Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910533	A. BUILDING: _____ B. WING _____	12/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PHILLIPPI CREEK	5501 SWIFT ROAD SARASOTA, FL 34231

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced complaint survey for #2019019518 was conducted from through at Brookdale Phillippi Creek, an assisted living facility in Sarasota, Florida. Complaint #2019019518 was substantiated. The following is a description of the deficiencies.	A 000		
A 052	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, including an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident. (b) In the presence of the resident, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into	A 052		

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A 052	Continued From page 1	A 052		

the dispensing cup of the [illegible].
(h) Using a [illegible] to perform [illegible] level checks.
(i) Assisting with putting on and taking off [illegible] stockings.
(j) Assisting with applying and removing an [illegible] but not with titrating the prescribed [illegible] settings.
(k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device.
(l) Assisting with measuring vital signs.
(m) Assisting with [illegible] bags.

(4) Assistance with self-administration does not include:
(a) Mixing, [illegible], converting, or [illegible] medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.
(b) The preparation of syringes for injection or the administration of medications by any injectable route.
(c) Administration of medications by way of a tube inserted in a [illegible] of the body.
(d) Administration of [illegible] preparations.
(e) Irrigations or debriding agents used in the treatment of a skin condition.
(f) [illegible], or [illegible] preparations.
(g) Medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident.
(h) Medications for which the time of administration, the amount, the strength of

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A 052	Continued From page 2 dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in section 429.256, F.S. and this rule. (b) In addition to the specifications of section 429.256(3), F.S., assistance with self-administration of medication includes, in the presence of the resident, reading the medication label aloud and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the	A 052		

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A 052	Continued From page 3 resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in section 429.256(4), F.S. 1. As used in section 429.256(4)(g), F.S., the term "competent resident" means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication. 2. As used in section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (g) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication.	A 052		

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A 052	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on observation, record review, and resident and staff interview, the facility failed to ensure the Medication Technicians (Med Tech) properly assisted 11 (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #12, and #14) of 11 residents who required assistance with self-administration of medication. The facility failed to ensure residents requiring assistance were present when medications were removed from labeled containers and provide supervision when taking the medication by not having medications left in their room. This practice led to Resident #9 hoarding medications, threatening [redacted] by overdose from the medications, and requiring hospitalization. The findings included: 1. On [redacted] at 8:25 a.m., Med Tech Staff A was observed at the medication cart preparing 3 different oral medications for Resident #4, who required assistance with self-administration of medications. While in the corridor outside of the resident's presence, Staff A removed the pills from the labeled [redacted] card packaging and placed the pills into a clear plastic medication cup. Staff A locked her cart and proceeded to the resident's room. After taking his [redacted], Staff A handed the resident the cup containing his medications without telling the resident what was in the cup. 2. On [redacted] at 8:30 a.m., Med Tech Staff A was observed preparing medications for Resident #5. Staff A removed 5 medications from their packaging and placed them in a plastic cup while in the hallway. Staff A wrote the resident's room number and name on the plastic cup. Staff A	A 052		

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A 052	Continued From page 5 proceeded down the hallway to the resident's room and handed the cup to Resident #5. The resident asked if she could take the pills later as just got from breakfast, and Staff A said the pills were due to be taken right now. After agreeing to take them, she pointed to the oblong tablet and asked what that was for. Med Tech Staff A did not answer her or tell her what any of the pills were in the cup. In an interview on at 10:10 a.m., Resident #5 said some Med Techs want her to take the meds in front of them, some leave them and the meds may be sitting on her counter by the sink when she comes from breakfast. Said she was not sure what one of the pills was for and thus the reason she asked about it. 3. On at 8:48 a.m., Med Tech Staff A prepared medications for Resident #6. Staff A removed 3 pills from the packaging and mixed Natural into a cup of water. After preparing the medications in the hallway, Staff A proceeded to Resident #6's room. Staff A handed the cup to Resident #6 who said, "Now what do we have? How many?" The resident asked if she should take all at once. The Med Tech said, "yes" and did not tell the resident what the pills were in the cup. 4. On at 8:59 a.m., Med Tech Staff A prepared medications for Resident #7. The medication was removed from the labeled packaging and put in a med cup. Staff A prepared to remove one of the medications, , (for 's), from a container that appeared worn and was dated as having expired on . There were several pills in the bottle and the directions were that the resident was to take one 4 times a day. Staff A	A 052		

