STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964912	03/30/2017
NAME OF PROVIDER OR SUPPLIER **BROOKDALE SOUTHPOINT**	STREET ADDRESS, CITY, STATE, ZIP CODE **6895 BELFORT OAKS PLACE** **JACKSONVILLE, FL 32216**	

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

0000 Initial Comments

An unannounced compliant investigation, CCR #2017000136, was conductaed at Brookdale Soutpoint ALF (Lic #9380) on . Deficient practice was found during the visit.

0052 Medication - Assistance with Self-Admin

Based on interview, record review, and observation, the facility failed to provide medications timely and with proper education for 1 of 3 residents (Resident #2) , or to prepare medication for self administration within eyesight of the residents, for 2 of 3 residents (Residents # 5 and 8) who were receiving assistance with medications.

The findings include:

At 8:30 AM on , Employee A, a Med Tech, was observed preparing medications for Resident #5. Employee A was standing at the medication cart, on the hallway where Resident #5 was located. Resident#5's door was shut. Employee A proceeded to unlock her cart, pop the medications into a dosage cup, and closed and locked her cart. She then entered Resident #5's handed her the medications to take, as well as an inhaler, and the resident took the medications and used the inhaler as prompted by Employee A.

At 7:19 AM on , Employee B, an LPN, was observed preparing for Resident # 2 to get her medications. The medications were scheduled for 9 AM, and the packs all had "9 AM" written on them. Employee B entered the the medication packs, and proceeded to pop the medications into the dosage cups while standing at the bedside for Resident #2. At no time did she explain to Resident # 2 what she was taking.

At 8:15 AM, Employee C, a med Tech, was observed at her medication cart preparing Resident #8's medications. Resident #8's door was shut at the time that Employee C pulled the medications from the cart and popped the pills into the dosage cup. After the medications were all distributed into the dosage container, Employee C opened Resident # 8's door and proceeded to hand her the cup with medication in it.

Resident #2 stated in an interview at 11:22 AM on that she was unaware of what medications she was given earlier in the morning when Employee B was assisting her with medications.

The facility's Policy and Procedure, titled "Medication and Treatment- General Guidelines for Medication Administration/ Assistance" includes a mandate that "Medications and treatments shall be administered

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one (1) hour before or one (1) hour after the prescribed frequency and time unless ordered by the physician/ healthcare provider or according to state regulation".

It continues on to instruct staff to "educate and communicate the purpose of the medication and /or treatments and therapies administered".

The Health and Wellness Director provided a follow up interview at 12:10 PM on . She stated the expectation of staff assisting with self-administration was that they would inform the Residents of the medications, and to dose the medications in the presence of the Resident. She also acknowledged that according to Policy and procedure, medications are to be given with the 1 hour time frames listed.

Class III