STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964787	05/20/2019
NAME OF PROVIDER OR SUPPLIER **BROOKDALE JENSEN BEACH**	STREET ADDRESS, CITY, STATE, ZIP CODE **1700 NE INDIAN RIVER DRIVE** **JENSEN BEACH, FL 34957**	

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

0000 - Initial Comments

A compliant investigation (#2019002204) survey was conducted on thru & at Brookdale Jensen Beach. The facility had deficiencies identified at the time of the survey.

The complaint investigation was conducted in conjunction with the Relicensure survey on the same date. See separate report for findings.

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

Based on record review and interview, the facility failed to ensure that all staff followed the appropriate procedure when assisting with self-administration of medication, which resulted in a medication error for 1 of 2 sampled staff (Staff A).

The Findings Included:

On at approximately 10:15AM, a interview was conducted with Staff A who revealed on at 05:09PM a medication error occurred while assisting Resident#1 with self administration of medications. Resident #1 was prescribed 50 mcg patch and was given 25 mcg patch that was prescribed to Resident#4. On at approximately 11:00AM, a interview was conducted with Resident#1 who was and aware of all of her medications, the dosage and the time to be given. Further review revealed Staff A did not remove the medication in its original package and read the label to the resident prior to putting the on. Staff A also did not immediately update Resident#1's MOR to reflect a medication error had occurred.

During an interview with the Administrator on at approximately 3:25 PM, she acknowledged the findings and provided no additional documentation for review.

Class III

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

Based on record review and interview, the facility failed to ensure that a record of a medication error was documented in the resident file for 1 of 4 sampled residents (Resident#1).

The Findings Included:

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	AL11964787	**05/20/2019**
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

On [redacted] at approximately 10:40AM a interview was conducted with Resident#1 and it was revealed that she was given the wrong medication dosage on [redacted]. Resident#1 is prescribed [redacted], 50 mcg, [redacted] patch to be applied every 48 hours for, [redacted]. On [redacted] at 5:09PM, Staff A assisted the resident with self administration of medications and applied a 25 mcg [redacted], patch that belonged to Resident#4. Review of Resident#1's electronic MOR dated [redacted] documents resident received 50 mcg [redacted], patch as prescribed, when she actually received the 25 mcg [redacted], patch belonging to Resident#4. The medicating error was not documented. Further review of the resident progress notes document Resident#1 received the wrong medication dosage. Review of Resident#1 [redacted] Count sheet has no documentation that Resident#1 received any [redacted], on [redacted], and the error was not documented. Review of Resident#4's [redacted] count sheet reveled documentation that a [redacted], 25 Mcg patch had been applied to the wrong resident. There was no documentation in the electronic MOR of the medication error.

During an interview with the Administrator on [redacted] at approximately 3:15PM, she acknowledged the findings and provided no additional documentation for review.

Class III