STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963982	R
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
BROOKDALE COLONIAL PARK	4730 BEE RIDGE ROAD SARASOTA, FL 34233	

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

0000 - Initial Comments

An unannounced follow-up survey was conducted on [redacted] at Brookdale Colonial Park, an Assisted Living Facility (ALF) in Sarasota, Florida. This was a follow-up to the Biennial with Limited Nursing Services (LNS) survey completed on [redacted].

The following is description of the deficiency, found at the time of the visit.

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

Based on record review and interview, the facility failed to ensure prescriptions were filled timely for 1 (Resident #16) out of 4 residents sampled.

The findings included:

Review on [redacted] of Resident #1's record revealed the diagnosis included [redacted] and hallucinations.

A record review on [redacted] of Resident #1's medical record revealed a physician order dated [redacted] for 5 milligram (mg) 1 tab by mouth once daily for [redacted] 40 mg by mouth once daily for 3 days, then decrease [redacted] to 20 mg by mouth once daily for [redacted] 20 mili equivalents (mEq) by mouth once daily for electrolyte replenishment from [redacted].

A review on [redacted] of the physician order dated [redacted] for Resident #1 revealed it was stamped faxed on [redacted] to a named Pharmacy. Resident #1 is using a different Pharmacy as evidenced by a service authorization form dated [redacted].

Review on [redacted] of the Medication Observation Record (MOR) for Resident #1 revealed that it documents on the back [redacted] 5 mg, [redacted] 40 mg, and [redacted] 20 mEq were not given because the medications were "on order."

Class III

State Form: Revisit Report

(Y1) **Provider / Supplier / CLIA / Identification Number**
AL11963982

(Y2) **Multiple Construction**
A. Building
B. Wing

(Y3) **Date of Revisit**
6/16/2015

Name of Facility
BROOKDALE COLONIAL PARK

Street Address, City, State, Zip Code
4730 BEE RIDGE ROAD
SARASOTA, FL 34233

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **A0025** Reg. # **429.26(7) FS: 58A-5.0182(1** LSC		ID Prefix **A0078** Reg. # **58A-5.019(2) FAC** LSC		ID Prefix **A0081** Reg. # **58A-5.0191(2) FAC** LSC	
ID Prefix **A0084** Reg. # **58A-5.0191(5) FAC** LSC		ID Prefix **A0087** Reg. # **58A-5.0194 FAC** LSC		ID Prefix **A0091** Reg. # **58A-5.0191(12) FAC** LSC	
ID Prefix **A0152** Reg. # **58A-5.023(3) FAC** LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** Gutley, HFES	**Date:** 6-18-15	**Signature of Surveyor:** Laura Olive, RNS	**Date:** 6-18-15
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Brookdale Colonial Park
4730 Bee Ridge Road
Sarasota, FL 34233

Dear Administrator:

This letter reports the findings of a State Licensure Revisit Survey conducted on . . . . . 16, 2015 by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit and the uncorrected deficiency that was identified on the day of the visit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than . . 2015.**

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form and Revisit Report

YOSF

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Fort Myers, FL 33901
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