Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964946	A. BUILDING: _____ B. WING _____	11/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MELBOURNE	1765 WEST HIBISCUS BLVD MELBOURNE, FL 32901

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A 000	Initial Comments A Relicensure survey, a Generator Monitoring and Complaint Investigation #2022013115 were conducted on . Brookdale Melbourne Assisted Living Facility & Memory Care with Limited Nursing Services (LNS) facility had deficiencies at the time of the visit.	A 000		
A 010 SS=D	429.26(.) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident,	A 010		

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A 010	Continued From page 1 additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the	A 010		

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A 010	Continued From page 2 applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's	A 010		

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A 010	Continued From page 3 record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities	A 010		

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A 010	Continued From page 4 holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on interview and record reviews, the facility failed to ensure 1 of 5 sampled residents had a coordinated plan of care which delineated how the facility and the hospice would meet the scheduled and unscheduled needs of the resident (#7). Findings: Resident #7's record revealed a facility admission date of . . . . Hospice documentation indicated the resident was admitted to services on . The resident's record did not contain a plan of care which delineated how the facility and the hospice would meet the scheduled and unscheduled needs of the resident, as required. On . . . at 12:40 PM, the director of nursing said there was no coordinated plan of care between the facility and hospice. Class III	A 010		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or . . . , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the	A 025		

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A 025	Continued From page 5 acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making . , , . for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.	A 025		

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A 025	Continued From page 6 (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on interview and record reviews, the facility failed to provide adequate supervision and provide care and services appropriate to meet the needs of residents by failing to ensure safety through proactive measures to minimize the potential for and injuries for 3 of 5 sampled residents who experienced with injuries (#1 & #7). Findings: 1. Resident #7's record revealed a facility admission date of . An admission 1823 health assessment form, dated , indicated the resident was at risk for . A current 1823, dated , indicated the resident's diagnosis was with behaviors, that she was "Alert & Oriented x 1 only", was at risk for and required assistance with all activities of daily living, ambulation and transferring. The facility's " Management" policy, last revised , defined a as unintentionally coming to rest on the ground, floor, or other lower level either witnessed or unwitnessed, with or without injury. The policy indicated that a post evaluation is completed after a resident's and individualized interventions are considered. The resident's record revealed the following documentation:	A 025		

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A 025	Continued From page 7 On . . . . . at 10:22 AM, the previous night's staff reported that the resident had a in the bathroom. The resident stated she was going to the bathroom, did not make it in time, on the floor, then slipped in the . . . . The resident had no complaints of , , and no injuries were noted. The intervention on the post evaluation was "educated on calling for assistance when needed". On . . . . . at 8:34 PM, staff was trying to redirect the resident to her room when she entered another resident's room, tripped over a doorstop, then . She sustained a on her left arm and complained of . . . . . was given. The intervention on the post evaluation was "redirection and reminders that resident should not be going into other resident's room". On at 8:30 AM, the resident was in bed and complained of excruciating lower . . . , pointed to her lower left lateral side, attempted to sit up, then began screaming. She complained of , had dry heaves and . 911 was called and she was transported to the hospital. On at 6 PM, the resident returned from the hospital. She was alert and complained of , with transfers. A large purple was seen on her right middle . . On . . . . . at 1:31 PM, the resident was seen by a health care provider due to complaints of . . . . . was ordered. On . . . . . at 6 PM, a caregiver saw the resident get up from the wheelchair without assistance, loose her balance, then to the ground. No apparent injuries were noted. The post	A 025		

