STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932514	11/08/2018
NAME OF PROVIDER OR SUPPLIER **THE BROOKSHIRE**	STREET ADDRESS, CITY, STATE, ZIP CODE **85 BULLDOG BLVD.** **MELBOURNE, FL 32901**	

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

0000 - Initial Comments

A Complaint investigation # 2018012376 was conducted on and . The Brookshire license # 7354 had deficiencies found at the time of the visit.

0008 - Admissions - Health Assessment - 429.26( ) FS; 58A-5.0181(2) FAC

Based on record review and interview the facility did not obtain a complete and accurate Resident Health Assessment form (AHCA form 1823) for 3 of 4 sampled residents (#1, 2 and 7).

Findings:

In an interview with residents #1 and 2 on at 10 AM, who both self -administered medications. Resident #1 stated she could not walk because of , , but used transfer sheet and had grab bars to hold on to assist with and toileting. She preferred to use the scoter rather than the wheelchair.

On at 11 AM the resident was observed to ambulate via scoter through the facility first floor and laundry room.

1. Resident record review for resident #1 revealed an admission date of . Health assessment report 1823 dated and listed diagnoses , , , , , and , , , , , . According to the health assessment her sensory/physical limitations indicated she was wheelchair bound. Page 2 of the health assessment did not address her needs regarding ambulation and again indicated wheelchair bound. That portion of the assessment was blank.

2. Resident record review for resident #2 revealed an admission date of . The

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observations and interviews the facility failed to ensure the unlicensed staff who assisted 2 of 2 medication passes (4 and 7) followed the correct procedure and did not read the prescription label out loud to the residents and signed the Medication Observation Record (MOR) before the residents took the medications.

Findings:

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Observations on at 1 PM resident # 4 resident went to staff to ask for medications. Staff A, a Certified Nursing Assistant (CNA) and "med tech" got water and 2 cups. She reviewed the MOR and signed for the . She retrieved the count book and signed it and wrote there were 18 pills available before she got the bubble pack. Asked why she knew there were 18 pills available without looking a bubble pack, she said she knew there were 18; she looked there before. She took an pill, put in cup and handed to resident, she observed him take the medication. She did not read the label out loud to the resident.

Observations on at 10 AM note staff A assisted resident # 7 in the following manner: got water for the resident, reviewed the MOR , put the pills in a cup (81 mg, 10 mg, myrbetrig ER 25, 100 mg, 50 mg , 40 mg, 400 mg 300 mg, 40 mg , 30 mg , 667 mg 2 caps and 5-325mg) and told the resident "This is your morning pills". She signed the MOR. She asked the resident if she wanted to check the bubble packs. The resident hesitated and said yes. The staff gave the cup with all the pills inside to the resident and observed her take the medications, she then secured the medications. She did not read the label out loud to the resident. The resident asked the staff if she was nervous because she was being watched; she replied no.

In an interview with the administrator on at 1 PM who said maybe the staff was nervous and that she had been trained the correct way.

Class III

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

Based on record review and interview, the facility failed to ensure the Medication Observation Record (MOR) was accurate and up-to-date for 1 of 4 sampled residents sampled. (#5).

Findings:

Resident #5 said in an interview on at 220 PM that she ran out of medications. She did not get her sleeping pill either. They told her they don't have it (sleeping pill) or the doctor has not ordered it. "You probably have to call him".

Health assessment report 1823 dated indicated the resident had short term memory loss and needed assistance with self-administration of medications. Order dated indicated

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(,) 5 mg at bedtime dispense #30 with 5 refills, discontinue (,) once arrived.

Observations on at 9:30 AM of the resident's medications revealed a refill dated for , 5 mg at bedtime; the original order dated was and 5 refill remained. Continued observations noted the handwritten MOR listed , 5 mg at bedtime and was blank. The controlled substance count sheet indicated 1 pill was given on , the bubble pack dated had a pill used at 10 PM on .

In an interview with the administrator on /1 at 10 AM, who offered no comment.

Class III

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

Based on observations, interviews and record review the facility failed to make every reasonable effort to ensure that prescriptions for 1 of 4 sampled residents (#5) who received assistance with self-administration of medication or medication administration were filled in a timely manner.

Findings:

Resident #5 said in an interview on at 220 PM that she ran out of medications. She did not get sleeping pill either. They told her they don't have it (sleeping pill) or the doctor has not order it. " You probably have to call him".

Review of the resident's medications on at 2:30 PM revealed the MOR listed , 30 mg at bedtime as needed for and was blank. In an interview with staff A, who said the medication was not in the cart, maybe the nurse had some in the overflow cabinet.

Health assessment report 1823 dated indicated the resident had short term memory loss and needed assistance with self-administration of medications.

Order dated indicated (,) 5 mg at bedtime dispense #30 with 5 refills, discontinue (,) once arrived.

Hospital discharge summary dated indicated , 30 mg at bed time as needed for . No prescription given.

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In an interview on at 3 PM with the nurse, who said after searching the overflow medications, that resident # 5 did not have or .

The director of nursing/administrator was made aware that resident #5 did not have sleeping medication. She contacted the Advanced Registered Nurse Practitioner (ARNP).

Phone interview with on at 3:30 PM who said she saw the resident on . She complained that she was not able to sleep and , . She discontinued and started on . A verbal order was given and order was send to pharmacy.

Observations on at 9:30 AM of the resident's medications revealed a refill dated for , 5 mg at bedtime; the original order dated was and 5 refill remained.

The facility became aware the resident did not have her medications after being informed by the Agency representative.

Class III