RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2015

Administrator
Brookdale Hunter's Crossing
4607 NW 53rd Avenue
Gainesville, FL 32606

RE: CCR #2015000292

Dear Administrator:

This letter reports the findings of a complaint licensure survey that was conducted on 2015 by a representative of this office.

Enclosed is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after **2015** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call this office at (386) 462-6201.

Sincerely,

Kristie J. Mennella
Field Office Manager

KJM/amw
Enclosure

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965013	**04/06/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
BROOKDALE HUNTER'S CROSSING	**4607 NW 53RD AVENUE GAINESVILLE, FL 32606**	

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

0000 - Initial Comments

On , an unannounced complaint survey CCR #2015000292 was conducted at Brookdale Hunter's Crossing Assisted Living Facility in Gainesville Florida. Deficient practice was identified as a result of this survey. The facility was not in compliance at this time.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on interviews, record reviews and observations the facility failed to ensure 1 of 6 sampled residents was appropriate for continued residency (Resident #3).\

Findings:

On at approximately 12:13 PM an interview was conducted with Licensed Practical Nurse (LPN) D. During the interview she was asked if there were any residents that have had a significant change in condition. She stated that Resident #3 was an inappropriate resident because she is a total lift. D stated that Resident #3 is not on hospice and she has to be in a reclining wheelchair because she cannot sit up straight.

On at approximately 1:05 PM an interview was conducted with direct care staff E in reference to resident #3. Staff E stated she provides activities of daily living (ADLs) for resident #3. She said resident #3 cannot get out of bed by herself, she cannot stand, and she is a total lift. Staff E stated resident #3 does not assist in any way when she is transferred. She said she was fed in her because she needs a reclining wheelchair and does not have one.

On a record review was conducted on resident #3 health assessment (AHCA form 1823) dated The assessment revealed on page 1, resident #3's or behavioral status was documented as "total." On page 2, the ADLs were documented as, "0 ambulation" The resident required total care for bathing, dressing, eating, self care Toileting was documented as, Transferring was documented as, total lift. Missing from page 4 section B, was the information that the resident does or does not needs help taking her medications.

On a record review of resident log for resident #3 was conducted. It was observed on at 9:30 AM facility LPN writes "Nurse went in assist with x 2 assisted transfer for breakfast. was unable to bare any weight. is absolutely unsafe for transferring. straightens back and hips while in w/c and almost slid out of w/c".

On at approximately 2:30 PM an observation was made of resident #3 being transferred from her bed to her wheelchair, by two facility staff members. Staff were observed sitting the resident up in bed by using the electric bed to position her in the sitting position. Staff then placed a two handle gate-belt around the resident, while the resident held on to the staffs arm with her right hand to keep herself in the sitting position. Once staff secured the gate-belt onto the resident, they moved the residents wheelchair next to the bed. The two staff members grabbed

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the resident by the gate-belt and conducted a total lift from the bed to the wheelchair. It was observed that the resident did not bare any weight or assist in the transfer to the wheelchair.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on record reviews and interviews the facility failed to maintain documentation of activities of daily living (ADL) training documentation for 3 of 4 direct care staff reviewed (A B and D).

Findings:

On a record review was completed on facility direct care staff members staff A, B and C. Staff A's date of hire was documented as Staff B's date of hire was documented as and Staff C's date of hire was documented as The review revealed staff A, B, and D were not certified nursing assistants. It was also observed that there was no ADL behavior needs training documentation for staff A, B , D in their training records.

On at approximately 1:05 PM an interview was conducted with direct care staff B. During the interview she stated she was not sure if she ADL behavior needs training.

On at approximately 3:30 PM the Director of Nursing was asked if she was able to locate the ADL behavior needs training for employees A, B, and D. She stated the human resource person cannot locate the training certificates, but the staff have the training in their foundations training.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview, the facility failed to ensure the most current health assessment (AHCA Form 1823) was included in the resident record for 1 of 3 resident records reviewed (resident #4).

Findings:

On at approximately 2:40 PM an interview was conducted with the wife of resident #4. During the interview she stated that her husband resident has had a significant change in condition since moving to the facility back in 2014. She stated that her husband was placed on hospice services in early 2015 so he could get more care and services do to his decline in condition.

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On a record review was conducted on resident #4. It was observed his current 1823 health health assessment was dated

On at approximately 2:52 PM an interview was conducted with the facility Director of Nursing in reference to resident #4. She stated that resident #4 was placed on hospice She said he does not have a current health assessment which reflects that because she hasn't gotten to it yet.

On at approximately 3:30 PM an interview was conducted with the facility DON regarding resident #4. She stated every time a resident is sent out to the hospital she does not except them back without an updated 1823 health assessment. She said she cannot locate resident #4 most current health assessment and the one dated is the only one in the residents file.

Class III