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A 025	Continued From page 8 evaluation did not have interventions. On . . . . . , the resident was admitted to hospice services. On at 6:45 PM, the resident was observed sitting on the floor in the dining room in front of a wheelchair. She was unable to tell staff what happened. The interventions on the post . evaluation were "bedside mat, bedside commode, hospice referral". On . . . . . at 10:12 AM, the resident was observed sitting on the floor in the dining room, she wore non-skid socks and was unable to remember what happened. She denied having , . . . A post . evaluation was not provided by the DON. On at 6:18 PM, the resident had a in the dining room while walking. A certified nurse's aide (CNA) was nearby and grabbed the resident, breaking her . . The resident hit her left . . on a dining room table then landed on her . Redness was noted to her . . . She denied having , . . The post evaluation did not have interventions. On . . . . . at 7:39 PM, the resident had a . . She was alert and able to make her needs known, she complained of , . . to her left ring and little ⌄ and . ⌄ and ⌄ were noted. A post . evaluation was not provided by the Director of Nursing (DON). On at 1:23 PM, another resident alerted staff that this resident had . . . in the dining room. The resident was then observed by staff sitting on her . . . . on the floor. No apparent injuries were noted. The post evaluation did	A 025		

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A 025	Continued From page 9 not have interventions. On . . . . . at 1 AM, staff observed the resident sitting on the floor near her bathroom door with socks on her . . . She was unable to verbalize what happened. was seen on her forehead. 911 was called, she was transported to the hospital, then returned that same morning. Hospital discharge instructions indicated she was seen for a minor closed injury and superficial . . . . . on her forehead following a . The intervention on the post evaluation was "awaiting new orders for possible floor mats". On at 2:37 PM, the resident was observed sitting on the floor in her apartment on the previous evening at approximately 9 PM. She sustained a on her left . The post evaluation did not have interventions. On at 2:07 PM, caregiver F said to prevent resident #7 from falling, she helped the resident walk with a walker, which she said the resident did not always use. The caregiver then said, "before you turn your , she's walking . . . we do the best job we can" with her. On . . . . . at 2:09 PM, caregiver A said regarding resident #7, "If I see her walking, I grab her . . . and encourage her to walk a little bit. If she's unsteady, I get her to sit down." On at 2:10 PM, caregiver G said, "I keep her within sight. I assist her with walking. I encourage her to sit down if she's unsteady." 2. Resident #1's record revealed she was admitted on . . . . . Her record contained a Resident Health Assessment form (1823) dated	A 025		

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A 025	Continued From page 10 . . . . . Her diagnoses included . . . . . , , , , , and . . . . . She required assistance with all activities of daily living, and supervision with eating. A review of facility reports revealed an unwitnessed on at 7:15 AM. The report was signed by the and documents the facility will continue 2 hr. checks. On at 7:45am a facility note documents resident was found on the floor in the hallway. The residents husband transported her to urgent care to be evaluated. She was diagnosed with a left . The incident report was signed by the DON. The area for service plan interventions contained no documentation. Review of facility reports revealed a on . . . . . at 7:15 AM. Resident #1 was found on the floor with to her left arm and . The report was signed by the DON. The area for service plan interventions contained no documentation. Review of a facility report signed by the DON revealed a on at 6:45 PM. The report reflected no apparent injuries, and the LPN will follow up. The area for service plan interventions contained no documentation. Review of a facility report dated . . . . . revealed resident #1 was found on the floor at approximately 6:45 PM. No injury was reported. The report was signed by the DON and contained no service plan interventions. On facility notes revealed a with no injuries at 5 AM. The report reflected that the	A 025		

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A 025	Continued From page 11 licensed practical nurse (LPN) will follow up. The report was signed by the DON and the area for service plan interventions contained no documentation. On , facility notes revealed another with no apparent injuries at 6:50 AM. The report revealed that the LPN will follow up. The report was signed by the DON and the area for service plan interventions contained no documentation. Review of a facility report revealed a on ..... at 3:50 AM. Resident #1 was lying on the floor next to her recliner and noted to have tremors. The incident report was signed by the DON and the area for service plan interventions contained no documentation. The facility note on ..... at 4 PM indicated the resident had activity and had a while being assisted to bed. She was transferred to the hospital for new onset of . On at 11:45 AM, Staff A said on in the morning at about 7:30 or 7:45 AM, she observed resident #1 on the floor in the hallway. She said resident #1 was sitting in the middle of the hallway with her sneakers on. The Health and Wellness Director (HWD) called resident #1's husband who came right away to assist her off the floor. She was refusing to let the staff assist her. Staff A said she sat on the floor with resident #1 until her husband arrived. He assisted her off the floor and transported her to an urgent care center because she was complaining of .. , . On at 3:05 PM, the DON confirmed there were no interventions added to resident #1 personal service plan after the because she	A 025		

