STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910533	07/27/2015
NAME OF PROVIDER OR SUPPLIER **BROOKDALE PHILLIPPI CREEK**	STREET ADDRESS, CITY, STATE, ZIP CODE **5501 SWIFT ROAD** **SARASOTA, FL 34231**	

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

0000 Initial Comments

An unannounced Complaint Survey for CCR# 2015004364 was conducted at Brookdale Phillippi Creek, an Assisted Living Facility (ALF) in Sarasota, Florida.

The complaint contained 4 allegation(s), of which 3 were substantiated. The following is description of the deficiencies found at the time of the visit:

0025 Resident Care - Supervision

Based on resident record review, facility record review and staff interview, the facility failed to offer personal supervision as appropriate for each resident. This included the daily observation of the activities of the resident while on the premises and maintaining a general awareness of the resident's whereabouts for Resident #4. Review of the resident record revealed Resident #4 left the facility without staff knowledge and was found down the street by staff.

The findings included:
Clinical record review revealed Resident #4 was admitted to the facility on . Review of resident log notes documented, "4/2 ( ) Late Last night (- - at 9:15) (resident aide) noticed resident asleep on couch in lobby and tried to assist resident back to . He refused stating he was going home and started walking towards the front door. This nurse locked the front door and redirected resident to elevator. After 10 minutes he finally agreed to go upstairs."
Review of resident log notes dated 1:10 p.m., documented " (staff members name) reports she couldn't find res. (resident) for lunch. A search was conducted. Resident was not in building. A search was conducted of the surrounding properties and he was found at (name of a nearby Assisted Living Facility). Resident returned to facility. Health Wellness Director, Executive Director, Power of Attorney, Medical Doctor all aware."
Interview on at 12:33 p.m., with the current Health Wellness Director said he was not the director at the time of the incident. The previous Health Wellness Director and Executive Director (ED) are no longer with the facility. The previous Health Wellness Director was at a meeting. Staff A came and reported that the resident was not in his . At that time the sign out book was checked and Resident #4 did not sign out. A was then conducted and Resident #4 was not found inside the building, so the parameters of the property were searched, as well as the nursing facility next to the property. The resident was not located so the search was expanded. The Health Wellness Director noticed Resident #4 down the street at another Assisted Living Facility parking lot. The resident was escorted back to the facility by the Health Wellness Director. Resident #4 told us he was "looking for his female friend."
Interview on at 2:10 p.m., with the ED said the resident was new. The front desk was being

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manned by the Memory Care Director at the time of the incident. Resident #4 was asking about his female friend. Staff thought he was talking about the skilled nursing facility next door and sent him over there. Staff was not aware he was a resident at the facility. The staff member is no longer working at the facility.
Interview on at 2:00 p.m. with Staff A, who said the facility has a resident list that is used for all meals. If the resident is not in the dining meals, then staff are instructed to go to their see if they are going to eat or not. Resident #4 was not in his , so the facility was searched to see if the resident was able to be located. The resident was not able to be located so the parameter of the facility was searched. The Memory Care Director was filling in for the front desk person, or walking by the front desk was not aware that Resident #4 was a resident at the facility. Resident #4 gave a name of a female. Staff said she was not at the facility and to try next door. When resident's leave the facility they are supposed to sign out if they are leaving the building.
Class III

0056 Medication - Labeling and Orders

Based on record review, and staff interview, the facility failed to have prescribed medications filled in a time manner for 1 (Resident #3) of 3 residents reviewed for medication administration.

The findings included:

Clinical record review revealed Resident #3 had physician orders dated for " take 30 ml (milliliters) by mouth three times daily as needed for ." Physician orders dated for " , 1 mg (milligram) take one tablet by mouth every day as needed for ." Physician orders dated / for " 10 mg take one tablet by mouth every night at bed time for ."

Medication reconciliation on at 12:00 p.m., revealed Resident #3 does not have her 1 mg or medications available.

Review of 2015 MAR revealed Resident #3 did not receive her 10 mg on , / , and , because the medication was not available.

Review of the reconciliation log for Resident #3's , revealed the last dose was given on and the amount left was 0.

Interview on at 12:21 p.m., with the Health Wellness Director (HWD) verified the and are not available. The HWD said staff is instructed to reorder the resident's medications. The medications are usually delivered within 24 hours. The facility uses 2 main

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pharmacies; however, if they are not able to fill the medication or unavailable, the pharmacy has an agreement with a local pharmacy.

Class III

0165 Risk Mgmt & QA: Adverse Incident Report

Based on resident record review, facility record review and staff interview, the facility failed to report a 1 Day and 15 Day Adverse incident to the State Agency for 1 (Resident #4) of 1 residents reviewed for elopement. The definition of an "adverse incident" means (a) an event over which facility personnel could exercise control rather than as a result of the resident's condition .... or (b) resident elopement, if the elopement places the resident at risk of harm or injury.

The findings included:

1. Review of Missing Resident Policy- SE-11 dated 4/1/7 and revised /. and states, "11. Within 24 hours of the missing resident/elopement, The Executive Director or designee will notify the appropriate State Agency."

2. Record review revealed Resident #4 was admitted to the facility on /. Review of resident log notes dated. "4/2 ( ) Late Last night (- - at 9:15) (resident aide) noticed resident asleep on couch in lobby and tried to assist resident back to . He refused stating he was going home and started walking towards the front door. This nurse locked the front door and redirected resident to elevator. After 10 minutes he finally agreed to go upstairs."
Review of resident log notes dated /. 1:10 p.m., " .(staff members name) reports she couldn't find res. (resident) for lunch. A search was conducted. Resident was not in building. A search was conducted of the surrounding properties and he was found at (name of a nearby Assisted Living Facility). Resident returned to facility. Health Wellness Director, Executive Director, Power of Attorney, Medical Doctor all aware."

3. Interview on / at 12:33 p.m., with the current Health Wellness Director said he was not the director at the time of the incident. The previous Health Wellness Director was at a meeting. Staff A came and reported the resident was not in his . At that time the sign out book was checked and Resident #4 did not sign out. A was then conducted and Resident #4 was not found inside the building, so the parameters of the property were searched, as well as the nursing facility next to the property. The resident was not located so the search was expanded. The Health Wellness Director noticed Resident #4 down the street at another ALF parking lot. The resident was escorted back to the facility by the Health Wellness Director. Resident #4 told us he was looking for his female

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friend.

4. Interview on at 2:10 p.m., with the Executive Director said the resident was new. The front desk was being manned by the Memory Care Director, at the time of the incident. Resident #4 was asking about his female friend. Staff thought he was talking about the skilled nursing facility next door and sent him over there. Staff was not aware he was a resident at the facility. This staff member is no longer working at the facility.

5. Interview on at 2:00 p.m., with Staff A, said the facility has a resident list that is used for all meals. If the resident is not in the dining meals, then staff are instructed to go to their see if they are going to eat or not. Resident #4 was not in his the facility was searched to see if the resident was able to be located. The resident was not able to be located, so the parameter of the facility was searched. The Memory Care Director was filling in for the front desk person, or walking by the front desk and was not aware that Resident #4 was a resident at the facility. Resident #4 gave a name of a female. Staff said she was not at the facility and to try next door. When resident's leave the facility they are supposed to sign out if they are leaving the building.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Brookdale Phillippi Creek
5501 Swift Road
Sarasota, FL 34231

RE: CCR #2015004364

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach your corrective action and any additional documentation to support correction of identified deficiencies and send to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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(s). 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

XG90

Fort Myers Field Office
2295 Victoria Avenue,
Fort Myers, FL 33901
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