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A 052	Continued From page 6 confirmed there was no other , for the resident available in the medication cart other than the expired bottle. Staff A proceeded to resident's room with all meds in a cup with exception of , . Resident #7 noted one pill was missing and Staff A explained she had to get the medication from the pharmacy. 5. On at 9:30 a.m., Med Tech Staff A prepared medications for Resident #8. The medication was removed from the labeled packaging and put in a med cup. Staff A went to locate the resident and handed her the cup with pills. The resident asked if her pill was there and Staff A said, "yes" but did not identify what medications were in the cup. In an interview, on at 9:30 a.m., Resident #8 said she was not sure what medications she took, and staff may have left medication in her room before but really didn't remember. 6. In an interview on at 10:41 a.m., Resident #12 said staff assist her with medications. They bring them and put them in the bathroom for her. The resident said she was not sure if they came and check to see if she took them. The AHCA health 1823 health assessment dated , indicated Resident #12 needed assistance with self-administration of medications. 7. On at 10:29 a.m., during a tour of the second-floor unit, Resident #1 was observed lying in bed. There was a medication cup with 3 pills next to a cup of water on the resident's bedside table. The resident was non-verbal but nodded yes, the pills were for her and kept pointing to her . The resident was unable to be	A 052		

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A 052	Continued From page 7 interviewed further in regard to the pills at her bedside. The AHCA form 1823 health assessment form dated . . . . . , indicated Resident #1 was aphasic, but can respond yes or no. The assessment indicated the resident needs assistance with self-administration of medications. In an interview on . . . . . at 11:09 a.m., Med Tech Staff B said he had given morning medications to Resident #1. Staff B said he did not leave any medications in the room and met the resident at the door with 6 pills. Observation of Resident #1's room revealed the medication cup and water were no longer there. Staff B viewed the photographic evidence and confirmed one of the pills was . . . . . (for indigestion) which was to be given twice a day. Staff B said the pill may have been left from the previous shift. 8. In an interview on . . . . . at 10:40 a.m., Resident #2 said staff bring her medications but don't tell her what it is, just give it to her. She said the Doctor comes once in a while and tells her or a nurse will if asked. Resident #2 said if she is in the bathroom, staff will sometimes leave the pills sitting on the counter by the sink. They tell her the pills are there but don't come to make sure she took them. The AHCA form 1823 health assessment form dated , noted Resident #2 was "forgetful" and needed assistance with self-administration of medications. 9. In an interview on . . . . . at 10:52 a.m., Resident #3 said staff bring his medication. He said they will either leave it on the counter for him or be there when he takes them. The resident	A 052		

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A 052	Continued From page 8 said he was not sure if they come . . . and check if he took it. The resident's counter was noted to have several empty med cups stacked on top of each other. On the resident's windowsill was a large stack of empty med cups and a loose yellow pill next to the stack. The AHCA form 1823 health assessment dated . . . . was reviewed and noted Resident #3 has , and needed assistance with self-administration of medications. On . . . . at 11:15 a.m., Med Tech Staff B confirmed the pill on Resident #3's windowsill was a . . . . that he takes once a day in the morning. 10. In an interview on at 11:10 a.m., Resident #14 said staff bring her medications. She said they bring them in a cup, and she doesn't see the package. Staff don't really tell her but knows what she gets. The resident said, "My kids would rather I didn't give my own meds." The resident said staff will leave the cup on the table, and she takes them as soon as she can but does wait on the . . . . as it gives her an upset if she takes it with all the meds. The AHCA form 1823 health assessment dated , indicated Resident #14 needs assistance with self-administration of medications. 11. On . . . at 10:12 a.m., Resident #9's room was observed to have 3 empty med cups with . . . . written on one of them. Record review for Resident #9 revealed a diagnosis of , ; major , ... , and . . . . . . The AHCA form 1823 health assessment dated . . . , indicated Resident #9 was alert with mild . . . . at times, and needs assistance with	A 052		