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A 025	Continued From page 12 did not know she had to do that. She says she now knows how to add that information to the resident's personal service plan.	A 025		
A 052 SS=D	429.256(.); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an . . , . that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives	A 052		

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A 052	Continued From page 13 assistance with self-administration under this section. (g) Assisting with the use of a [illegible], including removing the cap of a [illegible], opening the unit dose of [illegible] solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the [illegible]. (4) Assistance with self-administration of medication does not include: (a) Mixing, [illegible], converting, or [illegible] medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a [illegible] of the body. (d) Administration of [illegible] preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with [illegible], or [illegible] preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of	A 052		

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	AL11964946	A. BUILDING: _____ B. WING _____	11/29/2022

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A 052	Continued From page 14 medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as	A 052		

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A 052	Continued From page 15 prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interview, the facility failed to ensure the unlicensed staff who assisted 1 of 1 sampled resident with medications followed the correct procedures (#15). Findings: Observations made during a medication pass for	A 052		

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A 052	Continued From page 16 resident #15 on . . . . . at 2 PM revealed medication technician (med tech) F washed her . . . . then unlocked the medication cart. She removed a single bubble package then, while standing at the cart, popped one tablet into a cup. She placed the bubble pack into the cart then locked it. She took the cup to the resident in her room then identified the resident by name. She said the name of the medication aloud then handed the cup to the resident, who took the pill without help. The med tech returned to the cart then signed the medication observation record. The med tech did not take the bubble pack to the resident's room and pop the pill out in the resident's presence, as required. Immediately following the med pass, the med tech confirmed the finding. Class III	A 052		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings:	A 152		

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A 152	Continued From page 17 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable _ to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, . . . or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation, facility documentation and interview, the facility failed to provide a safe living environment and ensure that all existing architectural and structural systems were maintained in good working order. Findings: Observation on . . . . . at 10:37 AM found: in - a white plastic taped off around the wall area near the window. in . . - the blinds were broken and the wall area near the window was taped up with white plastic covering. Photographic evidence was obtained.	A 152		

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A 152	Continued From page 18 On . . . . . at 10:38 AM, an interview with the resident who resides in stated that this had been like this since Hurricane Ian. She said they told her that there was some water damage causing moisture in the walls and "way . . . in , the facility told her that it would only take 3 days for her wall to be repaired". The resident said now it is almost and still with this white plastic on the wall not fixed. She said no one had updated her of when it was going to be fixed. She allowed a picture to be taken of the wall. On at 10:46 AM, an interview with the resident who resides in . . . . stated the white plastic has been on her walls taped up since she moved in . . . . She allowed me to take a picture and her broken window blinds which caused the blinds to always stay up and provide no privacy. On at 11:30 AM, the Maintenance Director confirmed the findings. The Maintenance Director was asked to provide documentation of the construction contract for remediation with repairs. He said he did not have any documentation for the repair's completion date and that the construction company who was to repair originally was fired. They told the residents that all the walls would be repaired in three days. The Maintenance Director provided a map of all the rooms with wall water damages. He said there were about 40 rooms damaged and needed repair in total. Photographic evidence was obtained. On . . . . . at 3:55 PM, the Administrator confirmed the findings. She said that she had notified all the residents' family by text about the wall water damages but she did not send out a	A 152		

Agency for Health Care Administration

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A 152	Continued From page 19 formal letter. Class III	A 152		