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 _____	R 02/27/2020

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 revisit survey was conducted on [redacted] at Brookdale Phillippi Creek, an assisted living facility in Sarasota, Florida. This was a follow-up to complaint survey #2019019518 completed on [redacted]. The following is description of the deficiency found at the time of the visit.	{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	{A 052}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{A 052}	Continued From page 1 prescribed premeasured dose of medication into the dispensing cup of the . (h) Using a to perform - level checks. (i) Assisting with putting on and taking off stockings. (j) Assisting with applying and removing an but not with titrating the prescribed 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 bags. (4) Assistance with self-administration does not include: (a) Mixing, converting, or 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 of the body. (d) Administration of preparations. (e) Irrigations or debriding agents used in the treatment of a skin condition. (f) , , or 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	{A 052}		

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{A 052}	Continued From page 2 administration, the amount, the strength of 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	{A 052}		

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{A 052}	Continued From page 3 health care provider and documented in the 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	{A 052}		

This Statute or Rule is not met as evidenced by:
Based on observation, record review, and staff interview, the facility failed to ensure the medication technicians (Med Tech) properly assisted 3 (Resident #3, #11, and #18) of 3 observed residents who required assistance with self-administration of medication. The Med Tech failed to open the container and read the label in the presence of the residents. The facility also failed to assist 1 (Resident #5) of 4 residents reviewed with self-administration of a practitioner's ordered medication.

The findings included:

1. On at 8:10 a.m., Resident #3 was observed preparing 6 different oral medications for Resident #3 who requires assistance with self administration of medications. She entered the day room where the resident was and placed multiple labeled . . . card packaging on the table in the day room. Med Tech Staff A popped 6 different pills into her . . . and then transferred them in a medication cup. Staff A handed the cup of medications to the resident with a cup of water and said "Take your pills." Staff A did not read the medication labels to the resident nor did she tell Resident #3 what was in the cup.

Review of the clinical record revealed the active orders for Resident #3 specified: "Needs assistance with self-administration of medications".

2. On ..... at 8:15 a.m., Med Tech A was observed preparing 7 different oral medications for Resident #11 who requires assistance with self administration of medications. Staff A entered

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{A 052}	Continued From page 5	{A 052}		

the day room where the resident was and placed multiple cards packaging on the table in the day room. She popped all the pills in a medication cup and handed it to Resident #11. She said "This is your medications, take your pills". Med Tech Staff A did not read the medication labels to the resident and she did not tell Resident #11 what was in the cup.

Review of the clinical record revealed a resident health assessment for assisted living facilities dated specifying Resident #11 needs assistance with self-administration of medications.

3. On at 8:25 a.m., Med Tech Staff A returned to the day room carrying a plastic tray with multiple card packages of medication for Resident #18. She placed the cards on a table across the room from where the resident was sitting. She popped 5 different pills into a medication cup and walked toward the resident. She handed the cup of pills to Resident #18 with a glass of water. The resident took all the pills. Staff A did not speak to the resident. She did not read the label or identify the different medications in the cup.
Review of the clinical record revealed a Resident Health Assessment for Assisted Living Facilities dated specifying Resident #18 needed assistance with self administration of medications.

4. On at 8:30 a.m., during an interview with Med Tech Staff A, she verified she placed Resident #3's medications in her before placing them in the medication cup. She acknowledged it was an control issue. She verified she administered medications to Resident #3, #11 and #18 instead of assisting

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{A 052}	Continued From page 6 them to self-administer their medications. Med Tech Staff A said when she worked on the memory care unit she always administered medications to the residents because "they suffer from . . . . . and would not understand what she is saying". 5. On at 11:30 a.m., observation of the memory care unit medication cart revealed an unopened bottle of 0.5% , , with a fill date of . . . . . pertaining to Resident #5. is a medication used for , to reduce pressure inside the , . . LPN Staff G said as far as she knew Resident #5 did not receive the . . . Review of the clinical record revealed Resident #5 was admitted to the facility on with diagnoses including unspecified , ... The resident health assessment for assisted living facilities dated . . . included a physician order for 0.5% , solution, 1 drop in affected 2 times a day. The clinical record lacked documentation the facility assisted Resident #5 with the . . . . . since his admission date of . There was no documentation at the time of the survey the medication was discontinued. On at 4:55 p.m., during an interview, the health and wellness director said at the time Resident #5 was admitted they had absorbed residents from another facility and Resident #5 was one of them. She said off-site nurses were helping entering orders for the new residents and it was an oversight. She said they didn't catch it. The health and wellness director said she just sent a facsimile to the physician informing him the resident has not receive the ordered . . since his admission at the facility. Class III	{A 052}		

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