STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964980	11/04/2015
NAME OF PROVIDER OR SUPPLIER **BROOKDALE ORANGE PARK**	STREET ADDRESS, CITY, STATE, ZIP CODE **1248 KINGSLEY AVENUE** **ORANGE PARK, FL 32073**	

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

0000 Initial Comments

A complaint investigation (CCR 2015008815) was conducted at Brookdale of Orange Park on / . Brookdale of Orange Park Assisted Living Facility had deficiencies at the time of the investigation.

0008 Admissions - Health Assessment

Based on record review and interview with the Executive Director (ED), the facility failed to ensure a completed Health Assessment for 1 of 3 sampled residents. (Resident #3)

The findings include:

Review of Resident #3 1823 Health Assessment on / revealed the physician signed the assessment on / , however his name, License Number, Address and phone number of examiner was not included. Additionally, Page 5 of the health assessment was blank, no signature for administrator or designee.

On at 1:52 pm an interview with the ED as she reviewed the 1823 Assessment for Resident #3. She confirmed it was not fully completed by the physician or signed by the Administrator/designee and stated it needed to be signed.

Class III

0052 Medication - Assistance with Self-Admin

Based on observation, interview, record review and facility policy, the facility failed to ensure medications were pulled at the time they were to be assisted with self administration with medication by unlicensed staff for 1 of 2 sampled residents (Resident #3) and failed to provide an explanation of medication for 1 of 2 sampled residents. (Resident #2) In addition the facility failed to ensure that physician orders were followed for 1 of 2 sampled residents (Resident #3).

The findings include:

1. On at 9:15 am an observation of Assistance with Medication Administration with Employee A for Resident #3. The Medication observation Record (MOR) was open on the medication cart. It revealed all of the medication for Resident #3 was signed as given for / . A closer look at the MOR revealed all of the MORs in the medication book were pre-signed. Employee A said she's just

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started and hasn't given medications to anyone, except the 6:00 am medications. She said she was saving time by signing them all first. She confirmed she was not supposed to sign all of the MORs first before giving the medication. During med observation, Employee A removed 2 , with the drawer of the medication cart opened. She was bent over the drawer as if she was pouring the pills. She placed the 2 on the med cart afterward, and it appeared as if she was signing out the from the book, which was laid out open over the drawer of the med cart, not on the med cart. Review of the books with the cards revealed the count was accurate. When she completed the medications and placed the cards back in the med cart, she was asked to confirm how many pills she had in the soufflé cup. Employee A counted 4 pills. She was asked where the other pills were. Employee A asked "what pills?" She was asked to pull the medication cards out again and named each medication that this surveyor had recorded. She was able to identify which pills were missing by the color and shape and from the medication cards. It confirmed the and the for Resident #3 were not in the medication cup. She was asked where those 2 pills were. She stated she did not know. She said she heard them drop into the cup but maybe they popped back out. An observation of the carpeted floor revealed the pills were not on the floor. An observation of the box after removing all of the from the cart, revealed the 2 pills were not there. She was asked again her where the pills were, and she said she did not know. Employee A stated "how can I produce the medication from thin air?" The medication observation was stopped and Employee A was asked to bring the medication cart to the ED office. At 10:00 am the ED was apprised of the findings with the MOR's pre-signed and the the 2 missing medications. The ED stated the med techs are not supposed to pre-sign the MORs. She asked Employee A where the missing medications were. Employee A said, "Okay, I'm going to come clean, I pre-poured her medication". She opened the bottom drawer of the med cart and pulled the pre poured medications. There were 11 (30 cc) medication cups that were labeled with different resident names with medications in each of them. She said she pre-poured all of the medication when she came in this morning. She said she came in at 6:00 am. She said she would not have time to pass the meds timely and work in the dining I do patient care. She said, " We have to pre pour medications. The ED confirmed all pre-poured meds found in the cart and stated that it is against the facility policy. She said that Employee A has been passing meds for years at the facility. She said she would call her corporate clinical nurse to be advised on what to do. Employee A then confirmed she did not give all of the 6:00 am medications. There was an extra pill in Resident #3 pre-poured medications that were not congruent with the medications observed or the MOR. Employee A said that the extra pill was her 6:00 am medication and she had not given it yet. ED stated they will call all of the physicians and the families to notify them of this occurrence. (Photographic evidence)

2. On Assistance with Medication Observation on / with Employee B, Med Tech at 8:35 am revealed she poured the medication for Resident #2. Employee B then gave Resident #2 her medication. She failed to explain what she was giving to Resident #2.

