 (Staff B) of 4 staff reviewed.

The findings included:

Staff B was hired as a resident care aide on . Staff B's file contained no statement from a health care provider they had no signs or symptoms of communicable . . . . . .

On . . . . at 2:30 p.m., the Administrator agreed the documentation was not available.

Class III

0081 - Training - Staff In-Service - 58A-5.0191( ) FAC

Based on record review and interview, the facility failed to provide a minimum of a 2 hour preservice orientation prior to interacting with residents for 3 (Staff A, B, and C) of 3 staff reviewed, hired after

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The findings included:

Staff A was hired as a resident care aide on . Staff A's file did not contain a statement signed by both the administrator and the employee this had been completed.

Staff B was hired as a resident care aide on . Staff B's file did not contain a statement signed by both the administrator and the employee this had been completed.

Staff C was hired as a resident care aide on . Staff C's file did not contain a statement signed by both the administrator and the employee this had been completed.

On at 2:30 p.m., the Administrator said she was sure this had been done but could not produce the documentation.

Class III

0083 - Training - First Aid and - 58A-5.0191(5) FAC

Based on record review and interview, the facility failed to ensure a staff member who has completed courses in first aid, , , ( ) and holds a current valid card documenting completion of such courses, is in the facility at all times.

The findings included:

A review of the staffing schedule for the two weeks prior to survey, showed the overnight shift is covered by Staff C, Staff D, and Staff E.

A review of Staff C's employee file revealed no valid documentation of completing an approved first aid or course.

A review of Staff D's file revealed no valid documentation of completing an approved first aid course.

A review of Staff E's file revealed no valid documentation of completing an approved first aid or course.

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On at 2:30 p.m., the Administrator agreed the overnight shift staff did not have the required certifications.

Class III

N277 - LNS - Resident Care Standards - 58A-5.031(2) FAC

Based on record review and interview, the facility failed to maintain equipment needed to follow physicians orders for 1 (Resident #9) of 2 reviewed for limited nursing services (LNS)

The findings included:

A review of the LNS monthly assessments for and showed Resident #9 was on LNS services for at 2 liter PRN. A registered nurse (RN) signed the assessment. Review of the limited nursing services log shows resident continues on the service for at 2 liter per as needed for .

On at 10:55 a.m., when observing the resident's room, an concentrator or portable e-tank was not found. The Regional Director also looked for the equipment in the resident's room and in the facility.

On at 9:30 a.m., the Temporary Regional Director of Clinical Services acknowledged there were no progress notes in regards to the PRN order. She also said there wasn't an concentrator or portable e-tank in the facility for the resident to use if she needed the PRN .

On at 1:30 p.m., the Business Office Manager stated there was an additional charge for limited nursing services (LNS).

On at 1:45 a.m., the Temporary Regional Director of Clinical Services reported in of 2018 when the resident's order was changed from continuous to PRN, an order was written to discontinue LNS charting for continuous . The resident should have been assessed if she needed the continuation of LNS services. She admitted this is when the daily LNS charting stopped.

Class III

N278 - LNS - Records - 58A-5.031(3) FAC; 429.07 (3)(c)2, FS

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Based on record review and interview, the facility failed to have nursing progress notes maintained for 1 (Resident #9) of 2 residents receiving limited nursing services (LNS).

The findings included:

A review of the LNS monthly assessments for [redacted] and [redacted] showed Resident #9 was on LNS services for [redacted] at 2 liter [redacted] PRN. A registered nurse (RN) signed the assessment. No progress notes were maintained for the resident regarding the LNS services they were receiving.

On [redacted] at 9:30 a.m., the Temporary Regional Director of Clinical Services [redacted] acknowledged there were no progress notes in regards to the PRN [redacted] order. She also said there was no [redacted] concentrator or portable e-tank in the facility for the resident to use if she need the PRN [redacted].

On [redacted] at 1:30 p.m., the Business Office Manager stated there was an additional charge for Limited Nursing Services (LNS).

On [redacted] at 1:45 a.m., the Temporary Regional Director of Clinical Services reported [redacted] in [redacted] of 2018 when the resident's [redacted] order was changed from continuous to PRN, an order was written to discontinue LNS charting for continuous [redacted]. The resident should have been assessed if she need the continuation of LNS services. She admitted this is when the daily LNS charting stopped.

Class III