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A 052	Continued From page 9 self-administration of medications. A progress note indicated on at 9:30 a.m., the resident was sent to the hospital emergency room for evaluation after making a statement she wants to "end it all." In an interview on at 12:17 p.m., the Wellness Director said she received a call from Resident #9's family member who relayed the resident said she wanted to end her life, she had meds, and she had a plan. The Wellness Director said when she went to Resident #9's room she observed 2 med cups with a total of 15 pills. The pills appeared to be a morning dose and evening dose in one cup and an evening dose in second cup. The resident said these were her meds and asked if that was enough pills to overdose with. The Wellness Director said she talked with the resident who acknowledged she needed to get some help. The resident agreed to go to the hospital where she was admitted. In an interview on at 11:35 a.m., reviewed with Administrator concern of facility did not properly supervise Resident #9 allowing her to hoard medications and formulate a plan to end her life with an overdose. This practice placed opportunity for a resident with known major and known history at risk leading to her subsequent hospitalization. 12. Reviewed with Wellness Director observations of Residents #4, #5, #6, #7, and #8 not even being present when pills were removed from packaging; not being told what medications were in the cups even when they ask; a cup with pills being observed at bedside of Resident #1; stacks of cups on a windowsill with loose pill next to them in room of Resident #3; and residents reporting meds being left in the room and taking	A 052		

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A 052	Continued From page 10 their medications unsupervised. The Wellness Director confirmed that was not assisting with self-administration and would be administering, which Med Techs are not allowed to do. She indicated that she does expect staff to stay with the resident until the medication is taken and not left unsupervised. Class II **Photographic evidence obtained**	A 052		
A 056	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with chapters 465 and 499, F.S., and rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be	A 056		

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A 056	Continued From page 11	A 056		

appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist.
(d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record.
(e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable.
(f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner.
(g) Pursuant to section 465.0276(5), F.S., and rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include

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A 056	Continued From page 12 the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure medications were properly labeled and not expired for 1 (Resident #7) of 5 residents observed being assisted with medications. The findings included: On at 8:59 a.m., Med Tech Staff A prepared medications for Resident #7. Medication was removed from the labeled packaging and put in a med cup. One of the medications, , (for 's), was in a container that appeared worn and was dated as having been filled on for 360 tablets. The directions were to take 1 tablet by 4 times a day (90-day supply). The label indicated discard after . There were several pills in the bottle and Staff A	A 056		

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A 056	Continued From page 13 confirmed there was no other , for the resident available in the medication cart. The Medication Record indicated the , was started on . In an interview on at 9:20 a.m., the Wellness Director said the resident had been here for several months and confirmed the bottle indicated the , had been filled a year ago for a 90-day supply and was expired. The Wellness Director said she would contact the pharmacy. Class III **Photographic evidence obtained**	A 056		
A 165	429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in:	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910533	A. BUILDING: _____ B. WING _____	12/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 165	Continued From page 14 1. [illegible]; 2. [illegible] or [illegible] damage; 3. Permanent [illegible]; 4. [illegible] or [illegible] of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) [illegible], neglect, or [illegible] must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be	A 165		

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A 165	Continued From page 15 reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. 59A-36.016 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1),	A 165		

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A 165	Continued From page 16 above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to complete and submit the preliminary report (1-day report) to Agency for Healthcare Administration (AHCA) regarding a resident's plan to overdose on hoarded medication for 1 (Resident #9) of 15 sampled residents. The findings included: On at 10:12 a.m., Resident #9's room was observed to have 3 empty med cups with written on one of them. Record review for Resident #9 revealed a diagnosis of ; major , and . The AHCA form 1823 dated , indicated Resident #9 was alert with mild at times, and needs assistance with self-administration of medications. A progress note indicated on at 9:30 a.m., the resident was sent to the hospital emergency room for evaluation after making a statement she wants to "end it all". In an interview on at 12:17 p.m., the Wellness Director said she received a call from Resident #9's family member who relayed the resident said she wanted to end her life, she had meds, and she had a plan. The Wellness Director said when she went to Resident #9's room she observed 2 med cups with a total of 15 pills. The pills appeared to be a morning dose	A 165		

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A 165	Continued From page 17 and evening dose in one cup and an evening dose in second cup. The resident said these were her med's and asked if that was enough pills to overdose with. The Wellness Director said she talked with the resident who acknowledged she needed to get some help. The resident agreed to go to the hospital where she was admitted. The facility's adverse incident reports were reviewed on . There was no report for the incident on involving Resident #9. In an interview on at 11:35 a.m., reviewed with Administrator concern of facility did not properly supervise Resident #9 allowing her to hoard medications and formulate a plan to end her life with an overdose. This practice placed opportunity for a resident with known major , and known , history at risk leading to her subsequent hospitalization. The Administrator acknowledged the concern and confirmed no adverse incident report had been filed. Class III **Photographic evidence obtained**	A 165		