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On at 4:35 pm an interview with the Executive Director. She stated the medication technicians should tell the residents what the medication are for as they are giving medication.

Review of the facility policy entitled Medication and treatment-Administration/Assistance dated revealed, Medications may not be prepared in advance and must be administered within 1 hour of their prescribed time. It also stated the individual assisting with the medication must initial the resident ' s medication record on the appropriate line after medication assistance. It further record for Controlled Substances, count the number of tablet/capsules before preparing for distribution, compare actual number available on the next blank row on the count sheet, both numbers should be the same, if the two amounts are not the same, notify the nurse, ED or designee immediately.

3)Record review on of Resident #3 revealed the physician prescription for 0.5 mg give one by mouth daily was written on . Review of the 2015 MOR for Resident #3 revealed the 0.5 mg was not signed as given the month of since it was ordered on . The physician order on was to discontinue and . Review of Resident #3 MOR dated 2015 and 2015 revealed ( ) and ( ) continued to be signed as given through .

Class III

0054 Medication - Records

Based on observation, interview, record review and facility policy the facility failed to ensure the Medication Observation Record (MOR) was not pre-signed prior to Assistance with Self- Administration (21 of 21 resident MOR ' s), failed to ensure an accurate count of medication, and failed to prevent a medication error for 2 of 2 sampled residents. (Resident #2, #3)

The findings include:

1. On / at 9:15 am an observation of Assistance with Medication Administration with Employee A for Resident #3. The Medication observation Record (MOR) was open on the medication cart. It revealed all of the medication for Resident #3 was signed as given for / . A closer look at the MOR revealed all of the MORs in the medication book were pre-signed. Employee A said she's just started and hasn't given medications to anyone, except the 6:00 am medications. She said she was saving time by signing them all first. She confirmed she was not supposed to sign all of the MORs first before giving the medication. During med observation, Employee A removed 2 , with the drawer of the medication cart opened. She was bent over the drawer as if she was pouring the pills. She placed the 2 on the med cart afterward, and it appeared as if she was signing out the from

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the book, which was laid out open over the drawer of the med cart, not on the med cart. Review of the books with the cards revealed the count was accurate. When she completed the medications and placed the cards back in the med cart, she was asked to confirm how many pills she had in the soufflé cup. Employee A counted 4 pills. She was asked where the other pills were. Employee A asked "what pills?" She was asked to pull the medication cards out again and named each medication that this surveyor had recorded. She was able to identify which pills were missing by the color and shape and from the medication cards. It confirmed the and the for Resident #3 were not in the medication cup. She was asked where those 2 pills were. She stated she did not know. She said she heard them drop into the cup but maybe they popped back out. An observation of the carpeted floor revealed the pills were not on the floor. An observation of the box after removing all of the from the cart, revealed the 2 pills were not there. She was asked again her where the pills were, and she said she did not know. Employee A stated "how can I produce the medication from thin air?" The medication observation was stopped and Employee A was asked to bring the medication cart to the ED office. At 10:00 am the ED was apprised of the findings with the MOR's pre-signed and the the 2 missing medications. The ED stated the med techs are not supposed to pre-sign the MORs. She asked Employee A where the missing medications were. Employee A said, "Okay, I'm going to come clean, I pre-poured her medication". She opened the bottom drawer of the med cart and pulled the pre poured medications. There were 11 (30 cc) medication cups that were labeled with different resident names with medications in each of them. She said she pre-poured all of the medication when she came in this morning. She said she came in at 6:00 am. She said she would not have time to pass the meds timely and work in the dining do patient care. She said, " We have to pre pour medications. The ED confirmed all pre-poured meds found in the cart and stated that it is against the facility policy. She said that Employee A has been passing meds for years at the facility. She said she would call her corporate clinical nurse to be advised on what to do. Employee A then confirmed she did not give all of the 6:00 am medications. There was an extra pill in Resident #3 pre-poured medications that were not congruent with the medications observed or the MOR. Employee A said that the extra pill was her 6:00 am medication and she had not given it yet. ED stated they will call all of the physicians and the families to notify them of this occurrence. (Photographic evidence)

