STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964980	06/18/2018
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

On , 2018 a biennial Assisted Living Facility relicensure survey with Limited Nursing Services was conducted at Brookdale Orange Park (License #9423). Deficient practice was identified during the survey.

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, interview, and record review, the facility failed to provide a licensed nurse to administer medications to 1 resident (Resident #10) out of 3 residents observed during assistance with self-administration of medication.

The findings include:

On at 1:10 pm, Employee A, an unlicensed Medication Technician (MT), was observed as she prepared a (applied on the skin) medication for Resident #10. The instructions on the medication label read: ABH (- -) gel, apply 1 ml (milliliter) three times a day for agitation. The MT checked the order in the Medication Observation Record (MOR), and prepared 1 ml of the ABH cream by squeezing 1 ml out of a 10 ml, multi-dose syringe into a plastic medication cup. She requested that the resident sit on a chair in preparation for the medication, but the resident was unable to follow her direction. Resident #10 about the medication, but she responded with incoherant speech. The MT donned gloves and proceeded to apply the medication to the resident's lower back. She did not inform the resident that she would be applying the medication or what the medication was. At 1:15 pm, the surveyor asked the MT if Resident #10 could assist in any way with administration of the ABH gel, and she confirmed that the resident was completely unable to self-administer or assist with self-administration of her own medication.

A review of the chart for Resident #10 revealed an admission date of . A review of page 1 of the AHCA-1823 form (used to document the health assessment completed by health care providers) dated , indicated that she was admitted with a diagnosis of severe (type). Page 4 of the 1823 form was incomplete, and did not indicate the provider's assessment of the level of assistance needed for Resident #10's medication administration. A review of the resident's current medication orders confirmed that on she was ordered ABH cream, with instructions to apply to the lower back and wrist , three times a day for agitation.

An interview was conducted with the Health and Wellness Director (Director of Nursing) on at

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3:05 pm. At this time she confirmed that her expectation was that one of the facility's nurses would administer an ABH cream to a resident that was unable to self-administer.

Photographic Evidence Obtained

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on observation, interview, and record review the facility failed to update the medication observation record (MOR) after medications were offered for 1 of 3 residents (Resident #8) observed during medication pass.

The findings include:

On at 12:20 pm, Employee B, an unlicensed Medication Technician (MT), was observed as she prepared medication for Resident #8. She prepared a dose of PRN (as needed) (a medication for pain) according to the provider's medication order. She documented on the electronic MOR that the had been given to the resident, and then afterward entered the resident's the medication. The resident self-administered the . At 12:30 pm Employee B confirmed that it is her practice to sign off a medication before giving it, so that she doesn't forget. She reported that she was unsure of the facility's policy and procedure on when to document provision of medication.

Review of the facility's policy and procedure, entitled Medication & Treatment - General Guidelines for Medication Administration/Assistance (CS-40-7) revealed that medications were to be documented on the MOR after they were provided to a resident. Page 2, item 25 read as follows: Documentation of medications administered/assisted, or treatments administered/assisted, should occur promptly after the resident has taken the medication.

An interview was conducted with the Health and Wellness Director (Director of Nursing) on at 1:45 pm. At this time she confirmed that facility policy was for staff to document on the MOR immediately after a medication had been provided to a resident.

Photographic Evidence Obtained

Class III