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
	AL11964789	A. BUILDING: _____ B. WING _____	01/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE BONITA SPRINGS	26850 SOUTH BAY DRIVE BONITA SPRINGS, FL 34134

(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 CCR# 2018017173 was conducted through at Brookdale Bonita Springs, an assisted living facility (license #9322) in Bonita Springs, Florida. The complaint contained 1 allegation which was substantiated with deficiencies. The following is description of the deficiencies.	A 000		
A 056	58A-5.0185(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 appropriate for the resident to request the	A 056		

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A 056	Continued From page 1	A 056		

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 the practitioner's name, the resident's name for

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A 056	Continued From page 2 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 record review and interview, the facility failed to ensure medication, which the facility is providing assistance with self-administration or administering of, is accompanied by a written order for that specific resident and signed by the resident's health care provider for 1 (Resident #1) of 4 residents reviewed or observed for medications. The findings included: Review of the facility incident log revealed an incident on . . . involving Resident #1. The facts on the incident log revealed: Resident #1 was given another resident's morning medications in error. Reported immediately to Staff Registered Nurse, all parties were notified and resident was sent to the hospital for evaluation.	A 056		

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A 056	Continued From page 3 Review of medical records obtained from the hospital revealed Resident #1 was hospitalized . . . . . Records indicated Resident #1 was admitted through the emergency room after accidentally being given the wrong medications. Resident #1 was admitted to the telemetry floor. Telemetry showed no , , and , remained stable. She was monitored over 48 hours and remained , , and was discharged . . . to the assisted living facility. Resident #1 also had evidence of acute , injury, which resolved. On at 10:57 a.m., The Executive Director (ED) said incorrect medications were given by an agency nurse, Staff A Licensed Practical Nurse (LPN). The ED said they stopped using Staff A (LPN) and shortly thereafter stopped using agency nurses all together. The ED said they sent Resident #1 to the hospital because she was given another resident's medications. On at 11:07 a.m., the Health and Wellness Director (HWD) said following the incident with Resident #1 they got rid of agency nurses as soon as possible. The HWD said they had an informal discussion during a staff meeting regarding 5 rights of medication administration, however was unable to produce any documentation supporting staff members had received any corrective or informative training to prevent further errors of this type. The HWD reiterated it was an agency nurse that made the error. Class III	A 056		

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A 165	Continued From page 4	A 165		
A 165	429.23(&) FS; 58A-5.0241 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: 1. ; 2. or , damage; 3. Permanent ; 4. or 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	A 165		

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A 165	Continued From page 5 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 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	A 165		

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A 165	Continued From page 6 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 Department of Elderly Affairs may adopt rules necessary to administer this section. 58A-5.0241 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) 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 record review and interview, the facility failed to provide within 15 days a full report to the Agency for Health Care Administration (agency) regarding an adverse incident including the results of the facility's investigation into the adverse incident. The findings included: Review of the facility incident log revealed an incident on involving Resident #1. The facts on the incident log revealed: Resident #1 was given another resident's morning	A 165		

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A 165	Continued From page 7 medications in error. The incident was reported immediately to staff registered nurse, all parties were notified and the resident was sent to the hospital for evaluation. On at 11 a.m., the Executive Director (ED) provided a copy of the Adverse Incident Form v1.0 that was submitted to the agency on . . . . . The report showed further information had been requested by the Agency on . The facility submitted further information to the agency on . The Adverse Incident Reporting System showed requests were made by the Agency for further information and clarification on . . . . . and . . . . . The facility had no documentation they had responded to these requests. On . . . . at 10:05 a.m., the ED said she did the one day report but did nothing further because when she went in to do it the Agency had closed it and she could not add anything further to it. There was no further follow up attempted. Class III	A 165		