2. An observation on 1/ with Employee B, Med Tech at 8:35 am revealed she drew up 10 medications for Resident #2 and confirmed 10 medications in the medication soufflé cup. Employee B was asked to read the label of the ( ) Extra Strength (ES). The label on the medication card read, ( ) 500 milligrams (mg), give 2 by mouth three times a day as needed. She confirmed she pulled only 1, not 2 tablets as the label instructed. The label on the ES did not match the MOR. The MOR was for 500 mg, give 2 tablets twice a day by mouth. Additionally, Employee B signed out a 50 mg every 6 hours as needed for pain from the count sheet. The count did not match the remaining pills left on the medication card. The card label did not match the MOR. The MOR read 50 mg, give 1 tablet by

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mouth twice a day. It appeared 1 or 2 of the was unaccounted for. Employee B stated she did not sign the Controlled count between shifts this morning, but said she should have. She stated, "The other med tech was in a hurry and I forgot to sign it".

An interview with Employee D, LPN at 10:45 am stated the order for the changed recently, , 2015. She said she wrote the order change on a few of the cards, but not all of them.

Review of the facility policy entitled Medications and Treatment-Medication Error dated / stated, " All associates providing assisting medication to resident ' s are expected to follow the 7 Rights of Medication Administration, including the right dose " .

Class III

0056 Medication - Labeling and Orders

Based on observation, interview, record review and facility policy, the facility failed to ensure the medication labels matched the Medication Observation Record for 1 of 2 sampled residents (Resident #2).

The findings include:

1. On / at 8:35 am an observation of Employee B, Med Tech during Assistance with Self Administration of Medication as she was retrieving the medication. Employee B was asked to read the label of the ( ) Extra Strength (ES). The label on the medication card read, ( ) 500 milligrams (mg), give 2 by mouth three times a day as needed. The MOR recorded 500 mg, give 2 tablets twice a day by mouth. The card label did not match the MOR. The MOR read 50 mg, give 1 tablet by mouth twice a day. The label recorded , take 1 tablet by mouth every 6 hours as needed for pain. There was no indication on the card the medication had changed.

An interview with Emplovee D, LPN at 10:45 am on / stated the order for Resident #2's changed recently, , 2015. She said she wrote the order change on a few of the cards, but not all of them. She said Resident #2 had 6 cards of , she stated, "I should have written on all 6 cards". She confirmed the MOR and the medication label for the did not match. She also read the label and MOR for the and confirmed they did not match either.

Review of the facility policy entitled Medications and Treatments- Labeling dated , stated, "All medications should be labeled with the necessary information to provide safe medication

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management/assistance " .

Class III

0084 Trainina - Assis Self-Admin Meds & Med Mamt

Based on employee record review and an interview with the Executive Director (ED), the facility failed to ensure 1 of 2 sampled medication technicians had an up to date certificate for completion of Assistance with Self-Administration of Medication. (Employee A)

The findings include:

Employee record review revealed Employee A's Assistance with Self- Administration of Medication certificate was dated . There was no update since then in her employee record.

On / at 1:52 pm an interview with the ED stated we complete the Assistance with Self Administration Annually. She said Employee A was out sick for 2 months. The ED said she looked in Employee A's file and realized she missed the annual training update. She said she took her off the medication cart today and had a nurse come in. She said she will remain off the medication cart until she gets the training update.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Brookdale Orange Park
1248 Kingsley Avenue
Orange Park, FL 32073

RE: CCR #2015008815

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on , 2015 by a representative 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 a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents 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. Should you have any questions please call this office at -4201.

Sincerely,

Jana Meyering, CIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

MB/JM/sm
Enclosure
XG90

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