STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965138	**07/03/2019**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE DR PHILLIPS AL**	STREET ADDRESS, CITY, STATE, ZIP CODE **8001 PIN OAK DRIVE** **ORLANDO, FL 32819**	

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

0000 - Initial Comments

A Complaint Investigation (2019006407) was conducted at Brookdale Dr. Phillips Assisted Living on , . Deficiencies were identified at the time of the survey.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record reviews and interview, the facility failed to obtain a new 1823 health assessment form when 1 of 3 sampled residents (#3) experienced a significant change.

Findings:

Resident #3's record revealed a facility admission date of . Her current 1823 was dated . She was admitted to hospice services on . Her record did not contain a new 1823 when she was admitted to hospice, which is a significant change.

On at 1:45 p.m. the health and wellness director confirmed the findings and was unable to provide additional documentation.

Photographic evidence obtained.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record reviews and interview, the facility failed to follow a health care provider's medication order for 1 of 3 sampled residents (#4).

Findings:

Resident #4's record revealed a facility admission date of . Her current 1823 health assessment form, dated , indicated that her diagnoses included Type 2 and long-term use. She requires assistance with self-administration of medications.

A health care provider's order, dated , instructed to give Trulicity , inject 0.75 milligrams (mg) , one time a day every Monday for Type 2 .

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Documentation on her Medication Observation Record (MOR) revealed that "09," which indicates "other/see nurse notes," was documented for the Trulicity on and the nurse's note indicated "could not find on med cart."

The MOR nor the resident's record contained documentation to indicate the facility contacted a health care provider when the Trulicity could not be found to obtain instructions on whether to hold the or give it on another day.

On at 1:45 p.m. the health and wellness director confirmed the findings and said she did not know why the nurse looked in the cart for the Trulicity because it was not kept in the cart.

Photographic evidence obtained.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on record reviews and interviews, the facility failed to treat residents with consideration and respect when 5 of 5 sampled residents (#1, 2, 3, 4, and 5) had excessive pendant call responses and failed to follow its grievance procedure when 1 of 5 sampled residents (#5) presented a grievance.

Findings:

1. On at 9:30 a.m. resident #4 said it took the staff a long time to respond when she pushed her pendant for help.

Review of the facility's pendant call response reports revealed the following:

Resident #4 had a response time of 1 hour 34 minutes on , 2 hours 40 minutes on , and 2 hours 1 minute on .

2. At 9:48 a.m. resident #5 said staff do not always respond to his pendant calls in a timely manner.

Review of the facility's pendant call response reports revealed the following:

Resident #5 had a response time of 2 hours 45 minutes on , 2 hours 57 minutes on , and 2

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hours 23 minutes on .

3. At 9:55 a.m. resident #3 said she cannot walk, and it takes staff too long to respond to her calls.

Review of the facility's pendant call response reports revealed the following:

4. At 10:05 a.m. resident #1 said she has to wait a long time for staff to respond to her pendant calls.

Review of the facility's pendant call response reports revealed the following:

Resident #1 had a response time of 2 hours 49 minutes on .

5. Review of the facility's pendant call response reports revealed the following:

Resident #2 had a response time of 1 hour 59 minutes on , 2 hours on , and 1 hour 1 minute on .

At 2:35 p.m. resident #2's family member said the staff response times to her mom's pendant is lengthy.

At 1:05 p.m. the administrator confirmed the response times and could not provide an explanation.

6. Review of the resident council minutes revealed that on , resident #5 reported that call lights were not being answered. The minutes did not include documented follow up from the facility nor did the facility's grievance log contain any follow up to his concern.

The facility's grievance procedure indicates that the executive director will respond to resident grievances within 14 days of receipt of the complaint.

At 4:45 p.m. the administrator confirmed the findings.

Photographic evidence obtained.

Class III

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

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SUMMARY STATEMENT OF DEFICIENCIES
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Based on record reviews and interview, the facility failed to ensure medications were available for 1 of 3 sampled residents (#4) who received assistance with self-administration of medications and was away from the facility.

Findings:

Resident #4's record revealed a facility admission date of . Her current 1823 health assessment form, dated , indicated that her diagnoses included Type 2 , long-term use, , , , , , and . She requires assistance with self-administration of medications.

Her Medication Observation Record (MOR) listed , , -S, , and , all scheduled to be given at 5 p.m.

On , "03" was documented, which indicates "absent from home."

Her MOR nor her record contained documentation to indicate the facility made any efforts to make the medication available during her absence to ensure she received them as prescribed or that a health care provider was contacted to prescribe a medication schedule that coincided with her presence in the facility.

On at 1:45 p.m. the health and wellness director confirmed the findings and said the resident was on a leave of absence with her family.

A facility note, dated , indicated that her medications, monitor, , and needles were sent with her daughter because she would not be returning to the facility until 9 p.m. or later. The resident's record did not contain documentation to indicate this same option was made available during her absence with family on .

The facility's policy indicates that when a resident is going to be absent from the community for any period of time, the resident's current medications scheduled during the temporary absence time will be released to the resident/responsible party per state regulation.

Photographic evidence obtained.

Class III

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

Based on record reviews and interview, the facility failed to make every reasonable effort to ensure a prescription was filled in a timely manner for 1 of 3 sampled residents (#4) who received assistance with medications.

Findings:

Resident #4's record revealed a facility admission date of . Her current 1823 health assessment form, dated , indicated that her diagnoses included Type 2 , long-term use, , , , and . She requires assistance with self-administration of medications.

Her Medication Observation Record (MOR) listed 10 milligram (mg,) give 10 mg by one time a day for Acute . On and , "09" was documented, which indicates "other/see nurse's notes." The nurse's notes indicated that the medication was not available.

Her MOR listed , 5 mg tablet, give one tablet by one time a day for Essential , and , 10 mg tablet, give one tablet by at bedtime for . On , "09" was documented for the and on and , "09" was documented for the . The nurse's notes indicated that the was "not given needs to be ordered" and the "was on order."

The resident's record did not contain documentation to indicate the facility made every reasonable effort to ensure the medications were filled in a timely manner and before they ran out.

On at 1:45 p.m. the health and wellness director confirmed the findings.

Photographic evidence obtained.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observations, record reviews, and interviews, the facility failed to have an approval letter from the local emergency management agency for its emergency environmental control plan.

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SUMMARY STATEMENT OF DEFICIENCIES
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Findings:

On at 4:39 p.m. a request was made to review the facility's emergency environmental control plan and its approval letter from the emergency management agency. The facility's previous administrator was present and said the facility was not required to have an approval letter because they were granted a variance.

However, observations made with the previous administrator and the current administrator revealed the facility has a diesel generator in place that the previous administrator said will power emergency lights, the elevator, red plugs, and portable air conditioning units in the event of an outage. He said the facility is waiting on a new generator to be installed that will power the entire facility, which is why he believes the facility is not prepared to obtain an approval letter for its plan. He said the portable A/C units will cool seven activity rooms, six dining rooms, and one living room.

The facility's plan is dated and indicates the current generator will be used to achieve temperature at or below 81 degrees.

At 4:49 p.m. a representative from the local emergency management agency said the facility's plan was reviewed on , was rejected, and returned to the facility with instructions to make corrections and resubmit the plan for review however, the facility did not resubmit its plan.

Photographic evidence obtained.

Class III